Labor and Employment Alert: New Do's and Don'ts for Cafeteria Plans, FSAs and HRAs

Related Attorneys

Anthony C. Ciriaco

Jennifer Bibart Dunsizer

Jolie N. Havens

Related Services

Employee Benefits and Executive Compensation

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Summary: The IRS and DOL issued new guidance (IRS Notice 2013-54 and DOL Technical Release 2013-03) on September 13, 2013, prohibiting the application of pre-tax funds to the payment of individual health insurance premiums and imposing new conditions on health flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs). Most significantly, health FSAs can be offered only to employees who are eligible for a medical plan and HRAs can only be made available to employees who are enrolled in a medical plan.

No pre-tax funds may be applied to the purchase of individual health insurance policies

Although not common in large employers, some small employers have arrangements that reimburse employees – on a non-taxable basis – for all or a portion of employees' premiums for individual health insurance policies. The compliance of that sort of arrangement has been questioned over the years but now the IRS has come out with a clear prohibition.

Effective January 1, 2014, an employer will not be permitted to pay for its employees' individual health insurance policies on a non-taxable basis. In addition, employees' pre-tax salary reduction contributions can't be applied to the purchase of employees' individual health insurance policies. These prohibitions apply regardless of whether the individual health insurance policies are purchased through the new public Marketplaces (also known as Exchanges) or outside the Marketplaces.

The IRS views such arrangements as violating Affordable Care Act mandates (specifically, the prohibition on annual dollar limits on essential health benefits and, for non-grandfathered plans, the requirement to provide first dollar coverage of preventive services). That sort of violation is subject to an excise tax of $100 per day per affected individual under Code §4980D.

After-tax voluntary employee-pay-all arrangements are still permissible. An employer can still deduct amounts from pay (on an after-tax basis) for the payment of premiums on employees' individual health insurance policies, provided the employer does not promote or endorse the policies and limits its involvement to the payroll and remittance functions.

Health FSAs can only be offered to employees who are *eligible* for medical coverage

Effective January 1, 2014, you can only offer health FSAs to those employees who are also eligible for your medical plan. It is okay if an employee chooses to enroll in your health FSA and not your medical plan as long as he or she could have enrolled in your medical plan. Dependent care FSAs are not impacted.

> *Note:* Do you (as an employer) make contributions to employees' health FSAs? If an employer contributes more than $500 to an employee's health FSA (i.e., employer contributions in excess of the employee's salary reduction contributions), the employer contributions to the health FSA may be regulated as an HRA. Read on for HRA rules.

HRAs can only be offered to employees who are *enrolled* in medical coverage

The rules for HRAs are even more restrictive. You can make new credits available to an employee's HRA only during periods that the HRA is integrated with a medical plan. In order for an HRA to be integrated with a medical plan:

1. *An employee must be enrolled in a medical plan when new credits become available*.

You may only offer an HRA to those employees who are: (a) eligible for your medical plan; and (b) enrolled in either your medical plan or a medical plan sponsored by another employer (e.g., the employer of the employee's spouse).

2. *The medical plan must provide minimum value or, if the medical plan does not provide minimum value, the HRA must limit reimbursements to specified items*.

Confirm that your medical plan provides minimum value (and if the employee is enrolled in another employer's medical plan, that plan also provides minimum value). "Minimum value" means that the plan is expected to pay, on average, at least 60% of covered medical expenses for a standard population. Your 2014 Summary of Benefits and Coverage should include a statement as to whether your medical plan does or does not provide minimum value.

Most employer-sponsored medical plans (including HSA-compatible high deductible health plans) provide minimum value. However, if your medical plan (or, if the employee is enrolled in another employer's medical plan, that medical plan) does not provide minimum value, there is another path to integration: in order for an HRA to be treated as integrated with a medical plan that does not provide minimum value, HRA reimbursements have to be limited to co-payments, co-insurance, deductibles; and *non*-essential health benefits.

3. *The employee has to be given the option to waive HRA credits*.

Check whether HRA credits are forfeited when medical coverage ends. If not, the HRA program will need to give employees opportunities to waive HRA credits once medical coverage ends and at least

annually thereafter. Why would an employee want to waive HRA credits? Because the IRS is taking the position that access to even the smallest HRA credit balance is a type of minimum essential coverage (MEC) – and when an individual has MEC, he or she is blocked from getting premium assistance for the purchase of health insurance through the Marketplace. So, the employee would have to waive his or her HRA credit balance in order to buy subsidized health insurance through the Marketplace.

Stand-alone retiree HRAs are okay (but block retirees' access to premium assistance)

Retiree-only health plans are classified as so-called excepted benefits. As an excepted benefit, a retiree-only HRA is exempt from most ACA mandates. Because of this exemption, an employer can offer a retiree-only HRA even if it is not also offering a medical plan to its retirees. But the IRS still considers that retiree-only HRA to be MEC. Therefore, a retiree with access to an HRA would be blocked from getting premium assistance for the purchase of health insurance through the Marketplace. Unlike HRAs for active employees, you are not required to offer retirees opportunities to waive the HRA credit balance – but of course you may want to offer waiver opportunities. Some retirees may want to waive their HRA credit balances in order to buy subsidized health insurance through the Marketplace.

EAPs are not a problem

The IRS has come to the common sense conclusion that an employee assistance plan (EAP) with limited medical benefits is not subject to Affordable Care Act regulation as a medical plan. (If an EAP were subject to Affordable Care Act regulation as a medical plan, it would be out of compliance.) The IRS will classify EAPs as excepted benefits, provided that the EAPs don't provide "significant benefits in the nature of medical care or treatment." Until further guidance, you can use a good-faith reasonable interpretation in deciding whether your EAP provides "significant" medical benefits.

OTHER EMPLOYEE BENEFIT NEWS

2016 reports on 2015 health benefits

When the IRS postponed the implementation of the employer pay-or-play penalties from 2014 to 2015, the related reporting was also postponed. Now we have a first glimpse at what the IRS is considering for those reports. The IRS issued proposed regulations under Code §§6055 and 6056 on September 5, 2013. (Remember, final regulations may be significantly different.) Although two separate reports are envisioned, the IRS may provide options for combined reports.

Timing

Like Form W-2s, statements will need to go to employees and enrolled individuals by January 31, 2016 and the reports will need to be filed with the IRS by February 28 (March 31 if filed electronically).

Applicable large employer members are responsible for reporting eligibility for health coverage

If you are an applicable large employer (generally, 50 or more full-time employees), then the report you file in 2016 will identify, for each calendar month, each full-time employee and whether he or she was eligible for health coverage for that month. In the case of a controlled group of corporations or trades or businesses under common control, each member of the group would report separately.

> *Note*: If you currently have a controlled group member that is disregarded for tax purposes and that does not have a separate employer identification number for federal tax purposes because it is aggregated with its parent company and that disregarded entity has employees, you will need to apply for a separate EIN before 2016.

If an employee works for two or more members of the controlled group, the employee is supposed to be reported by each of the employing members.

One simplification under consideration is the option to report all employees who are offered adequate (i.e., at least minimum value) health coverage without having to determine whether specific employees are or are not classified as full-time. Instead, the applicable large employer member would certify that all of its employees to whom it did not offer coverage were not full-time employees (or were ineligible due to an initial waiting period). This option, if adopted by the IRS, may be particularly useful for employers where virtually all employees are benefits-eligible.

Other data elements to be reported will probably include:

- whether health coverage was available to an eligible employee's spouse and/or children. There is no employer pay-or-play penalty for failure to offer health coverage to an employee's spouse. However, the offer of coverage to the employee's spouse is relevant to the spouse's access to premium assistance for the purchase of health coverage through a Marketplace;
- the months during which an employee was ineligible due to a waiting period (not to exceed 90 days);
- the lowest employee contribution for single health coverage that provides adequate (i.e., at least minimum value) health coverage (ignoring discounts for participation in wellness programs other than discounts for non-smokers); and
- whether the employee contribution for single coverage is treated as affordable (using one of the safe harbor calculations).

Reporting entities are responsible for reporting enrollment for health coverage

The proposed regulations would require that actual enrollment in health coverage be reported by insurers, employers sponsoring self-insured health plans, and multiemployer plans (reporting entities). These reporting entities would be required to identify, for each month, the individuals enrolled in their health coverage. Since applicable large employer members are also required to report employees who are enrolled in the employers' health coverage, there would be duplicate reporting of enrolled employees (unless of course there is an option for combined reporting).

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This alert is a summary and cannot include all details that may be relevant to your situation. As always, please contact us if you want more information on these developments or other employee benefits matters.