IRS Notice 2015-87: HRAs, Affordability, and More

On December 16, 2015, the Internal Revenue Service (IRS) and other federal agencies released IRS Notice 2015-87, which is a "potpourri" update that covers many different topics relating to the Patient Protection and Affordable Care Act (ACA), including some relating to market reforms.

The Notice generally covers health reimbursement arrangements (HRAs) and other employer payment plans, the impact of HRAs, flex credits, opt-out incentives or fringe benefit payments on affordability calculations relating to applicable large employers (ALEs), IRS reporting that is required for ALEs, rules for health savings accounts (HSAs) for individuals eligible for benefits administered from the Department of Veterans Affairs (VA), COBRA rules in relation to unused health flexible spending arrangement (HFSA) funds and a reiteration of safe harbors relating to good faith reporting for ALEs.

Under the ACA, individuals are required to have health insurance while ALEs are required to offer health benefits to their full-time employees. In order for the IRS to verify that (1) individuals have the required minimum essential coverage, (2) individuals who request premium tax credits are eligible for them, and (3) ALEs are meeting their shared responsibility (play or pay) obligations, employers with 50 or more full-time or full-time equivalent employees and insurers will be required to report on the health coverage they offer. Final instructions for both the 1094-B and 1095-B and the 1094-C and 1095-C forms were released in September 2015, as were the final forms for 1094-B, 1095-B, 1094-C, and 1095-C. The IRS Notice reiterated that, for 2015 year reporting, relief is available to employers who make a good faith effort to comply with information reporting requirements, and they will not be subject to penalties for returns with incorrect or incomplete information. This does not apply to employers that fail to timely file an information return or furnish a statement.

HRAs and Employer Payment Plans

The Notice provides further guidance on IRS Notice 2013-54 that covered HRAs, HFSAs and other employer payment plans. The 2015 notice confirmed that an HRA covering fewer than two participants that are current employees (typically found in a retiree plan) may be used to purchase individual market coverage without causing the HRA to fail to comply with market reforms. HRAs that cover fewer than two participants that are current employees are not subject to the ACA's market reforms. Individuals covered by an HRA sponsored by a former employer with retained or available funds will not be eligible for a premium tax credit on the ACA's Marketplace.

The Notice also confirms that an HRA that covers two or more participants who are current employees may not be used to purchase individual market coverage after the employee covered by the HRA ceases to be covered by an integrated group health plan. Although Notice 2013-54 permitted using unused amounts in an integrated HRA, the IRS assumed the HRA would not provide a current employee the ability to purchase duplicative or substitute individual coverage. The agency has now clarified that an employee may not use an HRA to purchase individual coverage, either while he or she is covered by the group plan with which the HRA is integrated, or when the employee is no longer covered by the group plan. A current-employee HRA that permits the purchase of individual market coverage will be considered a group health plan that fails to meet market reforms because it is not integrated with another group health plan.

The Notice reiterated that an HRA (integrated or not) with unused amounts credited before January 1, 2014, including any amounts credited before January 1, 2013, and any amounts that were credited during 2013 under the terms of an HRA in effect on January 1, 2013, may be used after December 31, 2013, to reimburse medical expenses in accordance with those terms without causing the HRA to fail to comply with the annual dollar limit prohibition or the preventive services requirements.

The Notice also clarified that an HRA that can be used to reimburse medical expenses of an employee's spouse and dependents cannot be integrated with self-only coverage under the employer's group health plan. Because many HRAs do not currently contain restrictions that are necessary to integrate the HRA with employee-only coverage, federal agencies have provided a temporary safe harbor. Agencies will not treat an HRA available for the expenses of family members not enrolled in the employer's other group health plan for plan years beginning before January 1, 2016, as failing to be integrated with an employer's other group health plan for plan years beginning before January 1, 2016, nor will they treat an HRA and group health plan that otherwise would be integrated based on the terms of the plan as of December 16, 2015, as failing to be integrated with an employer's other group health plan for plan years beginning before January 1, 2017, solely because the HRA covers expenses of one or more of an employee's family members even if those family members are not also enrolled in the employer's other group health plan. However, to be integrated, the HRA must meet all other integration requirements and employers will be responsible for 6055 reporting (1094-B and 1095-B) for these HRAs as minimum essential coverage for each individual whose medical expenses are reimbursable by the HRA and who is not also enrolled in the employer's group health plan.

HRAs that may only be used to pay premiums for excepted benefits, such as dental coverage, will not fail to meet the market reform requirements.

Employer arrangements that reimburse the cost of individual market coverage under a cafeteria plan will not be integrated with the individual market coverage. These arrangements will be unable to comply with the ACA's annual dollar limit prohibitions or the preventive service requirements and will fail to satisfy market reforms. Practically speaking, these arrangements are prohibited regardless of how they are structured.

Affordability

An ALE that offers minimum essential coverage (MEC) to substantially all of its full-time employees may still owe penalties if the coverage it offers is inadequate because it is not "affordable" or it does not provide "minimum value." Coverage is considered affordable if it costs less than 9.5 percent of the employee's household income. Because employers rarely know an employee's household income,

employers may meet the affordability requirement through one of three safe harbor options – the W-2 safe harbor, the rate of pay safe harbor, or the federal poverty level safe harbor.

HRA contributions by an employer that may be used to pay premiums for an eligible employer sponsored plan are counted toward the employee's required contribution, subsequently reducing the amount required for their contribution. Practically speaking, an employer can design an HRA to reduce the employee premium and meet affordability requirements.

Similarly, an employer's flex contributions to a cafeteria plan can reduce the amount of the employee portion of the premium so long as the employee may not opt to receive the amount as a taxable benefit, the flex credit may be used to pay for the MEC, and the employee may use the amount only to pay for medical care. If the flex contribution can be used to pay for non-health care benefits (such as dependent care), it could not be used to reduce the amount of the employee premium for affordability purposes. Furthermore, if an employee is provided with a flex contribution that may be used for health expenses, but may be used for non-health benefits, and is designed so an employee who elects the employer health plan must forego any of the flex plan's non-health benefits, those flex benefits may not be used to reduce the employee's premium for affordability purposes.

However, for plan years beginning before January 1, 2017, and for benefits adopted prior to December 16, 2015, an employer flex contribution that is not a health flex contribution because it may be used for non-health benefits but that may be used by the employee toward the amount the employee is otherwise required to pay for the health coverage, will be treated as reducing the amount of an employee's required contribution.

Furthermore, only for coverage for plan years beginning before January 1, 2017, an employer may reduce the amount of the employee's required contribution by the amount of a non-health flex contribution (other than a flex contribution made under a non-relief-eligible flex contribution arrangement) for purposes of information reporting on Line 15 of Form 1095-C. However, because treating a non-health flex contribution as reducing an employee's required contribution may affect the employee's eligibility for the premium tax credit, the IRS encourages employers not to reduce the amount of the employee's required contribution by the amount of a non-health flex contribution for purposes of information reporting. After reports have been submitted, if the employer is contacted by the IRS concerning a potential penalty relating to the employee's receipt of a premium tax credit, the employer will have an opportunity to respond and show that it is entitled to the relief described in the Notice, to the extent that the employee would not have been eligible for the premium tax credit if the required employee contribution had been reduced by the amount of the non-health flex contribution or to the extent that the employer would have qualified for an affordability safe harbor if the required employee contribution had been reduced by the amount of the non-health flex contribution.

An employer's non-health flex contribution will not be used to reduce the employee's premium for purposes of determining their eligibility for a tax credit.

The IRS provided three examples regarding flex contributions:

> ***Example 1 (Health Flex Contribution Reduces Dollar Amount of Employee's Required Contribution).***
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> *Facts: Employer offers employees coverage under a group health plan through a section 125 cafeteria plan. An employee electing self-only coverage under the health plan is required to contribute*

$200 per month toward the cost of coverage. Employer offers employer flex contributions of $600 for the plan year that may only be applied toward the employee share of contributions for the group health coverage or contributed to a health flexible spending arrangement (health FSA).

Conclusion: The $600 employer flex contribution is a health flex contribution and reduces the employee's required contribution for the coverage relating to premium subsidy eligibility and for purposes of any related consequences under employer shared responsibility, including application of the affordability safe harbors.

Because the $600 employer flex contribution is a health flex contribution the $600 is taken into account as an employer contribution (and therefore reduces the employee's required contribution) regardless of whether the employee elects to apply the health flex contribution toward the employee contribution for the group health coverage or elects to contribute it to the health FSA. For purposes employer shared responsibility and the related reporting (Form 1095-C), the employee's required contribution for the group health coverage is $150 ($200 - $50) per month.

Example 2 (Employer Flex Contribution Does Not Reduce Dollar Amount of Employee's Required Contribution).

Facts: Employer offers employees coverage under a group health plan through a section 125 cafeteria plan. An employee electing self-only coverage under the health plan contributes $200 per month toward the cost of coverage. Employer offers employer flex contributions of $600 for the plan year that can be used for any benefit under the section 125 cafeteria plan (including benefits not related to health) but are not available as cash.

Conclusion: Because the $600 employer flex contribution is not usable exclusively for medical care, it is not a health flex contribution and therefore does not reduce the employee's required contribution for the coverage under employer shared responsibility and any related potential consequences. For purposes of reporting (Form 1095-C), the employee's required contribution is $200 per month.

Example 3 (Employer Flex Contribution Does Not Reduce Dollar Amount of Employee's Required Contribution).

Facts: Same as in Example 2, except that the employee may also elect to receive the $600 employer flex contribution as cash or other taxable compensation.

Conclusion: Same as conclusion for Example 2 because the employer flex contribution is not a health flex contribution. The same conclusion would apply if the employer flex contribution were available to pay for health benefits or to be taken as cash or other taxable compensation but not available to pay for other types of benefits.

Opt-Outs

The IRS announced that it intends to propose regulations that will treat an unconditional opt-out arrangement (an arrangement providing for a payment conditioned solely on an employee declining coverage under an employer's health plan and not on an employee satisfying any other meaningful requirement) in the same manner as a salary reduction for purposes of determining an employee's required contribution relating to affordability.

The IRS has determined that opt-out arrangements increase an employee's contribution for health coverage beyond the amount of the salary reduction. It provides the following example:

> *If an employer offers employees group health coverage through a section 125 cafeteria plan, requiring employees who elect self-only coverage to contribute $200 per month toward the cost of that coverage, and offers an additional $100 per month in taxable wages to each employee who declines the coverage, the offer of $100 in additional compensation has the economic effect of increasing the employee's contribution for the coverage. In this case, the employee contribution for the group health plan effectively would be $300 ($200 + $100) per month, because an employee electing coverage under the health plan must forgo $100 per month in compensation in addition to the $200 per month in salary reduction.*

However, the regulations will apply only for periods after the issuance of final regulations. Until then, federal agencies also anticipate that mandatory inclusion in the employee's required contribution of amounts offered or provided under an unconditional opt-out arrangement that is adopted after December 16, 2015, (a "non-relief-eligible opt-out arrangement") will apply for periods after December 16, 2015. This means that employers who are subject to affordability provisions should be very cautious and consult counsel if they plan on offering a new opt-out waiver after December 16, 2015. In particular, employers who have a new opt-out program beginning on or after January 1, 2016, should consult with their legal counsel if they are subject to affordability provisions.

Employers who have had opt-out arrangements in place prior to December 16, 2015, will not be required to increase the amount of an employee's contribution for reporting purposes on the 1095-C but individual taxpayers may rely on opt-out payments as increasing their cost for purposes of tax credit eligibility. Employees who must meet a condition to receive the opt-out payment (such as demonstrating they have MEC from another source such as their spouse) may treat the opt-out payment as increasing their required contribution for purposes of premium tax credit eligibility.

McNamara-O'Hara Service Contract Act (SCA) and the Davis-Bacon and Related Acts (DBRA)

The IRS noted that very complicated issues are presented by the SCA and the DBRA, which require federal contractors to pay prevailing wages and fringe benefits or cash out fringe benefits for workers.

As a result, until these issues are resolved, for purposes of play or pay and related reporting, employers may consider cash payments in lieu of fringe benefits as increasing the affordability of coverage, although employees are not required to consider the payments as making coverage more affordable for purposes of premium tax credit eligibility. Employers in this situation should work with employees to provide necessary information relating to affordability.

The following example was provided by the IRS:

> *Employer offers employees subject to the SCA or DBRA coverage under a group health plan through a section 125-cafeteria plan, which the employees may choose to accept or reject. Under the terms of the offer, an employee may elect to receive self-only coverage under the plan at no cost, or may alternatively decline coverage under the health plan and receive a taxable payment of $700 per month. For the employee, $700 per month does not exceed the amount required to satisfy the fringe benefit requirements under the SCA or DBRA.*

Conclusion: Until the applicability date of any further guidance (and in any event for all plan years beginning before January 1, 2017), for purposes of play or pay and employer reporting, the required employee contribution for the group health plan for an employee who is subject to the SCA or DBRA is $0. However, for purposes of affordability, that employee's required contribution for the group health plan is $700 per month.

Affordability and Penalty Calculation Percentages

Currently, the affordability of coverage is defined as costing no more that 9.5 percent of household income (or 9.5 percent of wages or of the federal poverty level) and it is adjusted annually. The IRS will be amending regulations to reflect these adjustment amounts and will update the percentage via IRS notice in future years. For 2015 this is set at 9.56 percent and for 2016 it is set at 9.66 percent.

Under the ACA, an ALE must offer minimum essential coverage to most of its full-time employees (and dependents) or pay a $2,000 per year ($166.67 per month), indexed, penalty on all of its full-time employees, if even one employee receives a premium tax credit. An ALE must also offer minimum value, affordable coverage to its full-time employees or pay a penalty of $3,000 a year ($250 per month), indexed.

The indexed amounts for the $2,000 penalty, based on calendar years, are:

2015: $2080
2016: $2160

The indexed amounts for the $3,000 penalty, based on calendar years, are:

2015: $3,120
2016: $3,240

Hours of Service

Under the ACA, any hour for which an employee is paid or entitled to payment must be counted as an hour of service. This includes:

- An hour worked
- Vacation
- Holiday
- Sick time
- Incapacity (including disability)
- Layoff
- Jury duty
- Military duty
- Paid leave

These rules are intended to mimic other federal regulations, but are not intended to credit hours to individuals who are terminated from employment. The IRS clarified that an hour of service does not include:

- An hour for which an employee is paid during which no duties are performed, if the payment is made to comply with workers' compensation, unemployment, or disability insurance laws.

- An hour of service for a payment which reimburses an employee for medical or medically related expense incurred by the employee.

The IRS confirmed that there is no 501-hour limit on hours of service required to be credited to an employee on account of a continuous period of time during which the employee performs no service, if the hours would otherwise qualify as hours of service (such as for a leave of absence).

Periods during which an individual is not performing services but is receiving payments from short-term disability or long-term disability will result in hours of service, if the individual retains status as an employee, unless the payments are made from an arrangement to which the employer did not contribute directly or indirectly. Disability paid for by the employee with after-tax contributions would be an arrangement to which the employer did not contribute, and would not result in hours of service. Workers' compensation payments under state or local government programs are not hours of service.

Educational Institutions

Educational institutions have special rules under the ACA relating to breaks in service. Generally employees may be treated as a new employee after a break in service of at least 13 weeks. Educational institutions are held to a standard of 26 weeks, and under the measurement and look-back method, employees of educational institutions (whether public or private, and from primary through university level) cannot have breaks in service of *four to 26 weeks* counted against them when measuring hours. Employees of educational institutions who return to work after a break cannot be treated as a new employee unless the break is longer than 26 weeks. The IRS has determined some educational organizations are attempting to avoid these rules by using staffing agencies for certain roles, under the idea that staffing agency employees would be subject to the 13 week rehire rule.

The IRS plans to propose amendments to regulations so that staffing agency employees providing services for educational organizations would be subject to the 26 week rule, not the 13 week rule. The amendments will apply as of the applicability date in the regulations.

Miscellaneous Provisions

AmeriCorps members providing services to a grantee will not be considered the grantee's employee for play or pay provisions.

Offers of TRICARE coverage due to employment will be treated as an offer of MEC under an eligible employer sponsored plan.

On July 31, 2015, the Surface Transportation and Veterans Health Care Choice Improvement Act (STVHCC) of 2015 was signed into law by President Obama. The Act, also known as H.R. 3236, is focused on surface transportation programs but affects HSA eligibility rules for individuals receiving care through the Veterans Administration (VA).

In order to establish an HSA, an individual must be eligible to do so. Eligibility, generally, requires an individual to have a high deductible health plan (HDHP) and prohibits them from having any other coverage for any benefit already covered by the HDHP. This includes TRICARE and previously included veterans' medical benefits (during any month that the individual received VA medical benefits).

The STVHCC provides that individuals who receive hospital care or medical services under any law administered by the Secretary of Veterans Affairs for service-connected disability are still HSA-eligible for any months after December 31, 2015.

The IRS Notice clarified that, for purposes of determining a veteran's eligibility for an HSA, any hospital care or medical services received from the VA by a veteran who has a disability rating from the VA may be considered hospital care or services administered by the VA for a service-connected disability.

Government Agencies and Controlled Groups

Government entities must apply a reasonable, good faith interpretation to the employer aggregation/controlled group rules of play or pay for purposes of determining whether a government entity is an ALE. Separate employer identification numbers are required for each government entity employer that is subject to reporting requirements.

COBRA and HFSA Carryovers

Carryover amounts for health FSAs should be included in determining the amount of the benefit that a qualified beneficiary is entitled to receive during the remainder of the plan year in which a qualifying event occurs.

> *An employer maintains a calendar year health FSA that qualifies as an excepted benefit. Under the health FSA, during the open season an employee has elected to reduce salary by $2,500 for the year. In addition, the employee carries over $500 in unused benefits from the prior year. Thus, the maximum benefit that the employee can become entitled to receive under the health FSA for the entire year is $3,000. The employee experiences a qualifying event that is a termination of employment on May 31. As of that date, the employee had submitted $1,100 of reimbursable expenses under the health FSA.*
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> *Conclusion: The maximum benefit that the employee could become entitled to receive for the remainder of the year as a benefit under the health FSA is $1,900 (($2,500 plus $500) minus $1,100).*

The maximum amount that a health FSA is permitted to require to be paid for COBRA continuation coverage (102 percent of the applicable premium) does not include unused amounts carried over from prior years.

> *An employee elects salary reduction with respect to a health FSA of $2,000. The employer provides a matching contribution of $1,000. In addition, the employee carries over $500 in unused benefits from the prior year. The employee experiences a qualifying event that is a termination of employment on May 31.*
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> *Conclusion: The maximum amount the health FSA is permitted to require to be paid for COBRA continuation coverage for the remainder of the year is 102 percent of 1/12 of the applicable premium of $3,000 ($2,000 of employee salary reduction election plus $1,000 of employer contributions) times the number of months remaining in the year after the qualifying event. The $500 of benefits carried over from the prior year is not included in the applicable premium.*

A health FSA must allow carryovers by similarly situated COBRA beneficiaries if it allows carryovers of unused amounts for similar situated non-COBRA beneficiaries. Health FSAs can condition carryovers on participation in the next year's FSA and may limit the ability to carryover amounts to a maximum period.

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