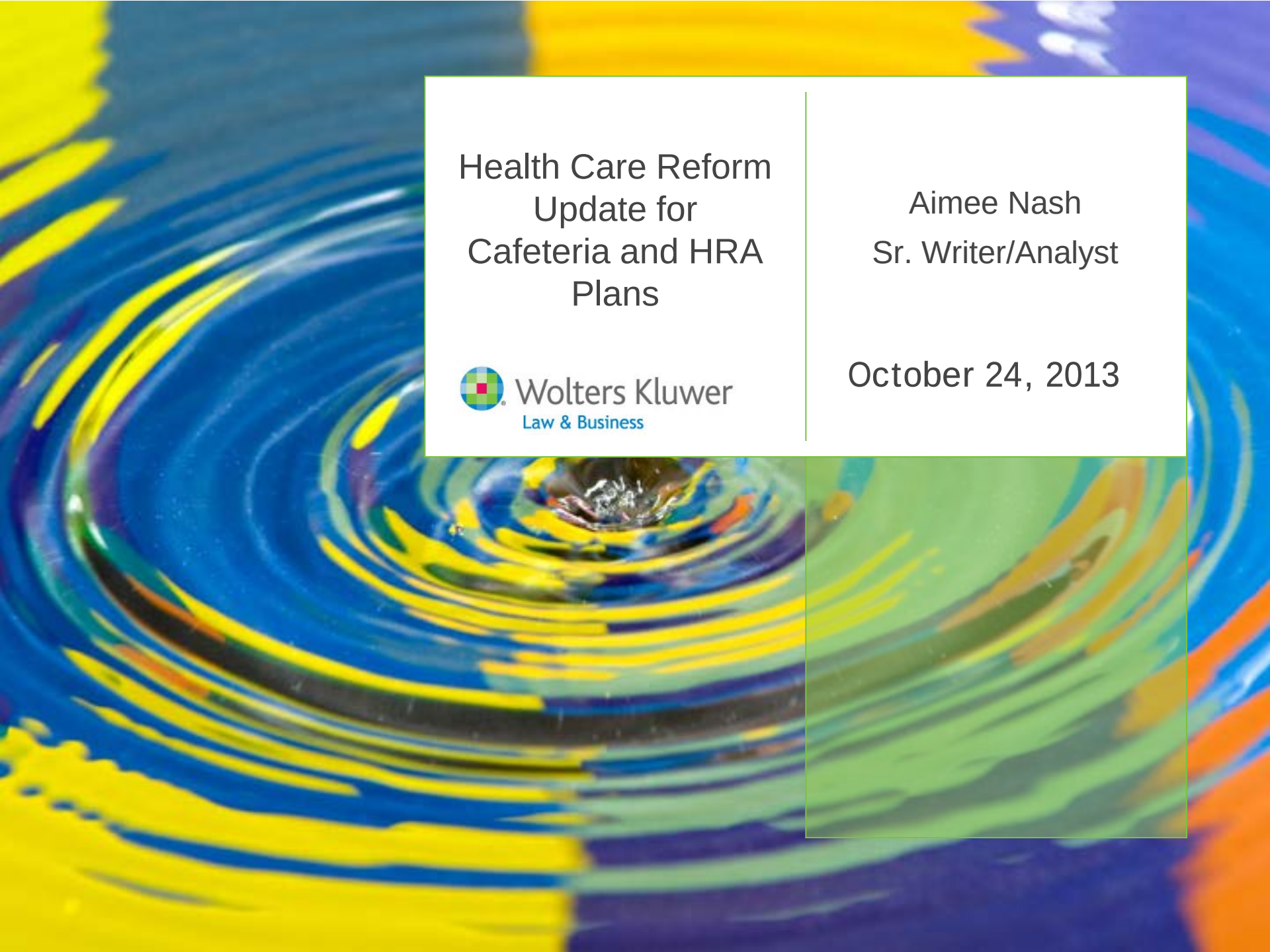

Health Care Reform Update for Cafeteria and HRA Plans

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October 24, 2013

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Agenda

- Group Health Plans and Excepted Benefits
- Notice 2013-54
  - Annual limits and **preventive care**
  - Premium Reimbursement
  - Integrated HRAs
  - Spend-down of stand-alone HRAs
- Other Reform Provisions
  - 90 day waiting period
  - SBCs
  - Individual tax credits/shared responsibilities
  - SHOPs
  - Cafeteria plan transition relief
- Wraps – newly relevant?

Group Health Plan

- Group Health Plan = plan subject to HIPAA Portability
  - Employer sponsored plans
  - Includes self-insured and insured plans
- Group Health Plans are subject to most health care reform provisions
- Excepted benefits are not Group Health Plans
- Excepted benefits are not subject to most health care reform provisions

Excepted Benefits

- less than two participants (retiree-only plans)
- Coverage for only a specified disease or illness
- Supplementary coverage (Medigap)
- limited to dental, vision and long-term care benefits (*that are not an integral part of a group health plan*)
- If plan is a health FSA
  - employer offers other group health plan coverage
  - maximum benefit payable to a participant under the FSA is less than or equal to the greater of:
    - two times the participant's salary reduction election under the arrangement for the year or
    - $500 **plus the salary reduction election (if applicable).**

[slide updated]

Excepted Benefits
HRA and Cafe Plans

- Most HRAs are not excepted benefits
  - Retiree-only HRAs are excepted benefits
- Many (most?) Cafeteria plans that offer health FSAs are excepted benefits
  - Note that **employer must offer other non-excepted group health coverage** (in addition to staying under the contribution limits)
  - Simple Cafeteria plan is likely not excepted benefits (min contribution requirements)

Example 1

- Employer offers a cafeteria plan
  - Health FSA
  - Pretax payment of AFLAC policies
  - No employer contributions
  - Employer does not offer any other medical plans
- Excepted Benefit?

Example 2

- Employer offers a SIMPLE cafeteria plan
  - dependent care account
  - premium conversion (pre-tax payment of employer's group health plan)
  - Large employer contribution (SIMPLE)
- Excepted Benefit?

Notice 2013-54

- 9/13/13 (DOL issued Tech Release 2013-03)
- Guidance means substantial changes for cafeteria and HRA plans
- Approach taken for HRAs and Cafeteria plans differs (i.e. integration does not appear to apply to cafeteria plans)
- Requirements/topics covered:
  - Annual limit prohibition
  - Preventive care requirements
  - Pre-tax payment of insurance premiums
  - Minimum essential coverage (impacts premium assistance)

Annual/Lifetime Limits

- Sec 1001 of PPACA (PHS Act section 2711)
- "Group health plan" and health insurance issuer may not establish annual or lifetime limit
  - Rule affects group and individual markets
- Phase-in of limits
  - 9/23/10 – 9/23/11: $750,000
  - 9/23/11 – 9/23/12: $1,250,000
  - 9/23/12 – 9/23/14: $2,000,000
  - After 9/23/14: prohibited

Annual Limits

- Plan may provide annual limits on benefits that are not "essential health benefits" (EHB)
- Self-insured plans, grandfathered plans and large group health insurance plans may choose not to provide coverage for a particular condition/EHB
- Individual and small group insurance must provide all EHBs

Notice 2013-54 and Annual Limits

- Interim final regulations (June, 2010) provided that FSAs are exempt from annual limit rules
- Notice 2013-54:
  - Exemption from the annual limit rules was only intended to apply to health FSAs that are offered through a Code section 125 (cafeteria) plan
    - "the Departments intend to amend the annual dollar limit prohibition regulations to conform to this Q&A 8 retroactively applicable as of September 13, 2013."
  - Q&A 7 "The Departments are also considering whether an HRA may be treated as a health FSA for purposes of the exclusion from the annual dollar limit prohibition."

Preventive Care

- Effective plan years beginning after September 23, 2010
- Group health plans are required to cover preventive care without cost sharing
  - Immunizations
  - Screens
  - Counseling (diet, diabetes, alcohol, etc.)
  - Women's preventive services (breast cancer, contraceptives, etc.)
  - Children's preventive services (screens, etc.)

Notice 2013-54 and Preventive Care – Cafeteria Plans

- "Because a health FSA that is not excepted benefits is not integrated with a group health plan, it will fail to meet the preventive services requirements."
- Impossible for cafeteria plan offering non-excepted benefits to meet preventive care requirements
- Integration does not apply (*can not apply? -- wraps?*)
- CONCLUSION: Cafeteria plans must be designed as excepted benefits

Notice 2013-54 and Preventive Care - HRAs

- Integration saves HRAs:
  - "...an HRA that is integrated with a group health plan will comply with the preventive services requirements if the group health plan with which the HRA is integrated complies with the preventive services requirements." (Q&A 2)
- Non-integrated (stand alone) HRA plan cannot meet preventive care requirements (Q&A 7)

Notice 2013-54 and Annual Limits HRAs

- CONCLUSION: HRAs have two options
  - Integrate with a group health plan or
  - Offer only excepted benefits

Different Approach
HRAs and Cafeteria Plans

- HRAs
  - Must be integrated with group health plan if HRA is offering non-excepted benefits or
  - Offer only excepted benefits
- Cafeteria Plans
  - Offer only excepted benefits

Cafeteria Plan Designs Excepted Benefits

- If offering health FSA
  - Must offer other group health coverage
  - Employer contributions at or below 1) 100% match or 2) $500

HRA Plan Designs
Excepted Benefits

- Retiree-only plans
- Limited coverage:
  - limited to dental, vision and long-term care benefits (*that are not an integral part of a group health plan*)
  - Coverage for only a specified disease or illness
  - Supplementary coverage (example: Medigap)

Dental, Vision, and LTC Integral Part of a Group Health Plan?

Limited scope dental/vision/LTC are excepted if:

- (i) ...they are provided under a separate policy, certificate or contract of insurance **or** are otherwise not an integral part of a group health plan...
- (ii) ... benefits are not an integral part of a group health plan... only if the following two requirements are satisfied
  - (A) Participants must have the right to elect not to receive coverage for the benefits and
  - (B) If a participant elects to receive coverage for the benefits, **the participant must pay an additional premium or contribution for that coverage.**
- Treas Reg section 54.9831-1(c)(3)

Dental, Vision and LTC as Excepted Benefits

- Reimburse premiums for individually purchased dental/vision/LTC policies
  - HRA
  - Cafeteria plan
    - premium conversion account (not health FSA)
    - No LTC coverage/reimbursements

Premium Reimbursements

- "Employer Payment Plan"
  - Includes employer reimbursement of premiums for non-employer sponsored hospital and medical insurance
  - Includes reimbursements from cafeteria plan – even if the account is solely funded by salary reductions
    - Cafe plan "qualified benefit means any benefit attributable to employer contributions..."
    - Cafe plan is "the exclusive means by which an employer can offer employees an election between taxable and nontaxable benefits without the election itself resulting in inclusion in gross income by employees"
  - Does not include post-tax arrangements and excepted benefits
- Employer Payment Plans are Group Health Plans
- Employer Payment Plans cannot integrate with individual policies (Notice 2013-54 Q&A 1)

Premium Reimbursements

- Cafeteria and HRA plans can reimburse individual premiums for excepted benefits
  - Dental and vision insurance premiums (that are not an integral part of a group health plan)
  - HRA only: long-term care insurance premiums (that are not an integral part of a group health plan)
  - Coverage for only a specified disease or illness
  - Supplementary coverage (example: Medigap)

Post-Tax Premium Payments Permitted

- Includes
  - Payroll practice of forwarding post-tax employee wages to a health insurance issuer
  - Post-tax reimbursement of substantiated premiums
- Ensure DOL's regulation at 29 C.F.R. section 2510.3-1(j) is met. Requires (in part):
  - No employer contributions
  - No employer endorsement of the program

POPs Unaffected

- Premium Only Plans = "cafeteria plan that offers as its sole benefit:
  - an election between cash (for example, salary) and
  - payment of the employee share of the **employer-provided accident and health insurance** premium"
- POPs are not Group Health Plans

Notice 2013-54 Impact Summary

- HRAs
  - Must be designed as integrated or
  - Offer only excepted benefits (retiree or excepted benefit premiums)
- Cafeteria Plans
  - If offer health FSA, must be designed as excepted benefits
  - Premium reimbursement limited to
    - Employee share of employer provided accident and health insurance (POP)
    - Excepted coverage (dental, vision, supplementary coverage, coverage of specific disease/illness)

Integrated HRAs

- Interim Final Regulations Annual Limits, 6/28/2010 - Preamble: exemption for HRAs integrated with other coverage as part of a group health plan:

"When HRAs are integrated with other coverage as part of a group health plan and the other coverage alone would comply with the requirements of PHS Act section 2711, the fact that benefits under the HRA by itself are limited does not violate PHS Act section 2711 because the combined benefit satisfies the requirements. "

Integrated HRA Defined

- FAQs about Affordable Care Act Implementation Part XI – 1/24/13

"... an HRA is not considered integrated with primary health coverage offered by the employer unless, under the terms of the HRA, the HRA is available only to employees who are covered by primary group health plan coverage provided by the employer and meeting the requirements of PHS Act section 2711."

Notice 2013-54

- Modifies the definition of integrated HRA
  - "integration does not require that the HRA and the coverage with which it is integrated share the same plan sponsor, the same plan document or governing instruments, or file a single Form 5500, if applicable."
- Two types of HRAs
  - Minimum Value (MV) Required
  - MV not required
- Minimum Value?
  - Covers at least 60% of costs
  - Helps prevent employer shared responsibility payment (2015)
  - Amounts first made available under integrated HRA may count towards MV if available for cost-sharing only (no premiums)

HRA Integration Options

"MV Required"	"MV Not Required"
Employer must offer other group health coverage	
- other coverage must provide MV	
Employees are only eligible for the HRA if they **are actually enrolled in a group health plan** (could be offered by another employer)	
- other group health plan must provide MV	
Reimburse any Code section 213(d) expense – HRA can reimburse for EHB not covered by the other group health plan (Q&A 6)	Reimburse only copays, co-insurance, deductibles, premiums, and medical care that does not constitute essential health benefits
An employee (or former employee) must be permitted to opt out of the HRA at least annually and/or permanently. Upon termination, the remaining amounts in the HRA are forfeited.	

Choosing Integration Design

Does the employer group health plan provide Minimum Value?

- No:
  - Cannot offer "MV Required" integration method
  - HRA may be contributing to MV (cannot reimburse premiums)
- Yes:
  - May choose either integration method
  - Key differences:
    - Eligible expenses – "MV Required" allows categories of coverage not covered by the employer's other group health plan (coverage will not be in violation of annual limit prohibition, even if it is EHB)
    - Enrollment for employees that are enrolled in another Group Health Plan (assuming HRA chooses to offer) somewhat limited

Designing an Integrated Plan

- Employer must offer another Group Health Plan (other than the HRA)
- Must limit eligibility to Participants enrolled in another group health plan
  - Limit to employer's plan?
- Reimbursements
  - Must be limited if other Group Health Plan does not provide Minimum Value
- Must offer Opt out
  - Annual or permanent
- Upon termination, the remaining amounts in the HRA are forfeited.

Spend-down for Non-Integrated HRAs

- DOL "anticipates" future guidance will provide a transition period for existing HRA plans (FAQ #4 FAQs about Affordable Care Act Implementation Part XI – 1/24/13, repeated in Notice 2013-54)
- Uunused amounts may be used after December 31, 2013 to reimburse medical expenses
- Unused amounts:
  - amounts credited before January 1, 2013 and
  - amounts that are credited in 2013 under the terms of an HRA as in effect on January 1, 2013
  - If the HRA terms on January 1, 2013, did not prescribe a set timing/amount to be credited, then amounts credited limited to 2012 amounts

Integrated HRA Spend-downs

- If employee ceases to be covered by Group Health Plan
  - Other than termination of employment
  - Could include loss of other Group Health Plan
- Unused amounts may be used under the terms of the HRA
  - If "MV not required" integration method used, eligible expenses may be very limited
- "Spend-down" benefits are minimum essential coverage (would interfere with premium assistance)

Waiting Periods

- Prohibition on waiting periods greater than 90 days
- Applies to Group Health Plans
- Does NOT apply to excepted benefits
  - All cafeteria plans
  - Some HRAs (retiree, etc.)
- Integrated HRA plans
  - Recommend entry dates for HRA same as other employer group health plan

SBCs

- Applies to Group Health Plans
- Does NOT apply to excepted benefits
  - All cafeteria plans
  - Some HRAs (retiree, etc.)
- Integrated HRA plans
  - Provide separate SBC for the HRA or
  - Note the HRA's effect "in the appropriate spaces on the SBC for deductibles, copayments, coinsurance, and benefits otherwise not covered by the other major medical coverage"

Cafeteria Plan Transition Relief

- Amendments due no earlier than 12/31/14
- Special right to revoke or make salary reduction election
- Relief limited
  - Applicable large employers (generally at least 50 full time employees) only
  - Non-calendar year plans only
  - Relief only applies to pre-tax premiums
- Delayed?
  - Special rule in preamble to employer shared responsibility regulations
- NOTE:
  - No requirement to dis-enroll participant from the employer-provided accident and health plan
  - Employee typically not eligible for premium assistance in government exchanges

Premium Tax Credit

- Applicable taxpayer
  - Household income 100 – 400% FPL (must file joint return)
  - Enrolled in QHP via exchange
  - Not eligible for other minimum essential coverage
    - Government sponsored
    - Employer-sponsored if affordable (cost not more than 9.5% income in 2014)
- Effective 1/1/14; Regs published 5/23/12

Individual Shared Responsibility

- Effective 1/1/14; regs released 1/30/13
- Applies to all individuals
  - Required to have minimum essential coverage
    - Employer provided, individual policy (exchange or private market), Medicare, Medicaid, etc.
    - Does NOT include specialized coverage (vision, dental, specific disease), worker's comp, disability
  - Qualify for an exemption, or
    - Religious, hardship, coverage gaps of 3 months or less, no filing requirement (low income), unaffordable, etc.
  - Make a payment on tax return

SHOP

- Employers with up to 50 employees eligible
  - Exchange may expand to employers up to 100 employees
  - Exchange may expand to allow large employers to participate
- Small business tax credit
  - Less than 25 full time employees
  - Average wages below $50,000
  - Pay uniform percentage of the premiums
  - Purchase through SHOP
- Employee share of premiums can be reimbursed pre-tax in cafeteria plan

Cost Sharing Limits

- Regs published 2/25/13; Effective plan years beginning on or after 1/1/14 for group health plans (plans subject to HIPAA Portability; sec 2707 and 1303(c) of PPACA)
  - Annual cost-sharing limit (tied to out-of-pocket limit for HDHPs in 2014) $6,250 for self-only/$12,500 for family in 2013
  - "The three Departments intend to engage in future rulemaking to implement section 2707(b)" (preamble to February 20, 2013 CMS-9980-F: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation)
  - DOL FAQ Part XII transition relief when multiple service providers
  - [Deductible limits apply to small group insured plans and individual plans; guidance has been released for these insured plans]

Employer Plans vs QHPs

- QHP: Exchange plans, non-grandfathered individual insurance (even if not on exchange) and small group insurance plans
  - Must cover all 10 essential health benefits (EHB)
  - Metal levels based on actuarial value
  - Cost-sharing limits on out-of-pocket and deductibles
- Employer plans: Self-insured plans and large insured group health plans
  - EHBs/metal levels do not apply
  - Minimum value applies to large employers
  - Cost-sharing limits on out-of-pocket

Resources/Guidance

- IRS
  - http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions
  - Q&As on employer and individual shared responsibility
- DOL
  - http://www.dol.gov/ebsa/healthreform/
  - SBCs, external appeals
- HHS/CMS
  - http://cciio.cms.gov/resources/regulations/index.html
  - Valuations, min coverage

Wraps

- Why wrap?
  - ERISA plan document requirements
  - ERISA SPD/disclosure requirements
  - Simplify 5500 filings
  - Clarify plan rules (subrogation, indemnification)
- No specific wrap requirements/rules
- New reasons with health care reform?

Thank You!

Materials/Recording:

https://www.ftwilliam.com/webinar.html

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