Reimbursement Arrangements for Individual Insurance Plans

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Overview

As employers seek ways to address the cost of health care, one alternative has been to offer coverage to employees using pretax benefit plans that allow the reimbursement of individually billed premium plans. This white paper addresses the issues surrounding individual insurance premium plans through a Section (§) 125 Cafeteria Plan or a Section 105 Health Reimbursement Arrangement (HRA) and the more recent impact on these arrangements as a result of the market reforms under the Affordable Care Act (ACA).

Background

The Internal Revenue Code (IRC) provides several ways that an employer may reimburse employees or allow them to pay for individual insurance on a pretax basis. The common methods are through a § 105 plan such as the EBC HRA or through a § 125 plan such as the BESTflex Plan.

Guidance to support the reimbursement of individual insurance policies through the EBC HRA can be found in IRS Notice 2002-45 and 2002-28 I.R.B. 93, Part II.

Reimbursement arrangements through a § 125 Cafeteria Plan are supported by the proposed regulations found in Federal Register 43937 (August 6, 2007) which specifically permit a cafeteria plan (but not a health FSA) to pay or reimburse substantiated individual accident and health coverage premiums. Additional support can be found in Rev. Rul. 61–146 (1961–2 CB 25) or see §601.601(d)(2)(ii)(b).

Plan years that begin or renew in 2014, must contend with new regulatory issues related to providing reimbursement of individual insurance premiums under the EBC HRA or BESTflex plans. The guidance provided on September 13, 2013 in IRS Notice 2013-54, prohibits an employer from reimbursing or paying for individual health insurance coverage on a pretax basis unless the plan is a "retiree-only" plan. Retiree-only plans must have less than 2 current employees participating to be protected from the market reforms described in this Notice. [1] **Effectively, this prohibits the use of an HRA or § 125 plan to provide tax free reimbursement or payment of individual health insurance premiums for active employees.**

Aside from the ACA market reforms relative to individual health insurance policies, an employer that offers the tax free reimbursement or payment of individual insurance plan premiums other than health insurance (e.g., individual dental plan, vision, accident, cancer care premiums, etc.) may still do so through an HRA or § 125 cafeteria plan. The tax free reimbursements of excepted benefits, those that are limited in scope, are still eligible for tax free status under the IRS guidance. However, employers must be aware that the mere sponsoring of the tax free vehicle (HRA or § 125 plan) for these individual plans might cause the regulators to construe this arrangement as a group plan, subject to all of the same Department of Labor (DOL), Health and Human Services (HHS) and other federal regulations and mandates that affect group plans (e.g., COBRA, HIPAA, FMLA, etc.).

[1] IRS Notice 2013-54

Group Plan Implications

Without careful planning and implementation, reimbursing individual policies through plans such as the EBC HRA or the BESTflex Plan, may cause the individual policy to be viewed as a group health plan subject to the requirements found in ERISA, COBRA, HIPAA and other federal and state mandates.

ERISA

Under the Department of Labor's (DOL) ERISA requirements, an employer may have limited involvement with an individual or voluntary accident or health plan and not have the plan be governed by ERISA. This safe harbor can be found in DOL Reg. § 2510.3-1(j). Certain actions will be considered "employer endorsement." Those actions may include assisting employees in filing claims or disputes, listing the policy with the employer's policies or paying the premiums through a cafeteria plan[2]. Hrabe v. Paul Revere Life Ins. Co., 951 F. Supp. 997 (M.D. Ala. 1996) found that the employer had in effect endorsed a disability plan and did not satisfy the safe harbor rules by simply listing the policy information in the cafeteria plan. Full details of the court case can be reviewed at:
http://law.justia.com/cases/federal/district-courts/FSupp/951/997/1381454/

To summarize the safe harbor requirements, as an employer you will want to ensure that you do as much as possible to avoid creating a group health plan.

- DO NOT make employer contributions towards insurance premiums
- DO NOT become involved in any employee decisions
- DO NOT restrict insurance or carrier choices
- DO NOT communicate that the policies are employer provided or part of an employer benefit
- DO NOT assist with any negotiations with insurers
- DO NOT execute any policy documents on behalf of your employees
- DO NOT answer any questions regarding the policy
- DO NOT maintain any claim forms, documents or copies of policies
- DO NOT assist with claims disputes, claims submissions or any other claims issues

Allowing employees to pay for what would otherwise be individual plans with pretax dollars through a cafeteria plan arrangement may be construed as employer sponsorship, triggering ERISA and other legal requirements.

HIPAA

HIPAA applies to any employer sponsored health plans. The employer's size is not relevant. If the individually billed premium plan is viewed as employer sponsored under HIPAA, individual underwriting and the way premiums are structured for those policies might not meet HIPAA's health status nondiscrimination rules[3]. Some factors that HIPAA prohibits the premiums to be based on are health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability and disability. Some individual policies would violate the HIPAA nondiscrimination rules.

[2] A detailed discussion can be found in Cafeteria Plans, by Thomas P. McCormick, Esq. and John R. Hickman, Esq. (Employee Benefits Institute of America)
[3] Code § 9802;ERISA § 702; PHSA § 2702; 66 Fed Reg. 1378; 66 Fed Reg. 1421; 66 Fed Reg. 1437

HIPAA's nondiscrimination rules only apply to major medical health plans; not to excepted benefits such as dental, vision, cancer or long term care insurance. However, these excepted benefits are still subject to HIPAA's administrative simplification requirement, privacy requirements and security requirements[4]. You may also want to review the Health Care Financing Administration (HCFA) Insurance Standards Bulletin 00-06 (Nov. 2000) that discusses when an individual insurance policy may be subject to HIPAA's requirements.

COBRA

Group health plans are subject to continuation rules under COBRA. In the event that individual policies offered under an HRA or § 125 cafeteria plan are viewed as group health plans, they too would be subject to COBRA's continuation rights. If applicable, the employer would be responsible for notification and continuation of coverage requirements for the 18, 29 or 36 months of COBRA coverage. Not all insurers will work with the employer to "guarantee" this type of coverage for individual policies. The employer may ultimately be responsible for finding comparable coverage or care.

In the case of *Stange v. Plaza Excavating, Inc.*, 2001 U.S. Dist. LEXIS 1190 (N.D. Ill. 2001), the court ruled in favor of the former employee. The ex-employee sued her former employer for sexual harassment and failure to provide COBRA continuation. The employer tried to have the case dismissed because the employee was covered under an individual policy. The court refused to dismiss the case and proceeded with the trial. The plaintiff won.

Other State and Federal Mandates besides ERISA, HIPAA and COBRA

Other state and federal mandates that may apply in the event an individual plan is construed to be a group plan include FMLA, USERRA, Title VII of the Civil Rights Act, the ADEA, the ADA, the Equal Pay Act and possible state nondiscrimination, family and medical leave laws and insurance regulations.

Court Decisions

Court cases where individual policies were determined to be group plans (under ERISA, COBRA, HIPAA, and other federal mandates) include:

- *Heidelberg v. National Foundation Life Ins. Co.*, 2000 U.S. Dist. LEXIS 16540 (E.D. La. 2000)
- *Johnston v. Paul Revere Life Ins. Co.*, 2001 U.S. App. LEXIS 2427 (8th Cir. 2001)
- *Brown v. Paul Revere Life Insurance Co.*, 2002 U.S. Dist. LEXIS 8994 (E.D. Pa. 2002)
- *Rubin v. Guardian Life Ins. Co. of America*, 2001 U.S. Dist. LEXIS 9347 (D. Ore. 2001)

Keep in mind that these cases are similar, but do not have all the same facts and circumstances. They also do not specifically address the issue of an individual policy being offered under a cafeteria plan. They do all have the same outcome, the individual policy was found to be a group plan.

[4] 45 CFR § 160.103

There have been several court cases that have found the employer had no involvement in the individual policies and therefore not group health plans. These include:

- Davis v. Metropolitan Life Ins. Co., 2004
- O'Brien v. Mutual of Omaha Ins. Co., 99 F. Supp 2d 744 (E.D. la 1999)
- New England Mutual Life Ins. Co. v. Baig, 166 F. 3d (1st Cir. 1999)

If an employer is challenged on whether the offer of individual plans by the employer rise to the level of being a group plan will be determined by the employer's involvement and the court's interpretations and decision.

Health Care Reform Implications

Employer Payment Plan cannot permit Tax Free Reimbursement or Pay Premiums for Individual Health Insurance

Regulatory guidance[5] issued in September, 2013, created a reference to an "employer payment plan" which in this context is the employer's pretax reimbursement or payment of "non-employer sponsored hospital and medical insurance." Through a series of questions and answers, the guidance prohibits an employer from paying for or reimbursing premiums for an individual health insurance plan on a pretax basis, unless the employer's payment plan is a "retiree-only" plan. Conversely, an employer's payment plan that is reimbursing or paying the premiums for individual insurance other than health insurance on a pretax basis is allowed for both "retiree-only" plans and active employee plans.

Basically, this means that the employer's § 125 cafeteria plan (e.g., BESTflex Plan) and/or HRA (e.g., EBC HRA) cannot reimburse or pay the premiums for individual health insurance unless the plan is a retiree-only plan because the BESTflex Plan and EBC HRA are employer payment plans.

In the same September 2013 guidance, the regulators refer back to Code § 9831(a)(2) and ERISA §732(a), to specify that the health care market reforms "do not apply to a group health plan that has fewer than two participants who are current employees on the first day of the plan year." In accordance with these code sections, the regulators have come to refer to plans that cover fewer than two current employees as "retiree-only" plans.

Consequently, if an employer designs their employer payment plan such that fewer than two of the participants are current employees (e.g., retirees, employees who have separated employment, etc.) on the first day of the plan year then that plan, either an HRA or § 125 cafeteria plan, can reimburse or pay for the individual health insurance premiums.

Employers must discontinue the practice of providing tax free assistance to purchase individual health insurance for active employee plans beginning with BESTflex or EBC HRA plans that begin or renew in 2014. For those employers that wish to continue offering assistance with individual health insurance

[5] IRS Notice 2013-54

plans, they may establish payroll practices of forwarding post-tax employee wages to a health insurance issuer at the direction of an employee without establishing a group health plan, if the standards of the DOL's regulation at 29 C.F.R. §2510.3-1(j) are met.

Providing after tax cash (additional taxable compensation) only to those purchasing individual medical plans creates an employer payment plan and is in violation of ACA market reforms.[6]

Failure to satisfy the market reforms set forth in the Affordable Care Act (ACA) can result in a $100 per day per person penalty.

Cafeteria Plan

After the implementation of the Public Marketplace due to the Affordable Care Act (ACA), insurance premiums used to purchase coverage through the Public Marketplace are not an eligible expense under a § 125 Cafeteria Plan[7]. Further, due to IRS Notice 2013-54, the cafeteria plan cannot reimburse the employee or pay for any individual health insurance plan. The only exception to this rule is premiums used to purchase coverage through a Small Business Health Options Program (SHOP) which are eligible as a pretax benefit[8].

Cafeteria Plan Individual Billed Premium Account

By selecting the Employer Contribution and Individual Billed Insurance Premium Account (IND Account) features, the BESTflex Plan can accommodate an employer's wish to fund all or part of their employees' individual insurance costs, other than individual health insurance, and allow the Individual Billed Premium Account to reimburse eligible premium payments. This IND Account provides for a plan year election amount and operates similar to a dependent care account in that the account can only reimburse expenses up to the deposits on hand and can only reimburse for the premiums after the month of coverage has expired (e.g., premium for March can be reimbursed at the end of March, etc.). The employer can contribute to the account and can provide that contribution as a periodic deposit (e.g., monthly, quarterly, etc.). If the individual insurance plan(s) the employee purchases costs more than the employer's contribution the employee can elect additional pretax dollars to this account through payroll so that the employee is reimbursed the total of their individual plan premium coverage pretax.

Example: *ABC Corporation provides an IND Account in its cafeteria plan and makes a contribution of $100 per month ($1,200 per plan year) for each employee that works at least 30 hours per week. Bob is an eligible employee and knows that the cost of his individual disability and dental insurance plans is $200 per month ($2,400 per year). Bob knows that his employer will contribute $1,200 for the year, so he elects an additional $1,200 in the IND Account to be deducted pretax from his paychecks ($100 per month) throughout the year. Bob has a total of $2,400 available to reimburse his eligible individual plan premiums. He submits a request for reimbursement along with the billing from his insurers to the plan administrator and can receive up to $200 tax free at the end of each month during the plan year.*

[6] IRS Notice 2015-17
[7] Code § 125(f)(3)(A)
[8] Code § 125(f)(3)(B), Pub. L. No. 111-148, § 1515(a)

Note: Disability premiums paid for with pretax dollars will result in a taxable disability benefit in the event a claim is filed and claim payment is received.

Employee Benefits Corporation can perform all administration duties. Plus, the cost to the employer is limited to whatever contribution they elect to make to the IND account and a nominal monthly per account fee.

Premium Only Plan

If an employer currently has or adopts a § 125 Premium Only Plan, such as the BESTflex Premium Only Plan, they have the option to fund insurance premiums on a pretax basis just like in the individual option described above, except in this case the employer would receive a "list" billing from the individual plan insurer(s) and make payment to the insurer on behalf of the employees. This is commonly how some voluntary insurance benefits like cancer care or accident insurance plans are billed and paid for from several insurers that offer these kinds of plans.

The employee portion of the eligible premiums would be deducted pretax or after-tax from the employee's pay checks and along with any applicable employer contributions will be forwarded on to the carrier for the coverage(s) that they employee has enrolled in each month. No reimbursement of premiums in this case because the employer is acting as the billing agent and is responsible for forwarding the premiums.

Example: *ABC Corporation provides an employer contribution of $50 per month for cancer and accident insurance coverage through the premium only portion of its cafeteria plan for each employee that works at least 30 hours per week. ABC Corporation will only contribute funds for plans purchased from an insurer that will bill the employer, on behalf of the employee, for that coverage. Bob is an eligible employee and the cost of his individual cancer care and accident insurance plans is $70 per month. Bob knows that his employer will contribute $50 per month. So, ABC Corporation deducts $20 per month pretax from Bob's checks so that they have sufficient funds to pay the monthly invoice of $70 from Bob's insurer.*

Individual Plan Sources

The individual insurance plans the employees purchase could be purchased through a private exchange or directly from the carrier of the plan (insurer).

Private Exchange

Private exchanges are established by private entities, such as insurance companies, consulting firms or third party administrators, to provide access to various insurance plans for an employer's employees to purchase rather than the employer contracting directly with an insurer to provide the coverage. If the insurance purchased though the private exchange is individual coverage, not group coverage, the cafeteria plan can reimburse the premiums for individual plans other than health insurance, such as dental, vision, cancer care, accident coverage, etc. If the private exchange bills the employee directly, then the employer would need to offer an individual premium reimbursement account in their cafeteria plan. If the private exchange provides a list bill to the employer, then the employer can use the Premium Only portion of their cafeteria plan to provide the pretax benefit.

Direct from Carrier
An alternative to private exchange coverage is to purchase plans, other than individual health insurance, directly from the insurance carrier. These premiums are eligible for reimbursement through the Individually Billed Premium Account (IND Account) if the insurer bills the employee directly or can be provided as a pretax benefit in the Premium Only portion of the cafeteria plan if the insurer provides a list bill to the employer.

EBC HRA

Stand-alone EBC HRA plans that begin or renew in 2014 are subject to the no annual and no lifetime limit requirement, unless the EBC HRA qualifies as an excepted benefit. An excepted benefit HRA includes retiree-only HRA plans (a plan that covers fewer than two current employees on the first day of the plan year) or HRA plans that reimburse only dental and/or vision expenses. All other stand-alone EBC HRA plan designs will be subject to the no limit provisions.

Employers that previously used the EBC HRA to reimburse individual premiums or that intend to do so in the future will be prohibited unless the EBC HRA is established to only reimburse premiums that are excepted benefit coverage (i.e. dental, cancer, accident, or vision coverage, etc.) or are premiums, including individual health insurance premiums, as part of a retiree-only plan[9].

EBC HRA plans that are integrated with an employer's group health plan will continue to be compliant and will not separately be subject to the no-annual or lifetime limit provisions since the underlying group health plan must comply. However, even though the integrated HRA is not subject to several ACA provisions, the integrated HRA cannot reimburse premiums for individual health insurance coverage.

Officially, to be an integrated HRA the HRA must satisfy the following:

- Employer must sponsor a group medical coverage plan other than the HRA
- Participation in group medical coverage through the employer or another employer's group medical plan (other than the HRA) is required to be in the HRA.
- Minimum Value may apply if the employer integrates its HRA with another employer's medical plan (such as the medical plan of a spouse's employer)
    - If the HRA reimburses all qualified medical expenses (not just expenses covered by the group medical plan), then the employee's other employer's group medical coverage is required to provide "minimum value". Minimum value means that a group health plan covers at least 60% of the cost of all benefits.
    - If the HRA reimbursement is restricted to cost sharing of deductible, co-pays, coinsurance, etc. of the group medical plan, then Minimum value not required.
- **Opt out provision is required**. An employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually and, upon termination of employment. If so, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA. This opt-out feature is required because the benefits provided by the HRA generally will constitute minimum essential coverage

[9] Department of Labor FAQs, January 24, 2013

under Code § 5000A and will therefore preclude the individual from claiming a Code § 36B premium tax credit.

Insurance reimbursement for dental and vision expenses will continue to be eligible in a post-ACA world. Employers that currently provide an EBC HRA to provide reimbursement for individual plan premiums through a non-integrated HRA will need to be careful to communicate the changes in eligible coverage to plan participants. Individual health premiums will no longer be eligible effective with the plan renewal in 2014.

State Law Implications

Several states have issued guidance or other regulations regarding the sale of individual insurance policies and pretax benefit plans. Some states view the reimbursement of individual policy premiums through a tax advantaged plan as a negative while other states view this as a positive approach. Please check with your state's Insurance Commissioner to ensure that offering these benefits through an EBC HRA or the BESTflex Plan does not violate any insurance regulation.

While it has not been challenged yet, a state's determination that reimbursement of individual policies creates a group health plan could be taken into consideration for determination under the federal regulations such as ERISA, HIPAA and COBRA.

It is also important to remember that state guidance will not supersede federal issues. As part of the analysis to offer individual insurance plan reimbursement, both the state and federal issues must be carefully reviewed.

Georgia

Proposed SB 28 "Insuring Georgia's Families Act" encourages employers to use a health reimbursement arrangement (HRA) to provide tax-free reimbursement of individual insurance policies. Policies reimbursed through an HRA will not be deemed to be a group policy under Georgia insurance law.

Massachusetts

The Massachusetts Health Care Reform Act of 2006 requires employers with 11 or more employees that reside in the state to implement a cafeteria plan to pay for group health benefits, Connector benefits or individual health insurance.

Oregon

Oregon Insurance Bulletin INS 2002-5 (Feb. 20, 2003) outlines the prohibition on the sale of individual health benefits plans that are reimbursed through an HRA or cafeteria plan. Since the employer is eligible to receive a tax benefit for the amount of insurance paid through either plan, the state views these as group plans. As group plans, they are subject to all group health plan rules including guaranteed issuance of coverage and rates must be based on group coverage.

Agents and insurers are subject to penalties for selling individual policies to employees of small employers up to $1,000 per violation for agents and up to $10,000 for insurers and agencies. In addition, they may have their licenses suspended or revoked.

Texas
Texas has provided language in the Texas Insurance Code (TIC) that prohibits individual insurance through certain arrangements. Texas TIC 1501.003 addresses arrangements when employers offer individual or group health plans through a HRA or a cafeteria plan. Individual insurance policies offered through an EBC HRA or BESTflex Plan create a small or large employer health benefit plan which is subject to all the provisions of group health plans including guaranteed issuance of coverage.

Wisconsin
Wisconsin's insurance laws address situations where individual health insurance policies are offered through a small employer if 3 or more individual policies are sold to eligible employees and the premiums are collected through an agreement with an employer. This could include collection through a cafeteria plan. These policies would then become subject to the group health plan provisions, including guaranteed issuance of coverage.

Retiree HRA

If an employer establishes a separate HRA for retirees it is possible to reimburse medical expenses including individual medical premiums without integrating participation in an employer sponsored group medical plan.

IRS Notice 2013-54 clarified that Retiree HRAs (less than 2 active employees) are exempt from this rule regarding the reimbursement of individual premiums tax free as illustrated in Q/A 10 below:

> **Question 10:** Is an HRA that has fewer than two participants who are current employees on the first day of the plan year (for example, a retiree-only HRA) minimum essential coverage for purposes of Code §§ 5000A and 36B?
>
> **Answer 10:** Yes. The Treasury Department and the IRS understand that some employers are considering making amounts available under standalone retiree-only HRAs to retired employees so that the employer would be able to reimburse medical expenses, including the purchase of an individual health insurance policy. For this purpose, the standalone HRA would constitute an eligible employer-sponsored plan under Code § 5000A(f)(2), and therefore the coverage would constitute minimum essential coverage under Code § 5000A, for a month in which funds are retained in the HRA (including amounts retained in the HRA during periods of time after the employer has ceased making contributions). As a result, a retiree covered by a standalone HRA for any month will not be eligible for a Code § 36B premium tax credit for that month. [10]

Note that unlike other HRAs, the market reforms generally do not apply to a retiree-only HRA and therefore would not impact an employer's choice to offer a retiree-only HRA that includes the offer of reimbursement of individual medical insurance and Medicare premiums.

[10] IRS Notice 2013-54 Q/A 10

QSEHRA

On December 13th 2016, President Obama signed into law the 21st Century Cures Act ("Cures Act").[11] The main thrust of the law is to improve medical research and reform certain elements of health care treatment and delivery, but tacked to the end of the bill is a provision allowing certain small employers to establish stand-alone health reimbursement arrangements to pay for their employees' medical insurance premiums and other expenses. Such arrangements, dubbed "Qualified Small Employer Health Reimbursement Arrangements" or "QSEHRAs", are exempt from a number of health care reform and group health plan requirements, and distinct from their traditional HRA cousins in a variety of ways.

A key element of QSEHRAs is that they are only available to employers that are not Applicable Large Employers ("ALEs") under the ACA.[12] An ALE is an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.[13] For purposes of determining whether an employer is an ALE, controlled groups of employers must count all of their employees together, and an employer may disregard certain seasonal workers if those workers take them above the 50 employee limit.[14]

A QSEHRA can only be offered by a qualifying small employer. To be an "eligible employer" means that in addition to meeting the size requirements, the small employer cannot offer any other group health plan coverage to any of its employees.[15] The law does not further define "group health plan", so unless further guidance is offered, an employer can only establish a QSEHRA if it offers no plan that could pay any medical coverage – not just major medical, but also including dental, vision, critical illness plans, etc. This is an important consideration for many small employers who may not offer a traditional medical plan, but do sponsor group coverage that may fall under this definition. Further, if an employer currently offers a group health plan to a certain segment of employees (for example, full-time employees working 30 or more hours per week), it could not offer a QSEHRA to any employees, even those who don't qualify for the employer's other coverage.

Thus, it appears that QSEHRAs were not intended to be commonplace options for the average employer, but rather to allow a narrow way for small businesses who have never offered employer-provided health insurance to provide some financial assistance to employees who choose to purchase it for themselves.

An employer offering a QSEHRA must make the same coverage available on the same terms to all eligible employees[16]; it cannot, for example, offer to reimburse a higher amount for employees working certain positions within the company. Eligible employees are broadly defined in the law – only part-time or seasonal employees, employees under the age of 25, certain foreign workers, employees who have

[11] Pub. L. No. 114-255, at https://www.congress.gov/bill/114th-congress/house-bill/34/text (last viewed Dec 29, 2016)
[12] IRC § 9831(d)(3)(B)(i) as added by Pub. L. No. 114-255 § 18001(a)(1)
[13] IRC § 4980H
[14] Id.
[15] IRC § 9831(d)(3)(B)(ii) as added by Pub. L. No. 114-255 § 18001(a)(1)
[16] IRC § 9831(d)(2)(A)(ii) as added by Pub. L. No. 114-255 § 18001(a)(1)

worked fewer than 90 days, and collectively bargained employees can be excluded from the plan.[17] As stated previously, Employees must be covered by a health plan that provides "minimum essential coverage" in order to receive the tax benefits of QSEHRA participation.[18]

Employers must report the total permitted benefit under a QSEHRA on each employee's W-2 as the cost of coverage under an employer-sponsored group health plan.[19] As with any HRA, self-employed individuals, including sole proprietors, partners, and more-than-2% shareholders of S corporations, are not eligible to receive tax-favored reimbursements under a QSEHRA.

Implementation Rules

Employers wishing to implement a QSEHRA should carefully review all of the requirements of the law to ensure compliance. In particular, employers must provide a written notice to all eligible employees at least 90 days prior to the start of the QSEHRA plan year (or by April 1, 2017 for employers implementing a QSEHRA before that time[20]).[21] The notice must include the following information: 1) the amount of the benefit available to employees for the plan year; 2) that the employee is responsible for providing information about the QSEHRA benefit to any health insurance exchange to which the employee applies for advance payment of a premium assistance credit; 3) that if the employee is not covered under minimum essential coverage for any month, any QSEHRA reimbursements will be included in the employee's gross income, and the employee may be subject to the individual mandate penalty under 26 USC § 5000A.[22] An employer who fails to provide the notice will be subject to a $50 per employee penalty (capped at $2,500 per year).[23]

Some employers may find QSEHRAs to be an attractive option for helping their employees cover medical insurance costs on a tax-free basis. Employers considering such plans must be mindful of the various rules imposed on QSEHRAs by the Cures Act, and understand the impact of offering such plans to their employees; particularly if they provide a maximum benefit that fails to fully cover employee premium costs. Updates to these guidelines will be issued with any future IRS guidance, as the employee benefits landscape continues to evolve.

[17] IRC § 9831(d)(3)(A) as added by Pub. L. No. 114-255 § 18001(a)(1)
[18] IRC § 106(g) as added by Pub. L. No. 114-255
[19] IRC § 6051(a) as amended and added by Pub. L. No. 114-255 § 18001(a)(6)
[20] Pub. L. No. 114-255 § 18001(a)(7)(D)(ii)
[21] IRC § 9831(d)(4) as added by Pub. L. No. 114-255 § 18001(a)(1)
[22] Id.
[23] IRC § 6652(o) as added by Pub. L. No. 114-255 § 18001(a)(5)

Conclusion

Employers are limited in the ways in which they can help employees pay for individual medical policies. The IRS has provided guidance outlined in this White Paper confirming that unless you have an HRA made up of retirees only or qualify to establish a QSEHRA, Employers cannot reimburse employees for the purchase of individual medical policies. Employers are prohibited from paying for individual medical policies on behalf of employees, offering taxable cash to only those individuals that have purchased individual medical plans, offering pretax dollars in an HRA arrangement, or permitting the employees to use an Individual Premium FSA for purposes of reimbursing individual medical premiums with pretax dollars in a cafeteria plan arrangement. An Employer can however, offer all employees additional taxable compensation if they do not offer a group medical plan as a way to help employees offset the cost of individual insurance plans.

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