FACT SHEET

REIMBURSEMENT VEHICLES AND THE ACA:

IMPACTS FOR EMPLOYERS

The IRS issued guidance on the application of certain provisions of the Affordable Care Act (ACA) to employer health care reimbursement vehicles, including Employer Payment Plans (EPPs), Health Reimbursement Arrangements (HRAs) integrated with group health plans (or, in certain limited cases, Medicare) and Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs).

The following information was created to help employers of all sizes better understand the potential ACA impacts of health care reimbursement vehicles:

CONSULT WITH EXPERTS

Consult an expert regarding your specific situation. The following is intended as general information only and is not intended as specific tax or legal advice. You should consult your ministry's attorney and/or accountant to discuss your organization's specific situation.

DETERMINE WHETHER YOU HAVE INDIVIDUAL OR GROUP COVERAGE

Many of the requirements discussed below depend upon whether a participant has an **individual** medical insurance policy or is covered under group medical coverage. If you are unsure as to what kind of coverage you have or are providing, consult your agent or provider.

In general, an **individual** medical policy:

- Is not connected to a specific employer (i.e., it is exclusive between an individual and an insurance coverage provider).
- Is issued to a single named person/family.

In general, **group** health coverage:

- Is associated with an employer.
- Can provide coverage for multiple employees and their families through the employer's plan.

Because of GuideStone's unique structure as a church benefits board, **ALL of our plans are group health plans. This includes** both Group Plans offered by employers and Personal Plans issued by GuideStone® to individuals.

As a result of our unique structure, GuideStone does not issue **individual** medical policies; rather, it provides **group** health coverage through the plans it makes available to employees of eligible employers. If an employer has employees who are enrolled in GuideStone Group Plans or that are eligible to enroll in GuideStone Personal Plans, the employer has met the legal requirements and "offered" a group health plan under the guidance discussed below.

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BECOME INFORMED ON THE ACA'S IMPACTS ON REIMBURSEMENT VEHICLES

EPPs

General definition: An arrangement under which an employer reimburses an employee for, or directly pays the cost of, individual insurance premiums or Medicare Part B or D premiums, regardless of whether the reimbursement or payment is made on a pre-tax or after-tax basis.

ACA impacts: In September 2013, the IRS issued Notice 2013-54 (the 2013 Notice), which provides that EPPs are considered group health plans and, therefore, are subject to ACA market reform provisions, specifically the prohibition on annual and lifetime limits and the preventive care requirements. This conclusion meant that an employer would incur significant tax penalties if it continued to operate an EPP after the effective date of the 2013 Notice, which was January 1, 2014, for most reimbursement arrangements.

Many employers who utilized EPPs thought that the 2013 Notice created ACA penalty exposure only if the premiums reimbursed under the EPP were pre-tax. However, in November 2014, several joint-agency Frequently Asked Questions were posted on the Department of Labor website, one of which clarified that taxing premium reimbursements did not, by itself, eliminate ACA penalty exposure. Accordingly, many employers found themselves facing potentially significant ACA penalties.

Tax relief was granted to certain employers in February 2015 when the IRS issued Notice 2015-17 (the February 2015 Notice). However, after June 30, 2015, employers were essentially prohibited from operating EPPs unless one of the following exceptions applies:

Excepted benefits: The EPP is used to reimburse employees for, or directly pay the cost of, coverage that qualifies as an excepted benefit for purposes of the ACA market reforms. Examples of excepted benefits include limited-scope dental and vision coverage and certain Medicare supplemental health insurance.

One-employee health plan: The EPP covers fewer than two participants who are current employees. The one-employee EPP can be used to pay for or reimburse individual coverage on a pre-tax basis. This includes coverage acquired on the exchange. Please note that an employer with more than one employee that limits coverage under the reimbursement arrangement to only one employee may violate certain nondiscrimination requirements applicable to group health plans, so that premium reimbursements are taxable.

Medicare reimbursement arrangements: The February 2015 Notice permits an employer to directly pay or reimburse employees for Medicare Part B or Part D premiums through an EPP that is "integrated" with another group health plan offered by the employer that complies with the ACA if the following requirements are satisfied:

- The employer offers a group health plan to the employee in addition to the EPP that does not consist solely of excepted benefits and that provides minimum value.
- The employee participating in the EPP is enrolled in Medicare Parts A and B.
- The EPP is available only to employees who are enrolled in Medicare Part A and Part B or Part D.
- The EPP is limited to reimbursement of Medicare Part B or Part D premiums and excepted benefits including Medigap premiums.

It is also important to note that the February 2015 Notice warns that Medicare reimbursement arrangements may be subject to restrictions under other laws.

ACCOUNT-BASED PLANS

General definition: Traditionally, an account-based plan is an employer-provided group health plan that provides reimbursements of medical expenses other than individual market policy premiums with the reimbursement subject to a maximum fixed dollar amount for a certain period. An HRA is a type of account-based plan that is funded solely by an employer under which an employee is reimbursed for certain medical expenses, the maximum reimbursement amount is specified and reimbursements are not taxable to the employee.

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Note: It is very important that you work with a qualified resource when setting up your organization's HRA or other account-based plan, as they can be complex. For example, certain excise taxes under the ACA will depend on how an HRA and corresponding medical plan are structured. GuideStone does not provide HRAs, but can refer ministries to a resource for assistance.

ACA impacts: Prior to the ACA, employees were allowed to submit receipts for individual policies or other medical expenses through an HRA established by their employer. After the ACA, HRAs or other account-based plans were considered group health plans subject to the requirements under the ACA that apply to other group health plans. On its own, an HRA or other account-based plan typically would not comply with ACA provisions that prohibit annual limits on benefits or require preventive care at no cost. HRAs can now be used as a vehicle to reimburse individual market premiums and certain other medical expenses per the 21st Century Cures Act (the Act), which introduced a special HRA known as a QSEHRA, and the establishment of individual coverage HRAs (ICHRAs) under the Trump administration.

QSEHRAs

On December 13, 2016, the Act was signed into law, providing a mechanism for eligible small employers to offer a new type of HRA known as a QSEHRA. A QSEHRA is not considered a group health plan, and individual market policy premiums and other qualifying medical expenses are permitted to be reimbursed under a QSEHRA. A QSEHRA must satisfy certain requirements, which are further described below.

An employer is permitted to establish a QSEHRA if the employer is not an applicable large employer (ALE) and **does not** offer a group health plan to any of its employees. Additionally, a QSEHRA must meet all of the following requirements:

- All employees of the employer must be covered by the QSEHRA, unless they have not completed 90 days of employment, are under the age of 25, are part-time or seasonal, or satisfy the other requirements outlined in the Act.
- The QSEHRA must be provided on the same terms to all eligible employees, as outlined in the Act.
- The QSEHRA must be funded solely by the eligible employer; no salary reduction contributions are permitted.
- The QSEHRA must provide for the payment of, or reimbursement of, eligible medical care expenses (under Code section 213(d), including premiums for individual health coverage) but only after the employee provides proof of health coverage or expense for the employee or family members.
- The 2022 limit of annual payments or reimbursements from the QSEHRA to an eligible employee must not exceed $5,450 ($11,050 if family members are covered under the QSEHRA), prorated for the number of months the individual is covered if not covered under the QSEHRA for the entire year.

An employer offering a QSEHRA is required to provide an annual written notice containing the information required by the Act. The Act also includes certain other provisions applicable to QSEHRAs that should be reviewed by employers that are considering implementing a QSEHRA, including provisions impacting coordination with the premium tax credit available for individual coverage acquired through an ACA exchange and the taxability of QSEHRA payments.[1]

ICHRAs

In June 2019, a rule issued jointly by the Departments of Health & Human Services, Labor and the Treasury authorized the use of Individual Coverage Health Reimbursement Accounts (ICHRAs) to directly reimburse persons for individual market coverage and certain medical expenses. However, employees should be aware that there are key requirements that an employer must meet to offer coverage under an ICHRA.

Notably an employer must:

- Offer an ICHRA to all employees within the same class or combination of classes.
- Adhere to certain minimum class size requirements.

[1]The Act also extends the excise tax relief set forth in the February 2015 Notice (and further described above) to plan years beginning on or before December 31, 2016.

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- Allow only employees that are verifiably enrolled in individual market coverage to participate.
- Require employees to notify them if their individual coverage is terminated.
- Offer only an ICHRA or a group health plan, but not both.
- Offer the ICHRA to all employees within a class under the same terms and conditions.
- Give employees the opportunity to opt out of future reimbursements annually.
- Distribute a notice to employees at least 90 days before the upcoming plan year that contains prescribed content related to the guidelines and administration of ICHRAs.

Bottom line: HRAs and other account-based plans cannot be used with individual insurance policy coverage unless the employer qualifies for and establishes a QSEHRA or an ICHRA. If the employer is not eligible to establish either, the HRA or other account-based plan must be integrated with group coverage (or, in certain cases, Medicare) or used for one of the limited circumstances below.

Establishing a Traditional HRA

Employers that do not offer a QSEHRA or an ICHRA are still permitted to offer certain non-integrated (aka stand-alone) HRAs, but only in very limited circumstances. For example, a non-integrated HRA may be used if it covers fewer than two participants who are current employees (e.g., retiree-only plans). In addition, a non-integrated HRA for two or more persons may be used for certain excepted benefits, such as limited-scope vision or dental plans.

For an HRA or other account-based plan to be integrated with group health plan coverage, it must be offered with the employer's group health plan that complies with the ACA. It must also satisfy one of two integration methods summarized below. The first integration method requires the group health plan with which the HRA or other account-based plan is integrated to satisfy the minimum value requirements of the ACA. GuideStone Personal Plans and Group Plans satisfy the minimum value requirements of the ACA. The second integration method does not require the group health plan with which the HRA or other account-based plan is integrated to satisfy the minimum value requirements of the ACA but, instead, requires reimbursements from the HRA or other account-based plan to be limited to certain expenses further described below.

The Market Reform Regulations also include a third integration method for certain employers with fewer than 20 employees that are not required to offer group health plan coverage to Medicare-eligible employees. This integration method permits HRAs or other account-based plans to be integrated with Medicare if certain requirements are satisfied.

The three integration methods are further discussed below.

1 Integration with a group health plan that satisfies minimum value requirements

The HRA or other account-based plan must satisfy all of the following requirements to be considered integrated with a group health plan that satisfies minimum value:

- The plan sponsor offers a group health plan (other than the HRA or other account-based plan) to employees that provides minimum value.
- The employee receiving the HRA or other account-based plan is actually enrolled in a group health plan that provides minimum value, regardless of whether the plan is offered by the plan sponsor of the HRA or other account-based plan (non-HRA minimum value coverage).

[2]According to IRS Chief Counsel Memorandum 201547006, an employer's payments for the cost of health insurance under a spouse's group health plan may only be excluded from an employee's gross income if the spouse paid for all or part of the coverage on an after-tax basis and not through salary reduction under a section 125 cafeteria plan. In addition, an HRA may not be used to reimburse an employee for the cost of coverage under a spouse's group health plan if the spouse paid for such coverage on a pre-tax basis.

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- The HRA or other account-based plan is available only to employees who are actually enrolled in non-HRA minimum value coverage, regardless of whether the non-HRA minimum value coverage is offered by the plan sponsor of the HRA or other account-based plan (e.g., the HRA may be offered only to employees who do not enroll in the employer's group health plan but are enrolled in other non-HRA minimum value coverage, such as a plan maintained by the employer of the employee's spouse).[2]
- Under the terms of the HRA or other account-based plan, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based plan at least annually, and, upon termination of employment, the remaining amounts in the HRA or other account-based plan are either forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based plan.

2 Integration with a group health plan that DOES NOT satisfy minimum value requirements

An HRA or other account-based plan must satisfy all of the following requirements to be integrated with a group health plan that does not satisfy minimum value:

- The plan sponsor offers a group health plan (other than the HRA or other account-based plan) to the employee that does not consist solely of excepted benefits.
- The employee receiving the HRA or other account-based plan is actually enrolled in a group health plan (other than the HRA or other account-based plan) that does not consist solely of excepted benefits, regardless of whether the plan is offered by the same plan sponsor (non-HRA group coverage).
- The HRA or other account-based plan is available only to employees who are enrolled in non-HRA group coverage, regardless of whether the non-HRA group coverage is offered by the plan sponsor of the HRA or other account-based plan.
- The benefits under the HRA or other account-based plan are limited to reimbursement of one or more of the following: co-payments, co-insurance, deductibles and premiums under the non-HRA group coverage, as well as medical care under *Internal Revenue Code* section 213(d) that does not constitute essential health benefits.
- Under the terms of the HRA or other account-based plan, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based plan at least annually, and, upon termination of employment, the remaining amounts in the HRA or other account-based plan are either forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based plan.

3 Integration with Medicare for certain small employers

This integration method is available to certain employers with fewer than 20 employees that are not required to offer group health plan coverage to Medicare-eligible employees. For these employers, an HRA or other account-based plan that may be used to reimburse Medicare Part B or D premiums will be considered integrated with Medicare with respect to employees who would be eligible for the employer's non-HRA group health plan if they were not eligible for Medicare, provided all of the following requirements are satisfied:

- The plan sponsor offers a group health plan (other than the HRA or other account-based plan) that does not consist solely of excepted benefits to employees who are not eligible for Medicare.
- The employee receiving the HRA or other account-based plan is actually enrolled in Medicare Part B or D.
- The HRA or other account-based plan is available only to employees who are enrolled in Medicare Part B or D.
- Under the terms of the HRA or other account-based plan, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based plan at least annually, and, upon termination of employment, the remaining amounts in the HRA or other account-based plan are either forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based plan.

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For purposes of all three integration methods, the Market Reform Regulations clarify that a forfeiture or waiver occurs even if the forfeited or waived amounts may be reinstated upon a fixed date, a participant's death or the earlier of the two events. Upon reinstatement, however, the reinstated amounts under the HRA or other account-based plan may not be used to reimburse or pay medical expenses incurred during the period after the forfeiture and prior to the reinstatement.

Further, IRS Notice 2015-87 (the December 2015 Notice) clarifies that an HRA is permitted to be integrated with an employer's group health plan only as to the individuals who are enrolled in both the HRA and the group health plan. Accordingly, if an employee's family member is covered under the HRA but not the group health plan, then the HRA fails to satisfy the ACA market reforms.[3] This rule likely applies to other account-based plans in addition to HRAs, although the December 2015 Notice and Market Reform Regulations do not specifically apply it to such plans.

The December 2015 Notice provides transition relief for certain HRAs covering employees' family members who are not enrolled in the employer's group health plan. For plan years beginning before January 1, 2016, these HRAs will not be treated as failing to be integrated with the employer's group health plan. In addition, the IRS will not 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 for plan years beginning before January 1, 2017, solely because the HRA covers the expenses of employees' family members who are not enrolled in the employer's group health plan. Further, the December 2015 Notice states that the employer is responsible for reporting the HRA coverage as minimum essential coverage under section 6055 of the I*nternal Revenue Code* for each individual who is not enrolled in the employer's group health plan but whose medical expenses are reimbursable under the HRA.

SUMMARY

Helping Employees Pay for Coverage: Different Approaches

GuideStone continues to discourage the use of the salary package approach with respect to health care and other benefits. Under this approach, the employer provides a salary package from which the employee must pay for his or her own medical coverage and other benefits on an after-tax basis. This approach can create adverse tax consequences, resulting in less value to both the employer and the employee. Additionally, under the ACA, any increase in an employee's salary to assist with payments of individual insurance policy premiums cannot be conditioned on the acquisition of health coverage. For more detailed information about compensation planning, please see our Compensation Planning Guide workbook.

Below are a few ways to consider helping employees pay for coverage.

Directly Paying the Cost of Employee Group Health Plan Coverage as a Part of Employees' Benefits Packages

As a reminder, an employer is still permitted to pay all or a portion of the cost of group health plan coverage for its employees. Both GuideStone Group Plans and Personal Plans medical coverage qualify as group coverage under the ACA.

The employer's payment of all or a portion of the cost of group health plan coverage for employees is not taxable to employees.

But keep in mind — if the employee is contributing to the cost of this group health plan coverage, a section 125 plan (described below) is required.

[3] On January 12, 2017, two joint-agency FAQs were posted on the Department of Labor's website that provide guidance on the integration of an HRA with a group health plan sponsored by the employer of an employee's spouse. According to the FAQs, an HRA may be integrated with a non-HRA group health plan sponsored by the employer of the employee's spouse that covers all of the family members covered by the HRA, as long as the applicable integration requirements are satisfied. The FAQs also clarify that an employer may rely on the reasonable representation of the employee in determining whether these requirements are satisfied. The FAQs also clarify that the family members covered under the HRA are not required to be covered under the same non-HRA group health plan, as long as the applicable integration requirements are satisfied. Accordingly, an HRA covering an employee, spouse and dependent child could be integrated with a combination of the employee's coverage under the non-HRA group health plan of the employee's employer and the spouse and dependent child's coverage under the non-HRA group health plan of the spouse's employer, as long as the applicable integration requirements are satisfied.

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Offering a Section 125 Plan to Allow Employees to Pay for a Portion of Premiums on a Pre-tax Basis

An employer may permit an employee to pay premiums for group health coverage on a pre-tax basis through a cafeteria plan that complies with section 125 of the *Internal Revenue Code* (e.g., a Flexible Spending Arrangement). A cafeteria plan may be used only for group health plan coverage, including coverage provided through GuideStone Group Plans and Personal Plans. A cafeteria plan cannot be used to acquire coverage on a federal or state exchange, other than coverage provided through the Small Business Health Options Program (SHOP) Marketplace.

There are a number of legal requirements applicable to section 125 cafeteria plans, including a written plan document requirement, certain nondiscrimination requirements, and other design and administration rules. Accordingly, it is important that a church or other ministry employer consult with an attorney, accountant or other professional in establishing a plan to ensure compliance.

Offering Certain Types of EPPs that Are Still Permitted

An employer is still permitted to offer EPPs that qualify for one of the exceptions further discussed above. These include EPPs that reimburse or directly pay the cost of excepted benefits, EPPs that cover only one employee and EPPs that reimburse Medicare Part B or Part D premiums and satisfy certain requirements.

Offering Integrated HRAs or Other Account-Based Plans

An HRA is an arrangement funded solely by an employer under which an employee is reimbursed for certain medical expenses, the maximum reimbursement amount is specified and reimbursements are not taxable to the employee. Under the ACA, HRAs along with other account-based plans are required to be integrated with group health plan coverage (or, in certain cases, Medicare) unless a limited exception applies. See the "Account-based Plans" section above for additional information about these types of arrangements and the integration requirements.

Offering a QSEHRA

A QSEHRA is a type of HRA for eligible small employers to help employees pay medical expenses. An eligible small employer must offer the QSEHRA to all employees (subject to limited exceptions) and cannot also offer a group health plan to any of its employees. The QSEHRA must also satisfy the requirements described above.

Because HRA requirements are complex, employers should arrange for an HRA administrator. Contact GuideStone for resource information.

Offering an ICHRA

An ICHRA is a new type of HRA specifically designed to be coupled with individual market coverage. There are specific guidelines that must be followed in order to offer this type of account; however, this type of HRA allows for an increased amount of flexibility.

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GuideStone welcomes the opportunity to share this general information. However, this information is not intended to be relied upon as legal advice. This information may be subject to interpretation or clarification over time, so we cannot guarantee its long-term accuracy or how it might be determined to apply in certain situations. However, we hope it will provide you a useful frame of reference as you endeavor to carry out your responsibilities and serve your employees.