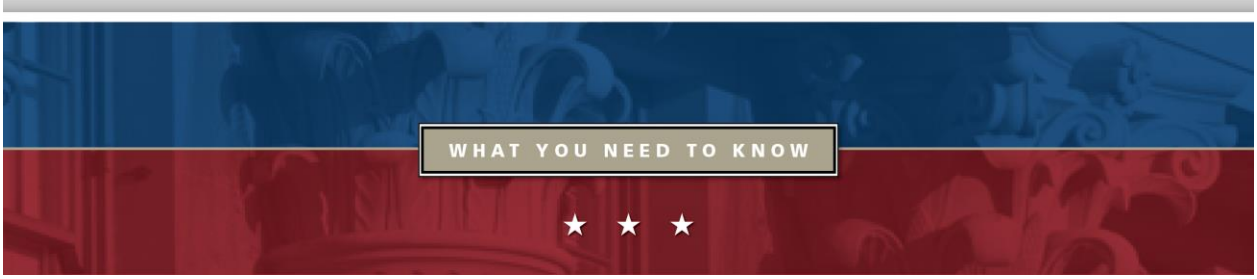

HRAs, HSAs and HFSAs under the ACA

Updated December 2016

The Patient Protection and Affordable Care Act (ACA) has had varying effects on the three account-based plans that employers often use in connection with their group health benefits. Health savings accounts (HSAs) are generally unaffected by the ACA, while the law has added several requirements for health reimbursement arrangements (HRAs) and health flexible spending accounts (HFSAs). Existing requirements for these plans still must be met; this article simply addresses changes or additional obligations imposed by the ACA.

HSAs

HSAs are not considered group health plans and therefore the ACA has imposed minimal requirements on these accounts. The maximum out-of-pocket limit under a high deductible health plan that is coupled with an HSA uses a cost-of-living index that is different than the index used generally for group health plans under the ACA – a high deductible health plan (HDHP) used with an HSA must use the lower of the two potentially applicable out-of-pocket maximums.

The Department of Health and Human Services (HHS) has stated that, beginning in 2016, an individual's cost-sharing may not exceed the self-only cost-sharing limit, even if family coverage is in effect. This means that for a family HSA, the family deductible for the related HDHP will need to be set at or above the minimum HSA deductible for family coverage, but with an individual out-of-pocket maximum that does not exceed the annual cost-sharing limit for self-only coverage.

The ACA increased the excise tax for non-medical disbursements from an HSA to 20 percent of the reimbursed amount.

HRAs

HRAs are considered group health plans, which means that many ACA requirements apply to HRAs. In many instances a stand-alone HRA will not be able to satisfy the ACA requirements. Beginning with the 2014 plan year, an HRA is not permitted unless:

- It is integrated with a group medical plan that does not have dollar limits and that provides first-dollar benefits for preventive care; or

- The HRA only provides “excepted benefits” such as reimbursement for dental or vision expenses; or
- The HRA only covers retirees.

In order for an HRA to be integrated:

- Only employees who are actually enrolled in group medical coverage (either through the employee’s employer or – if the employer chooses – a family member’s employer) may be eligible for the HRA; and
- The employee receiving the HRA must actually be enrolled in a group medical plan (either through the employee’s employer or – if the employer chooses – a family member’s employer); and
- The HRA must be written to give the employee the opportunity at least annually to permanently decline participation in the HRA, and when employment terminates the employee must be allowed to permanently decline participation in the HRA or the plan must be written so that the balance is automatically forfeited at termination. (This requirement is in place to avoid a person losing eligibility for a premium subsidy because of coverage under an HRA with a minimal balance.)

There are two types of integrated HRAs. An HRA that is integrated with a group health plan that provides at least 60 percent minimum value is not limited in the types of expenses it may reimburse, as long as the expense is considered a medical expense under the Internal Revenue Code. An HRA that is integrated with a group health plan that does not provide 60 percent minimum value generally may only reimburse:

- Deductibles, copays, and coinsurance; and
- Expenses for care that does not qualify as an essential health benefit under the ACA.

If an employer chooses to make HRA contributions to employees covered under a group health plan provided by another entity, it may simply get a certification of other coverage from the employee. The employer does not need to independently verify that the other coverage meets the ACA requirements.

Although stand-alone HRAs generally are no longer allowed, unused amounts that were credited to a stand-alone HRA before January 1, 2014, generally may be paid out as reimbursements even from an HRA that is not integrated.

A stand-alone HRA that qualifies as a post-employment HRA is still permitted. Under this type of an HRA, reimbursements are not made until after the individual has retired, or otherwise terminates employment. Employers that offer a post-employment HRA should ensure that if an individual is rehired the HRA does not reimburse expenses incurred during the period of reemployment. A post-employment HRA also may provide reimbursement to employees on long-term disability.

Under relatively recent guidance, an employer may not reimburse individual medical premiums from an HRA. In addition, an HRA may not reimburse group health premiums if the employee could pay those premiums pre-tax through a Section 125 plan sponsored by the employer.

Most recently, the 21st Century Cures Act (Cures Act) provides a method for certain small employers to reimburse individual health coverage premiums up to a dollar limit through HRAs called “Qualified Small Employer Health Reimbursement Arrangements” (QSE HRAs). This provision will go into effect on January 1, 2017.

Previously, the Internal Revenue Service (IRS) issued Notice 2015-17 addressing employer payment or reimbursement of individual premiums in light of the requirements of the ACA. For many years, employers had been permitted to reimburse premiums paid for individual coverage on a tax-favored basis, and many smaller employers adopted this type of an arrangement instead of sponsoring a group health plan. However, these "employer payment plans" are often unable to meet all of the ACA requirements that took effect in 2014, and in a series of Notices and frequently asked questions (FAQs) the IRS made it clear that an employer may not either directly pay premiums for individual policies or reimburse employees for individual premiums on either an after-tax or pre-tax basis. This was the case whether payment or reimbursement is done through an HRA, a Section 125 plan, a Section 105 plan, or another mechanism.

The Cures Act now allows employers with fewer than 50 full-time employees (under ACA counting methods) who do not offer group health plans to use QSE HRAs that are fully employer funded to reimburse employees for the purchase of individual health care, so long as the reimbursement does not exceed $4,950 annually for single coverage, and $10,000 annually for family coverage. The amount is prorated by month for individuals who are not covered by the arrangement for the entire year. Practically speaking, the monthly limit for single coverage reimbursement is $412, and the monthly limit for family coverage reimbursement is $833. The limits will be updated annually.

Outside of the exception for small employers using QSE HRAs for reimbursement of individual premiums, all of the prior prohibitions from IRS Notice 2015-17 remain. There is no method for an employer with 50 or more full-time employees to reimburse individual premiums, or for small employers with a group health plan to reimburse individual premiums. There is no mechanism for employers of any size to allow employees to use pre-tax dollars to purchase individual premiums. Reimbursing individual premiums in a non-compliant manner will subject an employer to a penalty of $100 a day per individual it provides reimbursement to, with the potential for other penalties based on the mechanism of the non-compliant reimbursement.

HFSAs

The HFSA contribution limit is indexed to cost-of-living increases. The maximum permitted employee contribution to an HFSA for the 2017 plan year is $2,600.

HFSAs are considered group health plans unless they are structured so that they qualify as an "excepted benefit." Because an HFSA typically has dollar limits and does not provide first-dollar benefits for preventive care, it will violate the ACA unless it qualifies as an excepted benefit. To qualify as an excepted benefit:

- The employee must also be eligible for group medical coverage through the employer; and
- The employer contribution may not exceed the greater of $500 or up to the employee's contribution.

In addition, an HFSA that only reimburses dental and vision expenses may qualify as an excepted benefit.

An HFSA may now offer a carryover option, instead of a grace period. Under the carryover option, a plan could allow participants to carry up to $500 in unused contributions to the next plan year. The $500 carryover does not count against the maximum annual employee contribution to an HFSA ($2,600 per year in 2017). Under the carryover option, any amounts that are unused by the end of the usual claims runout period for the plan year and that exceed $500 must be forfeited. Unused carryover amounts also must be forfeited if the participant terminates employment (unless the participant elects COBRA).

Example: Smith Corp. has a calendar year plan and a runout period that ends March 31. Bill elects an HFSA salary reduction of $600 for 2016, but submits no claims in 2016. Bill may carry $500 of his unused contributions into 2017, but $100 must be forfeited. Bill makes no election for 2017, but has the $500 carryover amount available. Bill submits $200 in claims in 2017, leaving $300, which may be carried into 2018.

A plan may have either a grace period or allow carryover, but it cannot allow both methods of extending the claims period for the same plan year. This presents a choice between allowing a limited amount ($500) to be available for the entire year through a carryover provision or allowing a potentially larger amount to be available only during the 2-1/2 month grace period under a grace period provision. The size of the average forfeiture may drive this decision.

A plan that chooses to offer the carryover option must amend the plan to include this option by the last day of the plan year from which amounts will first be carried over. However, a special rule allowed a plan that begins to offer the carryover option in 2013 to wait until the end of the 2014 plan year to adopt the amendment. If the plan offers a grace period currently, the grace period must be removed in the amendment that adds the carryover provision.

Reporting

The ACA includes a number of reporting requirements and fees. Account-based plans must report as follows:

	HSA	**HRA**	**HFSA**
W-2 Cost of Coverage Reporting	Do not report as cost of coverage; other reporting is required on W-2	Reporting not required, but permitted	Do not report
Summary of Benefits and Coverage (SBC)	Not required, but may include HSA information in the SBC of the connected HDHP	Generally include with medical plan with which integrated	Not required if an excepted benefit
PCORI fee	Do not report or pay	If integrated with an insured medical plan, file and pay, but only on covered employee (and not dependent) lives; if integrated with a self-funded medical plan that uses the same plan year, no reporting or payment is required	Not required if an excepted benefit
Transitional Reinsurance Fee (TRF)	Do not report or pay	Do not report or pay	Do not report or pay
Form 6055 and 6056 (coverage offered or provided) reporting	Do not report	Generally will not report	Do not report

	HSA	HRA	HFSA
Cadillac tax	Include all employer contributions; probably include all employee contributions made through a Section 125 plan	Include all contributions	Include all employee contributions plus any employer contributions that were reimbursed through paid claims

Minimum Essential Coverage, Minimum Value and Affordability

An HRA with a balance of any amount is considered minimum essential coverage (unless the employee has chosen to forfeit the balance). HSAs and HFSAs are never considered minimum essential coverage.

Current year employer contributions to an HRA that may be used for premiums may be considered when determining if the group medical plan with which the HRA is integrated is affordable. However, if the HRA is integrated with group health plan coverage of another employer (for example, the group health plan of the employee's spouse), amounts in the HRA cannot be taken into account for purposes of determining whether the plan of the employer that is not providing the group medical coverage meets the affordability or minimum value standards. Employer contributions to an HSA are not considered when determining if the HDHP with which the HSA is connected is affordable because HSAs generally may not be used to pay premiums.

Although final regulations have not yet been released, it is expected that current year employer contributions to an HRA that may only be used for cost-sharing (deductible, coinsurance, and copays) may be considered when determining if the group medical plan with which the HRA is integrated provides minimum value. Likewise, current year employer contributions to an HSA may be considered when determining if the group medical plan with which the HSA is integrated provides minimum value.

For any month an individual is covered by a QSE HRA/individual policy arrangement, the individual's subsidy eligibility would be reduced by the dollar amount provided for the month through the QSE HRA if the QSE HRA provides "unaffordable" coverage under ACA standards. If the QSE HRA provides affordable coverage, an individual would lose subsidy eligibility entirely. Caution should be taken to fully educate employees on this impact.

It is unclear whether employer contributions to an HFSA may be considered when determining minimum value or affordability.

Other

Employer contributions to an HRA, HSA, or HFSA are not considered when calculating the small business health tax credit.

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