Friday the 13th HRA Guidance Is Not all Horrifying

By Rich Glass, Esq.

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For the superstitious, Friday the 13th conjures up a day of bad omens and disastrous occurrences. For people who work with health reimbursement arrangements and premium reimbursement arrangements, the ominous trend continued on Friday, Sept. 13, 2013.

On that day IRS issued Notice 2013-54 and the U.S. Department of Labor’s Employee Benefits Security Administration issued Technical Release 2013-03, a mirror image of the IRS notice. For simplicity, let’s refer to the notice and technical release collectively as the Guidance. The Guidance was a follow-up to Patient Protection and Affordable Care Act Implementation Part XI, which EBSA issued on Jan. 24, 2013. The Guidance answered 12 questions relating to PPACA rules on annual limits (Section 2711 of the Public Health Service Act) and preventive services (Section 2713 of the PHSA). (It should be noted that the preventive services rules do not apply to grandfathered plans). And yet a common response after reading the Guidance is to ask at least four follow-up questions:

- What types of arrangements are prohibited?
- What types of arrangements are permitted?
- When does all of this take effect?
- What are the penalties for a prohibited arrangement?

What Types of Arrangements Are Prohibited?

The Guidance spreads out a wide net. It covers not only HRAs but also health flexible spending accounts and the newly coined “Employer Payment Plans.” An EPP includes any arrangement in which the employer reimburses the cost of premiums for coverage not sponsored by the employer. Some call these PRAs. Others look to their status as a qualified benefit under Code Section 125, specifically 26 C.F.R. §1.125-1(a)(3)(B) and Treas. Reg. §1.125-1(m). An EPP does not include an after-tax, employer-sponsored arrangement where amounts are paid for other health care coverage. One wonders how viable an after-tax, employer-sponsored arrangement is.

The bottom line on each of these (HRAs, health FSAs and EPPs) is they must be a HIPAA-excepted benefit or integrated with a medical plan that complies with the prohibition on annual limits and the cost-sharing requirements for preventive services.

IRS and EBSA clarified that an HRA, PRA or other type of pre-tax Employer Payment Plan, designed to reimburse individual insurance premiums, is not integrated with that coverage, even if the individual coverage complies with PPACA rules. Likewise, even though the Guidance never mentions stand-alone HRAs specifically, it is clear that these popular benefits will no longer be allowed, unless they cover HIPAA-excepted benefits only (for example, dental, vision). This spells the end...
for PRAs, cafeteria plan individual insurance reimbursements, direct employer individual insurance reimbursements and stand-alone HRAs that were implemented to comply with the mandates in the San Francisco Health Care Security Ordinance.

Those with an HCSO HRA will have some difficult choices, starting in 2014. They will need to find some alternative for satisfying the health care expenditure mandate. The HCSO regulations provide other compliance methods:

- payment of health insurance premiums;
- establishment of a self-funded and/or self-insured program;
- contributions to a health savings account (which would require employees to have high-deductible health plan coverage);
- direct reimbursement of expenses incurred in the purchase of health care services;
- direct reimbursement of costs incurred in the direct delivery of health care services; and
- payment to the city of San Francisco to fund the Health San Francisco program.

The HCSO requires that HRA contributions remain available for a minimum of 24 months. This, in turn, means that when the HCSO HRA has made its last contribution, the HRA technically must remain in effect for 24 months to allow participants to spend down the balance. The January 2013 FAQ appears to approve this spend-down approach for HRAs that were in effect on Jan. 1, 2013.

When the proposed regulations for annual limits were issued in June 2010, the departments (Treasury, Health and Human Services and DOL) created an exception from the annual limits prohibition for any “health flexible spending arrangement (as defined in section 106(c)(2)).” Most HRAs qualify as an FSA under Code Section 106(c)(2), so a reasonable argument existed that they were exempt from the annual limits prohibition. Q/A-8 in the Sept. 13 Guidance eliminates that argument, stating: “The Departments intended for this exemption from the annual dollar limit prohibition to apply only to a health FSA that is offered through a Code §125 plan.” And, of course, a health FSA under a cafeteria plan is prohibited from reimbursing insurance premiums.

Keep in mind that not all health FSAs are HIPAA-excepted benefits. As Q/A-7 of the Guidance points out, a HIPAA-excepted health FSA must meet these two conditions:

- the employer makes available GHP coverage that is not HIPAA-excepted; and
- the maximum benefit cannot exceed two times the salary reduction or, if greater, cannot exceed $500 plus the salary reduction.

For other HRA plan designs that are prohibited, see Table 1 on page 4.

**What Types of Arrangements Are Permitted?**

Let’s look at the two categories of arrangements that remain permissible: HIPAA-excepted HRAs and integrated HRAs.

First, HIPAA-excepted benefits include retiree-only plans, limited scope dental/vision plans, and plans that cover cancer, hospital indemnity, accident and disability. Thus, an HRA that covers only HIPAA-excepted benefits is permissible, even though it may not be all that viable. Retiree-only HRAs are permissible, even if they pay for individual insurance premiums. More large employers are moving to a retiree-only HRA model as they seek to control retiree medical costs.

Second, an HRA must pass one of two integration tests to be considered integrated with another non-HRA group health plan (for instance, a major medical plan).

See HRA Guidance, p. 6
<table>
<thead>
<tr>
<th>Plan Description</th>
<th>Reasons HRA Is NOT Permissible</th>
<th>Legal Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stand-alone HRA</td>
<td>• This HRA is the only medical plan offered by the employer&lt;br&gt;• This HRA is subject to the annual/lifetime limit and preventive services rules in PPACA; thus, a stand-alone HRA with a funding limit violates PPACA&lt;br&gt;• This prohibition includes stand-alone HRAs under the San Francisco HCSO</td>
<td>• Technical Release 2013-03&lt;br&gt;• IRS Notice 2013-54&lt;br&gt;• FAQs about ACA Implementation Part XI&lt;br&gt;• San Francisco HCSO&lt;br&gt;• San Francisco HCSO Regulations</td>
</tr>
<tr>
<td>Individual insurance premium HRA for employees</td>
<td>• This HRA is subject to the annual/lifetime limit and preventive services rules in PPACA and is not considered to be integrated with the individual insurance it pays for&lt;br&gt;• Some states already prohibit this practice, like Texas</td>
<td>• Technical Release 2013-03&lt;br&gt;• IRS Notice 2013-54&lt;br&gt;• FAQs about ACA Implementation Part XI&lt;br&gt;• IRS Notice 2002-45&lt;br&gt;• Texas Department of Insurance Commissioner’s Bulletin #B-0028-06</td>
</tr>
<tr>
<td>Self-employed individuals/owners HRA</td>
<td>• Self-employed individuals are not eligible to participate in an HRA&lt;br&gt;• Self-employed individuals include a 2 percent or more S-Corp shareholder, a sole proprietor, a partner in a partnership and a non-employee director&lt;br&gt;• Although there is no formal guidance addressing LLC owners, they are typically viewed as partners for this purpose and are also not eligible</td>
<td>• IRS Notice 2002-45&lt;br&gt;• IRS Revenue Ruling 2002-41</td>
</tr>
<tr>
<td>HRA funding based on age</td>
<td>An HRA cannot vary the funding levels based on an employee’s age</td>
<td>Treas. Reg. §1.105-11(c)(3)(i)</td>
</tr>
<tr>
<td>HRA funding based on salary</td>
<td>An HRA cannot vary the funding levels based on an employee’s compensation (that is, salary)</td>
<td>Treas. Reg. §1.105-11(c)(3)(i)</td>
</tr>
<tr>
<td>HRA funding based on years of service</td>
<td>An HRA cannot vary the funding levels based on an employee’s years of service</td>
<td>Treas. Reg. §1.105-11(c)(3)(i)</td>
</tr>
<tr>
<td>HRA funding based on cafeteria plan benefits</td>
<td>An HRA cannot be tied to a cafeteria plan:&lt;br&gt;• An HRA cannot be funded by employee pre-tax contributions&lt;br&gt;• An HRA cannot be offered as a choice among several cafeteria plan qualified benefits&lt;br&gt;• There cannot be a correlation between the HRA funding and the selection of cafeteria plan qualified benefits</td>
<td>IRS Notice 2002-45</td>
</tr>
<tr>
<td>HRA with disparate waiting periods</td>
<td>An HRA cannot vary waiting periods between highly compensated individuals and non-highly compensated individuals</td>
<td>Treas. Reg. §1.105-11(c)(3)(ii)</td>
</tr>
<tr>
<td>HRA balance tied to bonus or severance amount</td>
<td>An employer cannot base a bonus or severance at the end of employment on the HRA balance</td>
<td>IRS Notice 2002-45</td>
</tr>
<tr>
<td>Medicare-related HRA</td>
<td>• An HRA cannot reimburse Medicare Parts B, C and/or D premiums and Medicare supplemental policies (that is, Medigap) for current employees&lt;br&gt;• This is considered a prohibited incentive to elect Medicare instead of major medical plan coverage and violates the Medicare Secondary Payer Rules</td>
<td>42 U.S.C. §1395y(b)(3)(C)</td>
</tr>
</tbody>
</table>

42 U.S.C. §1395y(b)(3)(C)
### Table 2
Permitted HRA Plan Designs

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>Reasons HRA Is Permissible</th>
<th>Legal Authority</th>
</tr>
</thead>
</table>
| Integrated HRA   | • Bundled with a major medical plan, including a high-deductible health plan (fully insured or self-insured)  
• Must be enrolled in the major medical to receive the HRA benefit  
• HRA reimbursement can be limited to a category of expenses or be open-ended, if the major medical plan provides minimum value  
• HRA funding amounts can vary by coverage level (for example, self-only, family, other tiers)  
• HRA may be integrated with a spouse’s major medical plan  
• HRA must meet one of the two integration tests in Technical Release 2013-03 and IRS Notice 2013-54 | • Technical Release 2013-03  
• IRS Notice 2013-54  
• Patient’s Bill of Rights (IFR), §549815—2711T Page 37223 |
| Retiree-only HRA | • Employer controls costs of retiree medical coverage by funding a fixed amount each year for retirees  
• A retiree-only HRA is a HIPAA-excepted benefit and is not subject to HIPAA portability and many provisions under PPACA | • Technical Release 2013-03  
• IRS Notice 2013-54  
• IRS Notice 2002-45 |
| Stand-alone limited-scope HRA | • This HRA only pays for dental and vision expenses  
• This is a HIPAA-excepted benefit  
• This HRA is compatible with a Health Savings Account | • Technical Release 2013-03  
• IRS Notice 2013-54  
• IRS Notice 2005-86  
• IRS Revenue Ruling 2004-45 |
| Integrated post-deductible HRA | • This HRA only pays for medical care expenses once the statutory minimum deductible has been satisfied  
• This HRA is compatible with an HSA  
• HRA must meet one of the two integration tests in Technical Release 2013-03 and Notice 2013-54 | • Technical Release 2013-03  
• IRS Notice 2013-54  
• IRS Notice 2005-86  
• IRS Revenue Ruling 2004-45 |
| Combined & integrated limited-scope/post-deductible HRA | • This HRA combines the features of a limited-purpose HRA and a post-deductible HRA  
• This HRA is compatible with an HSA  
• HRA must meet one of the two integration tests in Technical Release 2013-03 and IRS Notice 2013-54 | • Technical Release 2013-03  
• IRS Notice 2013-54  
• IRS Notice 2005-86  
• IRS Revenue Ruling 2004-45 |
| Integrated HRA with or without a carryover | • Employers have the option of providing a full carryover of the HRA balance to the next plan year, a capped carryover or no carryover at all  
• HRA must meet one of the two integration tests in Technical Release 2013-03 and IRS Notice 2013-54 | • Technical Release 2013-03  
• IRS Notice 2013-54  
• IRS Notice 2002-45 |
| Integrated HRA with or without a spend-down | • This HRA allows participants to spend down the HRA balance after eligibility ends (for example, job termination)  
• COBRA must be offered  
• HRA must meet one of the two integration tests in Technical Release 2013-03 and Notice 2013-54 | • Technical Release 2013-03  
• IRS Notice 2013-54  
• IRS Notice 2002-45 |
| Integrated HRA with vacation/PTO/sick leave rollover | • This HRA allows terminating or retiring employees to contribute accrued but unused vacation, PTO and/or sick pay amounts to the HRA  
• An employer cannot allow the employee to take a portion in cash  
• There can be no cashout of the HRA upon death of employee/ex-employee/retiree  
• This rollover right must be applied uniformly  
• HRA must meet one of the two integration tests in Technical Release 2013-03 and IRS Notice 2013-54 | • Technical Release 2013-03  
• IRS Notice 2013-54  
• IRS Revenue Ruling 2005-24 |
| Spend-down-only of stand-alone San Francisco Health Care Security Ordinance HRA | • An employer may no longer contribute to a stand-alone San Francisco HRA  
• The HCSO requires balances to be available for at least 24 months so the employer could continue to offer the HRA as a spend-down only benefit | • Technical Release 2013-03  
• IRS Notice 2013-54  
• FAQs about ACA Implementation Part XI  
• San Francisco HCSO  
• San Francisco HCSO Regulations |
This plan must be sponsored by the employer or the employer of the employee’s spouse. Here are the five criteria for each test:

<table>
<thead>
<tr>
<th>Limited Reimbursement HRA Design (Minimum Value Not Required)</th>
<th>Open-ended HRA Design (Minimum Value Required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>GHP.</strong> A non-HRA group health plan exists, offering more than HIPAA-excepted benefits.</td>
<td>1. <strong>MV.</strong> A non-HRA GHP exists, providing MV.</td>
</tr>
<tr>
<td>2. <strong>Actual Enrollment.</strong> Employee is actually enrolled in non-HRA GHP.</td>
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</tr>
<tr>
<td>3. <strong>Availability.</strong> HRA is available only if covered in non-HRA GHP.</td>
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</tr>
<tr>
<td>4. <strong>Limited Reimbursement.</strong> HRA reimburses only: Copayments &amp; coinsurance • Deductibles • Premiums under the non-HRA GHP • Medical care expenses that are NOT essential health benefits</td>
<td>4. <strong>Open-Ended Reimbursement.</strong> HRA may reimburse any medical care expenses under §213(d) of the Internal Revenue Code.</td>
</tr>
<tr>
<td>5. <strong>Opt-Out.</strong> Employee has option to opt out of and waive reimbursements annually and upon termination of employment.</td>
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</tr>
</tbody>
</table>

What if the non-HRA GHP does not cover one or more essential health benefits (for example, prescription drugs)? Q&A-6 of the Guidance addresses this point. First, small group market insurance must cover all essential health benefits starting in 2014. Second, if the non-HRA GHP is either self-insured or large group market insurance, the HRA is still considered to be integrated as long as the HRA covers the essential health benefit not covered by the non-HRA GHP.

The Guidance also indicated that employee assistance programs can be considered HIPAA-excepted benefits through the end of 2014 as long as employers make a reasonable, good faith determination that the EAP does not provide significant medical care or treatment benefits.

For other HRA plan designs that are permitted, see Table 2 on page 5.

**When Does all of this Take Effect?**

This is not entirely clear.

As of this writing, it appears that a stand-alone HRA that was in effect before Sept. 13, 2013, can continue until the end of the current plan year. Q&A-8 seems to indicate that any new HRAs created on or after Sept. 13, 2013, will be out of compliance. FAQ Part XI permits HRAs that were in effect on Jan. 1, 2013, to continue contributions through the end of 2013 and allow participants to spend down their balances once the HRA no longer can accept contributions.

**What Are the Penalties for a Prohibited Arrangement?**

If an HRA violates the Code Section 105 nondiscrimination rules, the penalty is that reimbursements made to highly compensated employees are considered taxable. For violations of PPACA rules on annual limits and preventive services, the penalty is more severe: payment of a daily excise tax equal to $100 per participant. Let’s connect the dots:

- The excise tax applies to violations under 26 U.S.C. §9815, per page 1 of the Form 8928 instructions (Form 8928 is used to report excise taxes).
- Section 9815 states that all of the market reforms in Part A of Title XXVII of PHSA as amended by PPACA apply to GHPs.
- Part A of Title XXVII of PHSA was amended by PPACA in two places (Sections 1001 and 1201). Here are two of the market reforms listed in Section 1001 of PPACA:
  - no lifetime or annual limits (Section 2711); and
  - preventive health services (Section 2713)

What does all of this mean? Simply, HRAs are still viable. They simply cannot go it alone, except in limited circumstances. They need a little help from their friends (for example, a non-HRA group health plan).

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