ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES: Practical Q&A

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

Attorneys John R. Hickman, Ashley Gillihan, Carolyn Smith, and Dan Taylor provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte, Dallas and Washington, D.C. law firm. Ashley Gillihan, Steven Mindy, Carolyn Smith and Dan Taylor are members of the Health Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to Mr. Hickman at john.hickman@alston.com.

IRS QSEHRA Guidance Leaves Many "Gotchas" for the Unwary Small Employer

At the end of 2016, Congress included a provision allowing certain small employers an opportunity to help employees purchase individual market major medical coverage and pay for other medical expenses through tax-favored health reimbursement arrangements. The new health reimbursement arrangement vehicle, called a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA), has significant limitations under current tax provisions, and may not be appropriate for all small employers. Recently, the IRS issued comprehensive Q&A guidance addressing many of the compliance issues affecting QSEHRAs in the form of IRS Notice 2017-67.[1] We cover that guidance, as well as some of the more significant QSEHRA compliance requirements below.

Top 10 QSEHRA Compliance Traps for Small Employers.

Several significant legal and practical limitations and potentially significant penalties may arise for unwary small employers considering adopting a QSEHRA arrangement. For example, QSEHRAs are only available to employers that are not subject to the Affordable Care Act (ACA) employer responsibility penalties – i.e., employers that have less than 50 full-time and full-time equivalent employees and thus are not applicable large employers (ALEs). In addition, while many small employers are likely to find QSEHRAs attractive, there are some features that should be looked at carefully before deciding to move forward. These include a requirement that a QSEHRA can only be funded through direct employer contributions (meaning that no employee salary reduction contributions are permitted), nondiscrimination rules, and a provision prohibiting employers from maintaining another group health plan.

The top compliance concerns for an employer considering adopting a QSEHRA include:

1. The employer must generally have fewer than 50 full time employees (including FT equivalencies) counting employees of controlled group members. Stated differently, the employer must not be an applicable large employer (Non-ALE).

2. The employer (including controlled group members) cannot offer, sponsor, or endorse any other group health plan coverage including medical, vision, dental, or supplemental health indemnity (e.g., cancer, hospital indemnity, etc.) coverage.

3. The employer cannot pay for or endorse (to the point of being an ERISA covered benefit) any individual health or medical insurance benefit.

4. The employer must fund the QSEHRA with real employer contributions (not salary reductions) – meaning that the employer must actually pay for the cost of individual medical coverage; any additional employee contributions must be on an after-tax basis.

5. All full time employees must be provided the same QSEHRA benefit to satisfy applicable nondiscrimination requirements

6. The employer is required to have the employee substantiate: i) that all QSEHRA participants (including dependents for whom a reimbursement is paid) have minimum essential coverage (MEC) either through the QSEHRA purchased policy or another source; and ii) that an eligible medical expense was incurred for any reimbursements through the QSEHRA to be tax free.

7. Additional tax (PCORI fee) and reporting (W-2 reporting of QSEHRA benefit) is required as well as a new notice describing the QSEHRA benefit.

8. The employer must adopt and maintain a QSEHRA qualified HRA plan document.

9. If there is any outside administration of the QSEHRA arrangement, or if the QSEHRA has more than 50 participants (e.g., due to participation by part-time employees), the employer must comply with HIPAA's privacy and security requirements, which include adoption and maintenance of HIPAA privacy and security policies and procedures.

10. State law should be checked to ensure that employer participation with individual medical policy coverage is permissible. Some states consider individual health insurance paid for by employers to be group health insurance. Thus, insurers, brokers and agents working with small employers should carefully consider state-law implications, which might include prohibitions against marketing individual policies to small employers. Some states specifically prohibit employers from reimbursing individual premiums.

Why QSEHRAs?

The QSEHRA provision is designed to overrule agency guidance under the ACA prohibiting employer arrangements that seek to pay or reimburse the cost of individual market major medical insurance purchased by employees. This guidance specifically provides that stand-alone health reimbursement arrangements (HRAs), meaning HRAs that are not integrated with another ACA compliant group health plan, are not permitted.[2] While these restrictions are not clear from the statutory provisions of the ACA, regulations and other administrative guidance preclude this type of arrangement on the basis that they violate one or more ACA requirements applicable to group health plans, in particular, preventive care requirements and/or the prohibition on annual and lifetime dollar limits on essential health benefits.

The federal tri-agencies (Department of Labor, Department of Health and Human Services, and Internal Revenue Service/ Department of the Treasury) use the broad term "employer payment plan" to encompass the types of arrangements prohibited under this guidance. In some cases, even post-tax reimbursement of individual market major medical insurance is not permitted, depending upon the level of employer involvement in the arrangement. Prior to enactment of the Cures Act, employers that adopted these types of arrangements were subject to a $100 per person per day excise tax under Internal Revenue Code § 4980D (for private employers and churches) or a $100 per day penalty under Public Health Service Act § 2723 (for governmental employers).

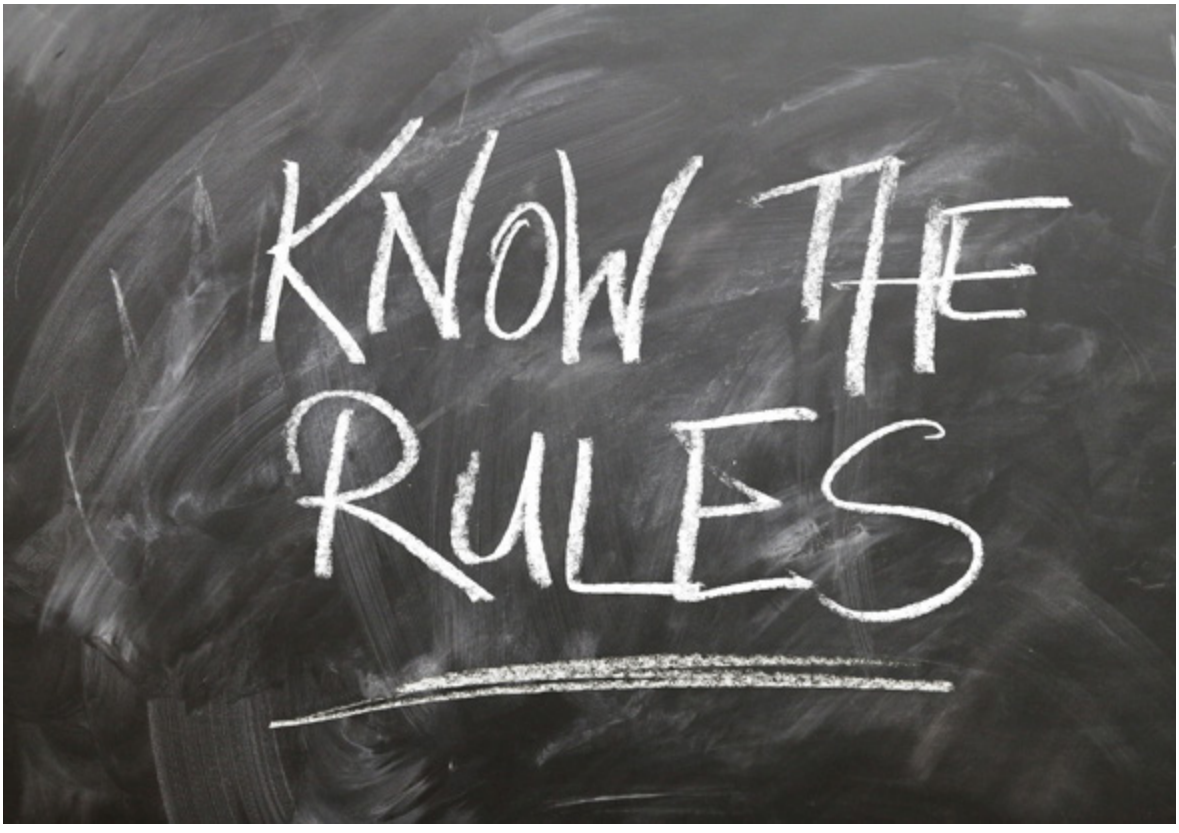
The Cures Act allows small employers to adopt this type of HRA arrangement, provided the requirements in the Cures Act are followed. QSEHRAs are not subject to the ACA market reforms and are not subject to COBRA requirements.

Eligible Employers

An employer is eligible to adopt a QSEHRA if *both* the following requirements are met:

(1) The employer is not an applicable large employer (ALE) as defined under the ACA employer responsibility penalties under tax code § 4980H. Under 4980H, ALE status is determined on a controlled group basis, so that for an employer to be eligible for a QSEHRA, the entire controlled group must collectively employ less than 50 full-time and full-time equivalent employees ***in the prior calendar year.***

(2) The employer (and any controlled group member) does not maintain a "group health plan" for any employees.



The Cures Act does not specifically define "group health plan" for purposes of the requirement that a small employer adopting a QSEHRA cannot offer a group health plan to any employee. The definition of group health plan in the tax code is fairly broad and includes more than just major medical coverage. Unfortunately, the IRS FAQ guidance uses this very broad definition of health plan for QSEHRAs, meaning that ***ABSOLUTELY NO other health coverage can be sponsored or endorsed by the employer or any controlled group member of the employer***.

For example, health flexible spending arrangements (FSAs) and supplemental benefits such as dental and vision plans are considered group health plans for some purposes (e.g., COBRA). Employer involvement with such coverage would invalidate the QSEHRA arrangement. Additional examples provide that employer contributions to an HSA may be permissible, but that employers cannot recommend or endorse any group health coverage to the extent that such endorsement may cause the coverage to be considered an ERISA covered plan.[3]

Permitted Contributions

Salary reduction contributions to a QSEHRA are not permitted. Thus, a QSEHRA must be funded solely by the employer. Moreover, as discussed below, the prior agency guidance continues to prohibit employees from paying any additional cost of the individual major medical coverage on a pre-tax basis. While employees may apparently pay any additional contributions through after tax payroll deductions, care must be taken to ensure that the employer is not considered to sponsor or endorse any specific health insurance carrier, policy, or form. [4]

Nondiscrimination Requirements

In general, a QSEHRA must be provided on the same terms to all eligible employees. Theoretically, the employer can vary the amount of reimbursements available under the arrangement based on age of the eligible employee (and family members if the arrangement covers family members) or the number of family members of the employee covered under the arrangement. However, any such variation must be made in accordance with the variation in price of an insurance policy in the relevant individual health insurance market. For this purpose, any variation must be determined by reference to the same insurance policy with respect to all eligible employees. Due to the administrative complexity of such a process (especially where, as noted above, a single carrier cannot be required), most employers will choose to provide a flat amount of QSEHRA benefit.

"Eligible employee" means any employee of the employer. However, a QSEHRA may exclude the following employees (as set forth in regulations applicable to self-funded health plans under Section 105 of the Code):

- Employees who have not completed 90 days of service;[5]
- Employees who have not attained age 25;
- Part-time or seasonal employees;
- Employees covered by a collective bargaining agreement; and
- Nonresident aliens who receive no earned income from the employer from sources within the United States.

Once an employee falls outside of one of the excludable categories (above), they must be provided coverage under the QSEHRA no later than the day following the day they cease to fall in one of the excludable categories above. Moreover, employees cannot waive participation in a QSEHRA (e.g., to preserve HSA eligibility) because the Cures Act requires that the QSEHRA be "provided" to all eligible employees.[6] This could cause individuals who would like to make HSA contributions to be ineligible if their employer provides a QSEHRA that allows for reimbursement of more than medical coverage premiums (e.g., it reimburses out of pocket medical expenses).[7]

Maximum Benefit Requirement

The maximum amount currently available under a QSEHRA for any calendar year cannot exceed $5,050 ($10,250 if the arrangement provides for payments for medical care for family members). The dollar amounts are indexed in $50 increments for inflation, based on changes in the Consumer Price Index for All Urban Consumers (the same index used for purposes of determining rate brackets under the income tax rules). Updated amounts will generally be available in October of each year.

The maximum dollar amounts are determined on a month to month basis (using current and proceeding year statutory limits) if a QSEHRA is offered on a non-calendar year basis and are pro-rated to reflect the number of months that the QSEHRA is provided if an employee is covered under the arrangement for less than a full year. A QSEHRA may allow the full year's benefit amount to be reimbursed at the time a claim is incurred, but any reimbursement for claims provided after termination must be prorated by the number of months of coverage (even if the claims were incurred prior to termination of coverage). While carryovers for unused benefits are allowed under the nondiscrimination requirement, any carryover amount when added to the current year's benefit must not exceed the statutory limits.[8]

Proof of "MEC Coverage" Requirement

Part of the definition of a QSEHRA is that the arrangement provides for the payment or reimbursement of medical expenses as defined under tax code § 213(d) "after the employee provides proof of coverage." While the term "coverage" is not defined for this purpose, the IRS has interpreted it to mean that each individual (including dependents) for whom an expense is reimbursed must have minimum essential (MEC) coverage (either through the QSEHRA or another plan). The "MEC substantiation" can be accomplished by obtaining: i) proof of third party coverage (e.g., an insurance card or EOB) and an attestation as to MEC; or ii) an attestation as to such coverage from the employee stating that the employee and individual have MEC, the date such coverage began, and the provider of coverage. For subsequent months, the attestation can be built into any reimbursement claim form or process.[9]

Tax Treatment of Reimbursements

Reimbursements are tax-free to the employee if the employee has MEC for the month in which the expense is incurred. MEC is defined under the ACA rules under tax code § 5000A(f). The QSEHRA itself is not MEC, so the employee must have some other type of coverage (e.g., in many cases, the individual major medical coverage they

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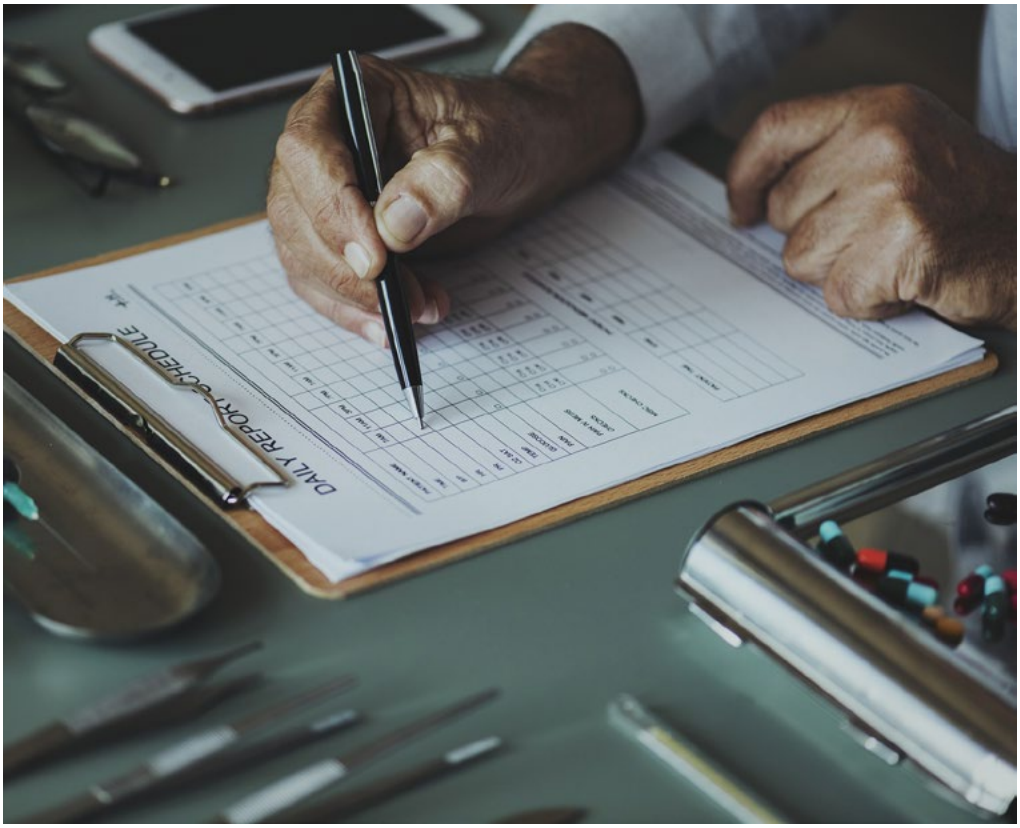
are purchasing) to qualify for tax-exempt treatment. The language does not restrict MEC to any particular type of coverage and thus, for example, would appear to include individual market coverage whether purchased on or off the Marketplace, group health plan coverage through another employer, and Medicare.

Once eligible, a QSEHRA can reimburse expenses for medical care as defined under tax code 213(d). Thus, reimbursement of individual major medical health insurance premiums, as well as other § 213(d) expenses, is permitted. Premiums paid by the employee on a pre-tax basis for coverage under a group health plan of another employer (e.g., the spouse's employer) would not qualify for tax-free treatment, but may be permitted to be reimbursed under a QSEHRA.[10] Additionally, a QSEHRA can reimburse over-the-counter drugs purchased without a prescription, but the reimbursements must be taxed due to the restrictions under Code § 106(f). [11]

In order for a reimbursement to be tax free, the employer must substantiate that the expense has been incurred, using methods similar to those allowed for reimbursing expenses under a cafeteria plan FSA or an HRA. Failure to require adequate substantiation (e.g., a third party receipt and statement from the participant) and/or seek repayment of erroneous reimbursements prior to March 15th of the year following the year in which the error is identified could result in all reimbursements under the QSEHRA being taxed. [12]



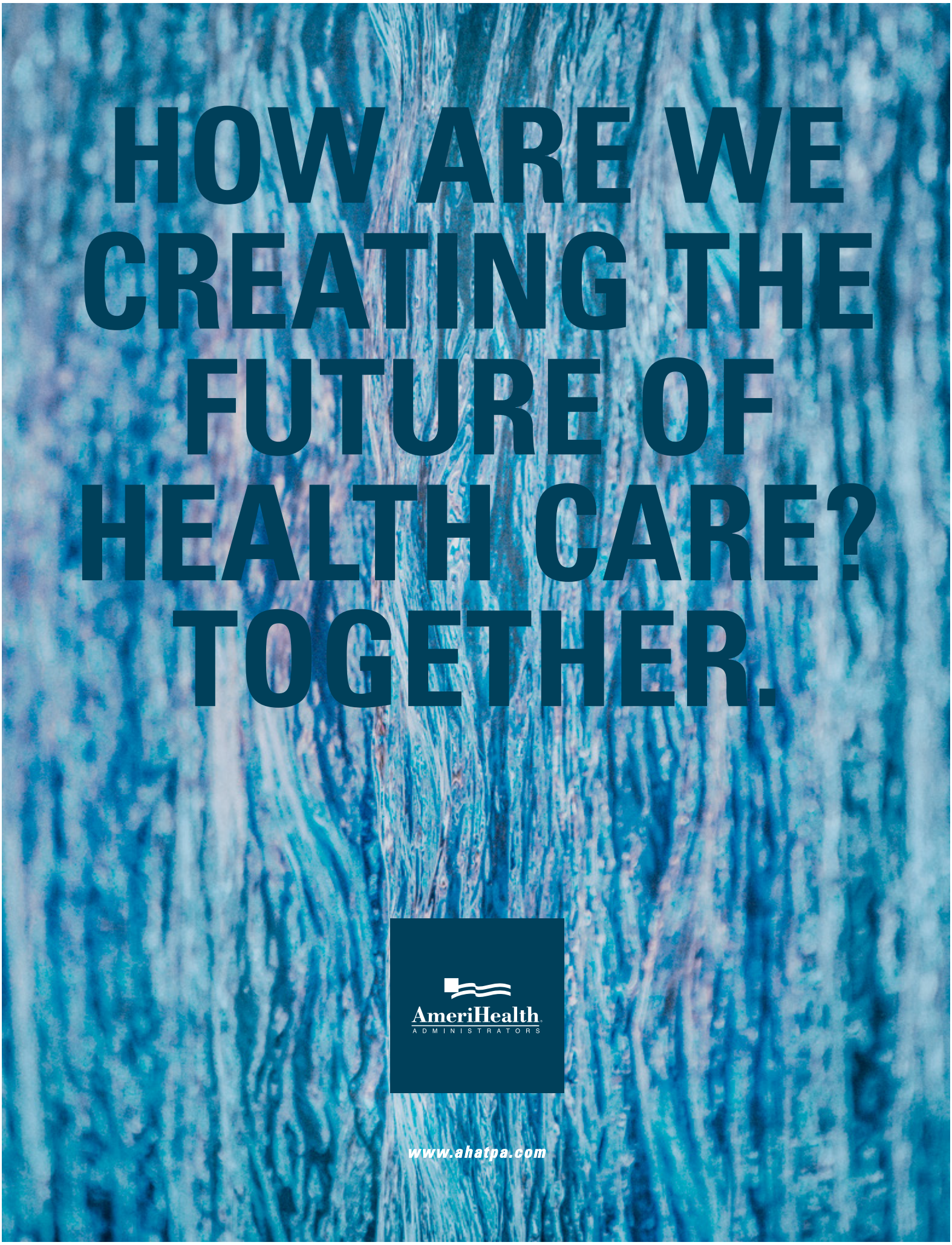
Notice, Reporting, and Substantiation Requirements

Employers are required to notify eligible employees of a QSEHRA 90 days before the beginning of the plan year of the QSEHRA (or February 19, 2018 if later). For newly eligible employees, the notice must be sent prior to the first day the employee becomes eligible for a QSEHRA. The notice can be sent in writing or using the IRS approved e-Sign procedure. The notice must include the amount of the benefit under the QSEHRA, a statement that the employee must inform the exchange as to the amount of the QSEHRA benefit and impact on the premium tax credit, and also inform the employee that payments may be taxable if the employee does not have MEC. The IRS guidance includes a sample notice as an appendix. [13]

Employers are required to include the total amount of any permitted QSEHRA benefit on W-2 in Box 12 using Code "FF". The IRS has indicated that the amount(s) to be reported for W-2 reporting purposes will generally correspond to the amount of reimbursement available regardless of the amount actually reimbursed during the year. In a series of FAQ examples, the IRS guidance clarifies issues related to pro-rated years, carryover benefits, and coverage valuation. [14]

Consequences for Failing to Meet QSEHRA Requirements

The requirement that QSEHRAs be funded by the employer (with no salary reduction contributions), the nondiscrimination rules, and the proof of coverage provision are all part of the definition of a QSEHRA. An arrangement that does not satisfy these requirements is not a QSEHRA and will be subject to the ACA market reforms and other requirements applicable to group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health plans. Thus, an employer that fails to meet the applicable requirements could be subject to the $100 per person per day excise tax or penalty (as applicable).

Coordination with ACA Premium Tax Credits

There is a special rule for coordinating QSEHRAs with eligibility for premium tax subsidies. An employee who is provided a QSEHRA is not eligible for a premium tax credit if the QSEHRA is "affordable." Affordability for this purpose is computed by looking at the self-only QSEHRA benefit in a manner similar for other employer coverage – i.e., looking to the amount of self-only permitted QSEHRA benefit made available, regardless of the amount paid. [15]

The QSEHRA is considered affordable for a month if excess of the self-only premium under the second lowest cost silver plan offered in the relevant individual health insurance market over 1/12 of the employee's permitted benefit under the QSEHRA does not exceed 1/12 of 9.5 (as adjusted for inflation) percent of the employee's household income.

If QSEHRA coverage does not meet the affordability standard, then the monthly premium tax credit is reduced by 1/12 of the annual benefit actually provided (e.g., self only or family as applicable) under the QSEHRA.

Cadillac Plan Tax

Benefits under a QSEHRA are taken into account for purposes of the so-called Cadillac plan tax under tax code § 4980I, currently scheduled to go into effect in 2022. For Cadillac plan tax purposes, the value of the coverage under a QSEHRA is the maximum amount of permitted benefit available under the arrangement to the employee and not the specific amounts reimbursed.

Even though QSEHRAs are subject to the Cadillac tax, it seems unlikely that the tax would apply with respect to such arrangements, assuming that the tax does go into effect. This is for two reasons. First, the maximum permitted benefit is significantly less than the Cadillac plan tax thresholds, which are $10,200 for single coverage and $27,500 for family coverage. These are the amounts that would apply in 2018; the thresholds will be higher in 2022 and are indexed in subsequent years. In addition, because QSEHRAs are available only to employers that do not have another group health plan (other than possibly certain types of supplemental coverage), no other coverage of that employer is likely to push the value over the threshold.

Patient-Centered Outcomes Research Trust Fund (PCOR) Fee

Small employers who sponsor QSEHRAs must also file Form 720 and pay the Patient-Centered Outcomes Research Trust Fund fee under Code § 4376 for plan years that end before October 1, 2019. The Form 720 is due on July 31 of the year following the last day of the plan year. The fee for plan years ending before October 1, 2018 is $2.38 per the average number of covered lives under the plan. ■

References

1 IRS Notice 2017-67, https://www.irs.gov/pub/irs-drop/n-17-67.pdf

2 The agency guidance prohibits pre-tax salary reduction and most other forms of employer reimbursement of individual major medical insurance. Other than as specifically allowed for QSEHRAs, this prior agency guidance continues to prohibit such "employer payment plan" arrangements.

3 See Notice 2017-67, FAQs 1-7 and 55.

4 See Notice 2017-67, FAQ 55.

5 Solely for QSEHRAs, the Cures Act reduces the Code Section 105 requirement from 3 years to 90 days.

6 See Notice 2017-67, FAQs 8-11.

7 See Notice 2017-67, FAQs 75.

8 See Notice 2017-67, FAQs 27 – 34

9 See Notice 2017-67, FAQs 41 – 43

10 See Notice 2017-67, FAQs 48 and 63.

11 See Notice 2017-67, FAQs 54 and 63.

12 See Notice 2017-67, FAQs 44-45.

13 See Notice 2017-67, FAQs 35-39.

14 IRS Notice 2017-67, Q/A 57 – 64.

15 IRS Notice 2017-67, Q/A 65 – 71.