WAIVER DEADLINE FOR NON-EXEMPT HRAS – IMMEDIATE ACTION REQUIRED

Employee Benefits Alert
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IMMEDIATE ACTION REQUIRED

Employers that sponsor self-insured mini-med reimbursement arrangements, health reimbursement arrangements (HRAs), and certain types of health flexible spending accounts (health FSAs) may need to take action **by September 22, 2011**.

This client alert updates our previous client alert addressing how the prohibition of annual dollar limits on essential health benefits under the Patient Protection and Affordable Care Act (PPACA) applies to self-insured health care reimbursement arrangements, particularly HRAs.

BACKGROUND

For plan years beginning *on or after* January 1, 2014, group health plans may not impose an annual dollar limit on any essential health benefit. For plan years beginning *before* January 1, 2014, annual dollar limits on essential health benefits are permitted, but only if the annual dollar limit is not lower than $750,000 for plan years that begin on or after September 23, 2010, $1,250,000 for plan years beginning on or after September 23, 2011, and $2,000,000 for plan years beginning on or after September 23, 2012 but before January 1, 2014.

The Department of Health and Human Services (HHS) may waive the restricted annual limits where application of those limits would result in a significant decrease in access to benefits or a significant increase in premiums. **September 22, 2011 is the deadline for submitting a waiver application**. Without a waiver, non-exempt group health plans must comply with annual limits.

HHS recently issued guidance on the waiver program as it applies to new and existing applicants seeking waivers and to HRAs.

What is a Group Health Plan?

A group health plan is a plan that provides medical care through insurance, reimbursement, or otherwise, including the following types of plans:

- Insured and self-insured major medical plans
- Insured and self-insured mini-med plans
- HRAs
- Health FSAs

Self-insured mini-med plans, HRAs, and health FSAs impose annual dollar limits that are lower than the limits prescribed by law; therefore, unless such a plan can fit within one of the exemptions or obtain a waiver from the government, the plan will need to comply with the law or be discontinued.

Although Health FSAs are generally exempt from the annual dollar limit restrictions, a Health FSA is subject to the restrictions if the maximum amount of reimbursement which is reasonably available to a participant is at least five times the value of such coverage. A Health FSA that only allows for employee contributions would not be subject to the annual dollar limit restriction.

How does a self-insured mini-med plan differ from an HRA?

A self-insured mini-med plan is a medical expense reimbursement plan that is like an insured or self-insured major medical plan except that the maximum annual reimbursement for expenses incurred during a plan year is limited to a specific dollar amount. Under a self-insured mini-med plan (unlike an HRA), the full benefit is available at any time during the year; however, the portion (if any) of the maximum benefit that is not used during the year does not carry over to the following plan year. Under an HRA, reimbursements are limited to the amount in the participant's account as of a given date, and some or all of the amount (if any) that is not used by the end of the coverage period (e.g., the plan year) may carry forward to the following coverage period. Both arrangements are employer-funded.

What is an Essential Health Benefit?

Essential health benefits are a set of health care service categories that must be covered by certain plans, starting in 2014. The PPACA considers the following general categories, including the items and services covered within the categories, essential health benefits:

- Ambulatory patient services
- Emergency services
- Hospitalization

- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

A self-insured mini-med, HRA, or health FSA (as discussed above) that reimburses expenses that fall into one of these categories is in the crosshairs of this new law.

Plans in Effect Before September 23, 2010

The steps an employer must take may depend upon whether the arrangement maintained by the employer is a mini-med reimbursement plan or an HRA as outlined in IRS Notice 2002-45 and Rev. Rul. 2002-41.

Health Reimbursement Accounts

The guidance from HHS on HRAs describes an HRA as a self-insured medical reimbursement plan funded solely by employer contributions and not through salary reduction that reimburses some or all of the medical care expenses of participating employees, spouses, and dependents up to a maximum dollar amount for a coverage period, and allows participants to carry forward the unused amounts remaining at the end of the coverage period for use in subsequent coverage periods.

A plan that maintains an account on behalf of a participant, and that carries forward the unused portion of the account into a subsequent period (e.g., from one plan year to the next) would constitute an HRA under this guidance.

An employer that maintains a group health plan that qualifies as an HRA under the guidance referenced above does not need to apply for a waiver or extend an existing waiver *so long as the HRA was in effect prior to September 23, 2010.*

HRAs that fall into this category get an automatic exemption from the annual dollar limit on essential health benefits until the plan year that begins on or after January 1, 2014, so long as the employer provides annual notices to eligible participants and subscribers, and retains all records pertaining to their waiver applications (i.e., plan documents, SPDs, enrollment information, and annual notices).

If an employer does not comply with the document retention and notice requirements, the exemption is null and void.

Mini-Med Reimbursement Plans

Through its specific reference to HRAs having carry-forward provisions, the guidance casts doubt on whether medical reimbursement arrangements without carry-forward provisions may rely upon the waiver exemption. Self-insured mini-med reimbursement arrangements do not have carry-forward provisions.

Consider the following example:

Acme Corp. maintains a medical expense reimbursement plan under which Acme agrees to reimburse employees for eligible expenses they (or their dependents) incur during a plan year up to a specified dollar amount (e.g., $5,000). The full amount is available at any time during the year; however, any amount not used by the end of the year is not available during the subsequent year.

Conservative employers would be well-advised to seek a waiver (or an extension of an existing waiver) for any arrangement, such as the one described in the foregoing example, that does not qualify as an HRA under the guidance issued by HHS and that is not otherwise exempt (see Exempt Arrangements, below). Forms and detailed instructions on the completion and submission of those forms are available at http://cciio.cms.gov/resources/other/index.html#alw. Any waiver will be effective until January 1, 2014.

As a condition of receiving a waiver, applicants must file annual updates on December 31, 2012 and December 31, 2013. Applicants must also provide an annual notice to eligible participants and subscribers, and retain all records pertaining to their applications to permit HHS to conduct an audit of their waiver applications.

Medical Expense Reimbursement Arrangements in Effect On or After September 23, 2010

Mini-med and HRAs established on or after September 23, 2010 are not eligible for a waiver exemption. Thus, the PPACA requires that such a plan either satisfy one of the exemptions (see Exempt Arrangements, below) or meet the restricted annual limit requirement. As a practical matter, this means that a mini-med arrangement or HRA must meet one of the exemptions or be redesigned or terminated.

EXEMPT ARRANGEMENTS

The following plans are not subject to the restriction on annual dollar limits:

- Plans that cover fewer than two current employees asof the first day of the plan year (e.g., retiree HRAs)
- Limited-scope HRAs and mini-med plans (e.g., plans that provide coverage that is limited to dental and visions expenses)
- Plans with an annual reimbursement limit less than or equal to $500 and without carryovers, provided the employer makes major medical coverage available to all employees who are eligible for the plan
- Plans that do not reimburse essential health benefits

- Plans that are integrated with a group health plan that is subject to the annual limit rules, though there is no clear guidance as to when a plan is considered "integrated" (it would appear an HRA is integrated with a major medical plan if the HRA is available only to employees enrolled in the medical plan)
- Plans that qualify as flexible spending arrangements. (i.e., the maximum amount of reimbursement that is reasonably available to a participant under the plan for a year is less than 500 percent of the value of the plan coverage); plans that have modest account balances will typically meet this requirement and employers may use the COBRA premium as a proxy for the value of the coverage

IMMEDIATE ACTIONS TO TAKE

If a group plan meets an exemption, no action is required.

Employers should determine whether a non-exempt medical expense reimbursement arrangement they maintain constitutes an HRA, as described above. If it is determined that the arrangement constitutes an HRA, employers should confirm that the arrangement was in effect before September 23, 2010. An employer who confirms that the arrangement was in effect before September 23, 2010 need not file a waiver application, but must still comply with the record retention and annual notice requirements. If the arrangement was established on or after September 23, 2010, steps should be taken to ensure that the HRA meets an exemption from the restriction on annual limits requirement.

If it is determined under HHS guidance that a non-exempt medical expense reimbursement arrangement does not constitute an HRA, employers should examine whether the arrangement satisfies the restricted annual limits requirement. If the arrangement does not meet the requirement, an employer should determine whether the arrangement was in effect before September 23, 2010. If the arrangement was in effect before September 23, 2010, the employer would be well-advised to pursue a new waiver or apply for an extended waiver. On the other hand, if the arrangement was not effective until on or after September 23, 2010, the restriction on annual limits requirement must be met.