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Paying Premiums for Individual Health Insurance Policies Prohibited

Due to the rising costs of health coverage, some employers have considered helping employees pay for individual health insurance policies instead of offering an employer-sponsored group health plan. In response, the Internal Revenue Service (IRS), Department of Labor (DOL) and Health and Human Services (HHS) (Departments) have been regularly issuing guidance addressing these arrangements.

Generally, the Departments' guidance has provided that **any employer arrangements that reimburse employees (or pay directly) for individual premiums are prohibited under the Affordable Care Act (ACA), whether employers treat the money as pre-tax or post-tax for employees**.

According to the Departments, these arrangements are considered group health plans that cannot be integrated with individual market policies to satisfy the ACA's market reforms. As a result, these plans will violate the ACA's market reforms, which can trigger penalties, including excise taxes of **$100 per day for each applicable employee** ($36,500 per year, per employee) under Internal Revenue Code (Code) Section 4980D.

According to the IRS, employers that do not want to provide group health insurance coverage, but want to help their employees with the purchase of health coverage, **can provide the employee additional compensation to do so, as long as the additional compensation is not restricted to the payment of medical expenses**. The additional compensation would not be excluded from the employee's income under Code Section 106, and would be reported with other income and wages on the Form W-2.

OVERVIEW OF THE ACA'S MARKET REFORM RULES

The ACA includes certain market reforms that apply to group health plans and health insurance issuers in the group and individual markets. These market reforms include, among other things, a prohibition on pre-existing condition exclusions, a preventive care coverage requirement and lifetime and annual dollar limits on essential health benefits.

On Sept. 13, 2013, the Departments issued guidance in Notice 2013-54, Technical Release 2013-03, and Insurance Standards Bulletin, *Application of ACA Provisions to Certain Healthcare Arrangements*, addressing the application of the ACA's market reforms to health reimbursement arrangements (HRAs) and employer payment plans. Subsequent guidance reiterated and clarified the application of the ACA's market reforms to employer payment plans.

On May 13, 2014, the IRS issued FAQs on Employer Healthcare Arrangements to clarify the consequences for employers that reimburse employees for premiums they pay for individual health insurance. Also, the Departments issued ACA Implementation FAQs, Part XXII on Nov. 6, 2014, to clarify that these arrangements **do not comply with the ACA's market reforms and may subject employers to penalties. This guidance essentially prohibits all employer arrangements that reimburse employees for individual premiums, whether employers treat the money as pre-tax or post-tax for employees.**

Then, on Feb. 18, 2015, the IRS issued Notice 2015-17 to reiterate that **employer payment plans are group health plans that will fail to comply with the ACA's group market reforms**. The notice also:

- Provided transition relief from the excise tax for employer payment plans sponsored by small employers (those not subject to the ACA's employer shared responsibility rules) and to S corporation healthcare arrangements for 2-percent shareholder-employees **(this transition relief expired June 30, 2015)**;

- Addressed whether employers may reimburse employees for Medicare or TRICARE premiums for active employees under the ACA; and
- Stated that employer payments for individual premiums can be excludable from an employee's income under the tax code, but will still violate the ACA's market reforms.

Finally, on Dec. 16, 2015, the IRS issued Notice 2015-87, which provides further guidance (in Q&A-1 to Q&A-6) on the application of the ACA's market reforms to HRAs and employer payment plans.

The Departments noted that they expect to issue further clarifications regarding other aspects of employer payment plans and HRAs in the near future.

HEALTH REIMBURSEMENT ARRANGEMENTS (HRAS)

HRAs have been used by employers to help employees pay for the cost of individual insurance policies on a tax-free basis. Unlike health flexible spending accounts (FSAs) and health savings accounts (HSAs), HRAs can be used to reimburse health insurance premiums. Also, unlike an HSA, an individual does not need to be covered under a high-deductible health plan (HDHP) to participate in an HRA. This has made HRAs particularly compatible with individual health insurance policies.

Because HRAs are considered group health plans, they are generally subject to the ACA's market reform rules. However, federal agencies have concluded that, on their own, HRAs cannot satisfy these rules. Therefore, an HRA must generally be integrated with other group health coverage to satisfy the ACA's market reforms. **Stand-alone HRAs that do not qualify for an exception (such as retiree-only HRAs) are no longer permitted due to the ACA's annual limit prohibition, effective for plan years beginning on or after Jan. 1, 2014.**

Integrated HRAs vs. Stand-alone HRAs

- An **HRA that is integrated with a group health plan** complies with the ACA's annual limit prohibition and preventive care requirements if the group health plan with which the HRA is integrated complies with the ACA requirements. Thus, integrated HRAs are still permitted.
- **Stand-alone HRAs** cannot satisfy the ACA's annual limit and preventive care reforms on their own and, thus, are no longer allowed (unless the HRA qualifies for an exemption, such as the exemption for retiree-only HRAs).

The Departments' guidance includes two ways for an HRA to be considered "integrated" with another group health plan. In addition, the Departments' guidance confirms that an HRA used to purchase individual market coverage cannot be integrated with that individual coverage, and thus is considered a stand-alone HRA.

Some stand-alone HRAs are not subject to the market reforms because they fall under an exception, such as retiree-only HRAs. **However, stand-alone HRAs that do not fall under an exception are not permitted due to the ACA's annual limit prohibition and preventive care requirements.**

Thus, effective beginning with the 2014 plan year, employers cannot offer a stand-alone HRA for employees to purchase individual coverage, inside or outside of an Exchange, without violating specific ACA provisions and risking exposure to severe financial penalties.

Integration for Family HRAs

Notice 2015-87 provides that an HRA available to reimburse the medical expenses of an employee's spouse and/or dependents (a family HRA) cannot be integrated with self-only coverage under the employer's other group health plan. An HRA is permitted to be integrated with the employer's other group health plan coverage for purposes of the application of the group market reforms **only as to the individuals who are enrolled in both the HRA and the employer's other group health plan**. If the spouse and/or dependents are not enrolled in the employer's group health plan coverage, the coverage of these individuals under the HRA cannot be integrated with the coverage under the employer's group health plan, and the HRA coverage generally would fail to meet the group market reforms.

12/13; BK 2/16

The IRS noted that an HRA could be structured to be continuously integrated if eligibility for coverage under the HRA automatically applied only to individuals covered under the employer's other group health plan, so that eligibility for expense reimbursement would expand automatically if the employee changed coverage from employee-only coverage to coverage including a spouse and/or dependents (and vice versa, for example, if the employee changed coverage from family coverage to employee-only coverage).

Also, to facilitate transition to compliance with the group market reforms through the use of integrated HRAs, the IRS will not treat an HRA available for the expenses of family members not enrolled in the employer's other group health plan for plan years beginning before Jan. 1, 2016, as failing to be integrated with an employer's other group health plan for plan years beginning before Jan. 1, 2016, nor will they treat an HRA and group health plan that otherwise would be integrated based on the terms of the plan as of Dec. 16, 2015, as failing to be integrated with an employer's other group health plan for plan years beginning before Jan. 1, 2017, solely because the HRA covers expenses of one or more of an employee's family members even if those family members are not also enrolled in the employer's other group health plan.

To be integrated with the employer's group health plan, however, the HRA must meet all the other requirements of the applicable guidance on integration with a group health plan. In addition, the employer will be responsible under Section 6055 for reporting the coverage as minimum essential coverage for each individual the medical expenses for whom are reimbursable by the HRA who is not also enrolled in the employer's group health plan.

Clarifications for HRA Amounts Previously Credited

Notice 2013-54, Q&A-5, provides that unused amounts that were credited to an HRA while it was integrated with other group health plan coverage may be used to reimburse medical expenses in accordance with the terms of the HRA after an employee ceases to be covered by the other integrated group health plan coverage without causing the HRA to fail to comply with the market reforms. However, Notice 2015-87 clarifies that this rule assumes that the HRA terms would not provide a current employee the ability to purchase duplicative or substitute individual market coverage.

Thus, Notice 2015-87 provides that a current-employee HRA fails to be integrated with another group health plan if the amounts credited to the HRA may be used to purchase individual market coverage. This failure occurs, for example, even if the current-employee HRA terms provide that:

- It may be used to purchase individual coverage while the current employee is covered by a group health plan with which it is integrated (which coverage generally would be duplicative and thus not purchased by the current employee); or, alternatively,
- Unused amounts previously credited to the HRA may be used to purchase individual market coverage in periods during which the participant is no longer covered by a group health plan with which the HRA is integrated.

Accordingly, a current-employee HRA that includes terms permitting the purchase of individual market coverage will constitute a group health plan that fails to meet the market reforms because it is not integrated with another group health plan.

Exceptions

An HRA that covers fewer than two participants who are current employees (such as one covering only retirees or other former employees) is not subject to the ACA's market reforms. This includes a **retiree-only HRA** under which available amounts are determined in whole or in part by amounts credited during the period that the individual was a current employee covered by an HRA integrated with another group health plan.

However, this former-employee-only HRA constitutes an eligible employer-sponsored plan for purposes of the ACA's individual mandate requirement for any month during which funds are retained in the HRA (including amounts retained in the HRA during periods after the employer has ceased making contributions). As a result, a participant in

an HRA with available funds for any month will not be eligible for a premium tax credit for coverage purchased through an Exchange for that month.

Also, Notice 2015-87 provides that, whether or not an HRA is integrated with other group health plan coverage, unused amounts credited before Jan. 1, 2014 (including any amounts credited before Jan. 1, 2013, and any amounts that were credited during 2013 under the terms of an HRA in effect on Jan. 1, 2013) may be used after Dec. 31, 2013, to reimburse medical expenses in accordance with those terms without causing the HRA to fail to comply with the annual dollar limit prohibition or the preventive services requirements.

If the HRA terms in effect on Jan. 1, 2013, did not prescribe a set amount or amounts to be credited during 2013 or the timing for crediting those amounts, then the amounts credited during 2013:

- May not exceed the amounts credited for 2012; and
- May not be credited on an earlier schedule or at a faster rate than the crediting schedule or rate that applied during 2012.

EMPLOYER PAYMENT PLANS

In Revenue Ruling 61-146, the IRS provided that if an employer reimburses an employee's substantiated premiums for non-employer sponsored hospital and medical insurance, the payments are excluded from the employee's gross income under Code Section 106. This exclusion also applies if the employer pays the premiums directly to the insurance company. This IRS guidance allowed an employer to pay an employee's premiums for individual health insurance coverage without the employee paying tax on the amount.

Notice 13-54 referred to this type of arrangement as an "**employer payment plan**." Specifically, an employer payment plan is:

- A group health plan under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy; or
- An arrangement under which the employer uses its funds to directly pay the premium for an individual health insurance policy covering the employee.

Similar to the guidance for HRAs, Notice 2013-54 provides that an employer payment plan that reimburses employees for their individual insurance policy premiums will not comply with the ACA's annual limit prohibition and preventive care requirements because these arrangements, by their very definition, include dollar limits on the amount of reimbursements or payments. **Thus, effective beginning with the 2014 plan year, these plans are essentially prohibited**.

If an employer offers a group health plan that satisfies the market reforms by providing coverage for essential health benefits without annual limits and, in addition, offers an arrangement to pay for other medical expenses, Notice 2013-54 allows the group health plan to be combined (or "integrated") with the arrangement to determine if it satisfies the ACA's market reforms. **However, if the employer does not offer a group health plan—such as when the employee is covered by an individual health insurance—the arrangement to pay the premiums cannot be combined with any other coverage to determine if it satisfies the market reforms**.

This means that these employer health care arrangements **cannot be integrated with individual market policies to satisfy the ACA's market reforms**. Consequently, these types of arrangements may be subject to penalties, including excise taxes of **$100 per day for each applicable employee** ($36,500 per year, per employee) under Internal Revenue Code (Code) Section 4980D.

Interaction with Code Section 105 and 106

IRS Office of Chief Counsel issued two IRS Information Letters—Letter 2014-0037 and Letter 2014-0039—regarding the ability of employers to reimburse employees' medical expenses with pre-tax dollars under Code Section 105.

12/13; BK 2/16

These letters note that, **although the ACA has not changed the tax treatment under Code Section 105 or 106, these arrangements violate the ACA's prohibition on annual limits because they reimburse medical expenses up to a fixed amount**.

Section 106 excludes these payments as payments by an employer under a group health plan, because the reimbursement arrangement itself is treated as a group health plan. As a group health plan, the arrangement must meet the ACA's group market reform rules, including not providing a limit on the annual or lifetime benefits that the employee may receive under the arrangement (such as a reimbursement limit equal to the premiums paid).

According to the IRS, employers that do not want to provide group health insurance coverage, but want to help their employees with the purchase of health coverage, can provide the employee additional compensation to do so, as long as the additional compensation is not conditioned on the purchase of individual health coverage or otherwise restricted to the payment of medical expenses. The additional compensation would not be excluded from the employee's income under Section 106, and would be reported with other income and wages on the Form W-2.

The Departments' prior guidance suggested that an employer payment plan does not include an employer-sponsored arrangement that allows an employee to choose either cash or an after-tax amount to be applied toward health coverage. Thus, it was widely believed that premium reimbursement arrangements made on an after-tax basis would generally still be permitted.

However, FAQ guidance issued on Nov. 6, 2014, clarified that after-tax reimbursements and cash compensation for individual premiums also do not comply with the ACA's market reforms and may trigger the excise tax penalties. **This guidance essentially prohibits all employer arrangements that reimburse employees for individual premiums, whether employers treat the money as pre-tax or post-tax for employees**.

Cash Reimbursements

According to the new FAQs, an employer arrangement that provides cash reimbursement for an individual market policy is considered to be part of a plan, fund or other arrangement established or maintained for the purpose of providing medical care to employees, **without regard to whether the employer treats the money as pre-tax or post-tax for the employee**. Therefore, the arrangement is group health plan coverage subject to the ACA's market reform provisions.

The Departments stressed that these employer health care arrangements cannot be integrated with individual market policies to satisfy the ACA's market reforms. As a result, these plans will violate the ACA's market reforms, which can trigger penalties, including excise taxes under Code Section 4980D.

Employees with High Claims Risk

The FAQs also clarify that an employer cannot offer a choice between enrollment in the standard group health plan or cash **only to employees with a high claims risk**. This practice constitutes unlawful discrimination based on one or more health factors, in violation of federal nondiscrimination laws.

Although employers are permitted to have more favorable rules for eligibility or reduced premiums or contributions based on an adverse health factor (sometimes referred to as benign discrimination), the Departments assert that offering cash-or-coverage arrangements only to employees with a high claims risk is **not permissible benign discrimination**. Accordingly, these arrangements will violate the nondiscrimination provisions, regardless of whether:

- The employer treats the cash as pre-tax or post-tax for the employee;
- The employer is involved in purchasing or selecting any individual market product; or
- The employee obtains any individual health insurance.

The Departments also noted that the choice between taxable cash and a tax-favored qualified benefit (the election of coverage under the group health plan) is required to be a Code Section 125 cafeteria plan. Offering this choice to

high-risk employees could result in discrimination in favor of highly compensated individuals, in violation of the cafeteria plan nondiscrimination rules.

Reimbursement of Medicare and TRICARE Premiums

Notice 2015-17 notes that an arrangement under which an employer reimburses (or pays directly) some or all of Medicare Part B or Part D premiums for employees constitutes an employer payment plan. Similarly, an arrangement under which an employer reimburses (or pays directly) some or all of medical expenses for employees covered by TRICARE constitutes an HRA. In both cases, if the arrangement covers two or more active employees, it is a group health plan subject to the ACA's market reforms.

An employer payment plan or an HRA may not be integrated with Medicare coverage or TRICARE to satisfy the market reforms, because Medicare coverage and TRICARE are not group health plans for integration purposes. However, an employer payment plan or HRA that pays for or reimburses Medicare Part B or Part D premiums, or medical expenses for employees covered by TRICARE, is integrated with another group health plan offered by the employer for purposes of the market reforms if:

- The employer offers a group health plan (other than the employer payment plan or HRA) to the employee that does not consist solely of excepted benefits and offers coverage providing minimum value;
- The employee participating in the employer payment plan or HRA is actually enrolled in Medicare Parts A and B or TRICARE;
- The employer payment plan or HRA is available only to employees who are enrolled in Medicare Part A and Part B or Part D, or TRICARE; and
- The employer payment plan or HRA is limited to reimbursement of Medicare Part B or Part D premiums, or cost-sharing, and excepted benefits, including Medigap premiums or TRICARE supplemental premiums.

Note that, to the extent that this type of arrangement is available to active employees, it may be subject to restrictions under other laws, such as the Medicare secondary payer provisions or laws that prohibit offering financial or other incentives for TRICARE-eligible employees to decline employer-provided group health plan coverage, similar to the Medicare secondary payer rules.

An employer payment plan that has fewer than two participants who are current employees (for example, a retiree-only plan) on the first day of the plan year is not subject to the market reforms, and, therefore, integration is not necessary to satisfy the market reforms.

Also, an employer may provide more than one type of healthcare arrangement for its employees (for example, a Medicare Part B employer payment plan and a TRICARE-related HRA), provided that each arrangement meets the applicable integration or other rules.

CAFETERIA PLANS

A Section 125 Plan, or a cafeteria plan, can be used by employers to help employees pay for certain expenses, including health insurance, on a pre-tax basis. The proposed cafeteria plan regulations from 2007 allow for the pre-tax payment or reimbursement of individual health insurance policy premiums under a cafeteria plan. However, the ACA changes this rule and now prohibits cafeteria plans from paying or reimbursing premiums for individual health insurance policies, effective for 2014.

The ACA's prohibition on including individual health insurance policies under a cafeteria plan applies to policies purchased on an Exchange and through the private market, as follows:

- ***Exchange Coverage***: The ACA provides that individual health insurance offered through an Exchange cannot be reimbursed or paid for under a cafeteria plan. Exchange coverage may be funded through a cafeteria plan

12/13; BK 2/16

only if the employee's employer elects to make group coverage available through the Exchange's Small Business Health Options Program (SHOP).

- ***Non-Exchange Coverage***: Notice 2013-54 indicates that, effective for 2014, cafeteria plans may not be used to pay premiums for individual health insurance policies that provide major medical coverage. However, it appears that this restriction does not apply to individual policies that are limited to coverage that is excepted from the ACA's market reforms, such as retiree-only coverage or limited-scope dental or vision benefits.

Thus, effective for 2014, the tax exclusion provided through a cafeteria plan is only available when group coverage is purchased. However, Notice 2013-54 provided a transition rule for certain cafeteria plans for plan years beginning before Jan. 1, 2014. For cafeteria plans that, as of Sept. 13, 2013, operate on a plan year other than a calendar year, the restriction on purchasing individual Exchange coverage through a cafeteria plan did not apply before the first plan year that begins after Dec. 31, 2013. However, individuals were not permitted to claim a subsidy for any month in which they are covered by an individual plan purchased through an Exchange as a benefit under a cafeteria plan.

Notice 2015-87 reiterates that an employer arrangement reimbursing the cost of individual market coverage offered under a cafeteria plan is an employer payment plan, **regardless of whether it is funded solely by salary reduction or also including other employer contributions, such as flex credits**.

Code Section 105 Reimbursement Plans

The Departments also noted in the new FAQ guidance that certain vendors are marketing products to employers claiming that, instead of providing a group health insurance plan, employers can establish a Code Section 105 reimbursement plan that works with health insurance brokers or agents to help employees select individual insurance policies allowing eligible employees to access subsidies for Exchange coverage.

The FAQs assert that these arrangements are problematic for several reasons. First, these arrangements are, themselves, group health plans. Therefore, employees participating in the arrangements are ineligible for Exchange subsidies. The mere fact that the employer is not involved with an employee's individual selection or purchase of an individual health insurance policy does not prevent the arrangement from being a group health plan.

Second, as explained in previous guidance, these arrangements are subject to the ACA's market reform provisions, including the annual limit prohibition and preventive care coverage requirement. As noted before, these employer health care arrangements cannot be integrated with individual market policies to satisfy the market reforms and, therefore, can trigger penalties, including excise taxes under Code Section 4980D.

Notice 2015-17 also addresses Revenue Ruling 61-146, which has been cited by some as authority permitting employer payment plans under the tax code. Under Rev. Rul. 61-146, employer reimbursements of an employee's individual insurance premiums are excluded from the employee's gross income under Code Section 106. This exclusion also applies if the employer pays the premiums directly to the insurance company.

> According to the IRS, this guidance regarding the tax exclusion continues to apply. **This means only that the payments are excludable from the employee's gross income under Section 106 (regardless of whether the employer includes the payments as wages on the Form W-2)**. However, the IRS stated that **Rev. Rul. 61-146 does not address the application of the ACA's market reforms, and should not be read as containing any implication regarding the application of those market reforms**.

An arrangement under which an employer provides reimbursements or payments that are dedicated to providing medical care (such as cash reimbursements for the purchase of an individual market policy) is, itself, a group health plan. Accordingly, the arrangement is subject to the ACA's market reform rules applicable to group health plans, **without regard to whether the employer treats the money as pre-tax or post-tax to the employee**. These employer health care arrangements cannot be integrated with individual market policies to satisfy the market reforms and, therefore, do not comply with the ACA.

The notice supplements two Information Letters previously issued by the IRS Office of Chief Counsel near the end of 2014. Letter 2014-0037 and Letter 2014-0039 addressed the ability of employers to reimburse employees' medical expenses with pre-tax dollars under Code Section 105. In the letters, the IRS noted that the ACA has not changed the tax treatment of the reimbursement for employee medical expenses under Code Section 105.

However, under the ACA these arrangements are considered to be group health plans, and therefore must satisfy the ACA's market reform rules. One of these market reform requirements is a prohibition on annual or lifetime dollar limits on essential health benefits. The IRS Information Letters noted that an agreement by the employer to reimburse medical expenses up to a fixed amount is a group health plan under which there is an annual limit on essential health benefits and, thus, fails to comply with the prohibition on annual limits.

STUDENT HEALTH COVERAGE PREMIUM REDUCTION ARRANGEMENTS

On Feb. 5, 2016, the IRS issued Notice 2016-17 to provide guidance on the application of the ACA's market reform requirements to certain arrangements offered by an institution of higher education to its students that are designed to reduce the cost of student health coverage (whether insured or self-insured) through a credit, offset, reimbursement, stipend or similar arrangement (**a premium reduction arrangement**).

According to the IRS, many colleges and universities provide students (typically graduate students) with student health coverage at greatly reduced or no cost as part of their student package, which often includes tuition assistance and a stipend for living expenses. The student health coverage can be provided either through individual health insurance or through coverage that is self-insured by the college or university. For these students, the bill they receive from the school for the health coverage premium may take into account a premium reduction arrangement.

Because some of these students also perform services for the school (such as teaching or research), questions have been raised over whether premium reduction arrangements offered in connection with student health plans might be viewed as employer payment plans that violate the ACA's market reform provisions. Notice 2016-17 provides that, in many cases in which a college or university offers a premium reduction arrangement to its students, the payment arrangement will not constitute an employer payment plan under the Departments' previous guidance. In other cases, however, these arrangements might meet the definition of an employer payment plan.

Whether a particular arrangement constitutes a group health plan will depend on all of the facts and circumstances.

Temporary Transition Relief from Enforcement

Notice 2016-17 also provides **temporary transition relief from enforcement** in certain circumstances. The Departments understand that some schools that have been offering these types of premium reduction arrangements might not have recognized at the time of the Departments' previous guidance that, in certain circumstances, the arrangements might constitute an employer payment plan and, therefore, violate the ACA's market reform requirements because they are not integrated with group health plan coverage and cannot integrate with individual insurance coverage.

As a result, the Departments recognize that schools may need additional time to adopt a suitable alternative or make other arrangements to come into compliance. Accordingly, Notice 2016-17 provides that the Departments will not assert that a premium reduction arrangement fails to satisfy the ACA's market reform requirements if the arrangement is offered in connection with other student health coverage (insured or self-insured) **for a plan year or policy year beginning before Jan. 1, 2017** (therefore including, for example, plan years or policy years that are roughly coterminous with academic years beginning in the summer or fall of 2016, and ending in 2017).

PENALTIES

On May 13, 2014, the IRS issued FAQs addressing the consequences for employers that do not establish a health insurance plan for their own employees, but instead reimburse those employees for premiums they pay for health insurance (either through an Exchange or outside of an Exchange). Because these employer payment plans do not

12/13; BK 2/16

comply with the ACA's market reforms, the IRS indicated in the FAQs that these arrangements may be subject to an excise tax of **$100 per day for each applicable employee** ($36,500 per year, per employee) under Code Section 4980D.

INCREASES IN EMPLOYEE COMPENSATION

Notice 2015-17 clarifies that, if an employer increases an employee's compensation, but does not condition the additional compensation on the purchase of health coverage (or otherwise endorse a particular policy, form or issuer of health insurance), **it is not considered an employer payment plan**.

According to the IRS, providing employees with information about the Exchange or the premium tax credit is not endorsement of a particular policy, form or issuer of health insurance. Because this type of arrangement generally will not constitute a group health plan, it is not subject to the ACA's market reforms.

REIMBURSEMENT FOR INDIVIDUAL MARKET COVERAGE CONSISTING SOLELY OF EXCEPTED BENEFITS

Notice 2015-87 clarified that an HRA or employer payment plan that, by its terms, reimburses (or pays directly for) premiums for individual market coverage only if that individual market coverage covers only excepted benefits does not fail to comply with the market reforms solely due to the ability to reimburse the employer for that individual market coverage. The market reforms do not apply to a group health plan that is designed to provide solely excepted benefits.

As a result, an HRA or employer payment plan and the excepted benefits individual market coverage for which the arrangement pays are not subject to the annual dollar limit prohibition or the preventive services requirement and, therefore, do not fail to satisfy those market reforms.

Example 1.

Facts: The terms of an HRA provide that the HRA may only be used to reimburse premiums for individual market coverage that covers only excepted benefits, but not individual market coverage that covers benefits other than excepted benefits.

Conclusion: The HRA is not subject to the annual dollar limit prohibition or the preventive services requirement.

Example 2.

Facts: The terms of an HRA provide that the HRA may be used to reimburse premiums for individual market coverage, with no requirement that the individual market coverage cover only excepted benefits. A covered employee is reimbursed by the HRA for premiums for individual market coverage that covers only excepted benefits.

Conclusion: The HRA is subject to the annual dollar limit prohibition and the preventive services requirement, because the terms of the HRA would have permitted reimbursement of premiums for individual market coverage that is not limited to excepted benefits.

TRANSITION RELIEF

Small Employers—Expired June 30, 2015

In Notice 2015-17, the IRS noted that small employers have often helped employees pay for individual coverage. These employers would normally be subject to an excise tax of $100 per day for each employee. However, Notice 2015-17 provided a delay in the excise tax penalty for employers that are not applicable large employers (ALEs) under the ACA's employer shared responsibility rules. These employers may have needed additional time to obtain group health coverage or to adopt a suitable alternative.

Notice 2015-17 provided that an excise tax would not be assessed for violations of the ACA's market reforms by certain employer payment plans that pay (or reimburse employees) for individual health policy premiums or Medicare

12/13; BK 2/16

Part B or Part D premiums. This relief did not extend to stand-alone HRAs or other arrangements that reimburse employees for medical expenses other than insurance premiums.

This relief did not extend to stand-alone HRAs or other arrangements that reimburse employees for medical expenses other than insurance premiums.

> **This transition relief was available on a temporary basis**. Employers could be eligible for relief from the excise tax as late as June 30, 2015. **Because the transition relief expired on June 30, 2015, these employers may now be liable for the excise tax.**

Employers that were eligible for this relief were not required to file IRS Form 8928 (regarding failures to satisfy requirements for group health plans) as a result of having these arrangements during the period for which the employer is eligible for the relief.

S Corporation Healthcare Arrangements for 2-percent Shareholder-employees

Under IRS Notice 2008-1, if an S corporation pays for (or reimburses) premiums for individual health insurance coverage covering a 2-percent shareholder, the payment or reimbursement is included in income, but the 2-percent shareholder-employee may deduct the amount of the premiums (provided that all other eligibility criteria for deductibility are satisfied). Notice 2015-17 refers to this as a **2-percent shareholder-employee healthcare arrangement**.

The Departments stated that they may issue additional guidance on the application of the market reforms to a 2-percent shareholder-employee healthcare arrangement. However, until further guidance is issued (and at least through the end of 2015), the excise tax will not be assessed for any failure to satisfy the market reforms by a 2-percent shareholder-employee healthcare arrangement.

Furthermore, until additional guidance provides otherwise, an S corporation with a 2-percent shareholder-employee healthcare arrangement will not be required to file IRS Form 8928 (regarding failures to satisfy requirements for group health plans, including the market reforms) solely as a result of having a 2-percent shareholder-employee healthcare arrangement. **However, this guidance does not apply to reimbursements of individual health insurance coverage with respect to employees of an S corporation who are not 2-percent shareholders.**

The IRS is also considering whether additional guidance is needed on the federal tax treatment of 2-percent shareholder-employee healthcare arrangements. However, until additional guidance provides otherwise, taxpayers may continue to rely on Notice 2008-1 with regard to the tax treatment of these arrangements for all federal income and employment tax purposes.

To the extent that a 2-percent shareholder is allowed both the deduction described above and a premium tax credit for coverage through an Exchange, Revenue Procedure 2014-41 provides guidance on calculating the deduction and the credit with respect to the 2-percent shareholder.

Notice 2015-17 also noted, however, that the 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. Thus, an arrangement covering only a single employee (whether or not that employee is a 2-percent shareholder-employee) generally is not subject to the market reforms, whether or not the reimbursement arrangement otherwise constitutes a group health plan.

However, if an S corporation maintains more than one of these types of arrangements for different employees (whether or not 2-percent shareholder-employees), all are treated as a single arrangement covering more than one employee, so that this exception does not apply.

12/13; BK 2/16