General Board
Pension and Health Benefits

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Health Care Reform—New Restrictions on Tax-Favored Health Coverage for HRAs, FSAs, Premium Payment or Reimbursement Plans, and Cafeteria Plans

Notices published by the U.S. Department of Labor, Department of Treasury (IRS) and Department of Health and Human Services (HHS)—collectively called the Departments—provide Guidance on how health insurance market reforms through the Affordable Care Act (ACA, i.e., federal health care reform) impact certain employer tax-favored health care arrangements, including:

- health reimbursement arrangements (HRAs),
- health care flexible spending accounts (health FSAs),
- health savings accounts (HSAs),
- employee assistance programs (EAPs), and
- cafeteria plans.

This Guidance was provided in **DOL technical release 2013-03** and **IRS Notice 2013-54**.
Most importantly, the Guidance addresses the application of annual limits prohibitions[1] on essential health benefits under the ACA (the Annual Limit Rule) and the requirement for health plans to cover preventive health services[2] with no cost-sharing (the Preventive Service Rule) to:

- HRAs;
- arrangements where an employer directly pays premiums for an individual health insurance policy for an employee or reimburses an employee who purchases an individual health insurance policy (called "Employer Payment Plans")[3], and
- certain health FSAs.

The Annual Limit Rule and the Preventive Service Rule are collectively known as ACA's "Market Reforms."

The Guidance also explains §125(f)(3) of the Internal Revenue Code (Code), which prohibits the use of Cafeteria Plans (Section 125 plans) for purchasing coverage through the health insurance Marketplaces established by the ACA (also called exchanges). Further, the Guidance offers clarification about employee assistance programs (EAPs).

This document summarizes the Departments' September 2013 Guidance in these three areas, as related to employers within The United Methodist Church (UMC).

[1] Starting in 2014, the ACA bans group health plans, including account-based plans, from placing lifetime and annual dollar limits on essential health benefits.
[2] All non-grandfathered group health plans must cover in-network preventive services without cost sharing (i.e., no out-of-pocket cost to participant), or be integrated with other coverage that meets this mandate.
[3] Tax-favored Employer Payment Plans were permitted under IRS guidance from 1961, Revenue Ruling 61-146.

Highlights

The following prohibitions took effect January 1, 2014:

1. Stand-alone HRAs can no longer be used to provide employer-sponsored health coverage to active employees.
2. Employer Payment Plans are prohibited for active employees.
3. Premiums for coverage elected through the ACA Marketplace or a state-based exchange cannot be paid for or reimbursed through an employer's Cafeteria plan.
4. Health FSAs can be offered to employees only if those employees also are eligible for the employer's group health plan (major medical plan).
5. Benefits under an employee assistance program (EAP) are "excepted benefits" and, therefore, not subject to the ACA's Market Reforms.

These prohibitions are discussed in more detail below.

1. *Stand-alone HRAs can no longer be used to provide employer-sponsored health coverage to active employees*. Stand-alone HRAs cannot satisfy the ACA's Market Reforms. This means stand-alone HRAs will not be viable for providing employer-sponsored health coverage to active employees.

   Exception 1: An HRA that is *integrated* with an underlying group health plan that complies with the Market Reforms will be permitted. The rules for integration are explained below under "Acceptable HRAs."

   ***Exception 2*:** Retiree-only[4] HRAs are considered eligible employer-sponsored plans and "minimum essential coverage" under ACA. Therefore, retirees covered in a retiree-only HRA satisfy the ACA's individual mandate (requiring most Americans to have health insurance) and are not subject to the individual mandate penalty. Pre-65 retirees who are not yet eligible for Medicare but are covered by a retiree-only HRA will not be eligible for premium tax credits (federal assistance for lower-income individuals) for coverage they might select through the Marketplace.

2. *Employer Payment Plans are prohibited.* Employer Payment Plans are considered "group health plans" and therefore cannot be ACA-compliant on a stand-alone basis because they would violate the Market Reforms.

3. *Premiums for coverage elected through the ACA Marketplace or a state-based exchange cannot be paid for or reimbursed through an employer's Cafeteria plan.* Cafeteria plans include "premium-only" plans (POPs). POPs cannot reimburse employees or allow employees to pay on a pre-tax basis for premiums for individual health insurance plans purchased in the ACA Marketplaces.

   Exception: Small Business Health Options Program (SHOP) Marketplace plans adopted by a small employer for its employees can be paid or reimbursed through a Cafeteria plan.

4. *Health FSAs can be offered to employees only if those employees also are eligible for the employer's group health plan.* The employee is not required to be enrolled in the group health plan in order to be eligible for the health FSA. Employees who are not eligible for the employer's group health plan also are not eligible for the health FSA.

5. *Benefits under an EAP are "excepted benefits" and, therefore, not subject to the ACA's Market Reforms.* This prohibition assumes that the EAP does not provide "significant benefits in the nature of medical care or treatment."

[4] Under the ACA, a "retiree-only plan" is a plan that does not cover any more than one current employee.

UMC Implications

Employer Payment Plans (EPPs) and stand-alone HRAs have been common health plan arrangements in local churches in The United Methodist Church and other denominations, particularly for coverage of lay employees. These are arrangements where the lay employees (and some local pastors and deacons) purchase coverage on the private market for individual health insurance policies, and the local church then either (1) reimburses the employee for all or part of the premium cost, or (2) directly pays all or part of the individual policy premium to the insurance company, with non-taxed employer dollars (money not reported as taxable income to the employee). These also include arrangements where local churches reimburse lay employees, deacons or local pastors for incurred medical expenses with nontaxable dollars. *These plans and arrangements are no longer permitted as of January 1, 2014.*

UMC local churches should terminate such plans as of December 31, 2013 and explore other options for providing health coverage to lay employees and select local pastors and deacons. Alternative options include:

- adopting a small group market plan through the SHOP Marketplace for small employers, or
- increasing (taxable) compensation without any conditions (i.e., without requiring the employee to buy an individual health insurance policy).

You can read more about the SHOP Marketplace **here**.

Background and Terms

Prior to the ACA, the following three types of plans were common. Before discussion restrictions the ACA has place on these plans, it may be useful to review how these plans operated before the ACA.

- An **HRA** is an arrangement funded solely by an employer to reimburse an employee in tax-exempt dollars for medical care expenses (including health insurance premiums) incurred by the employee, up to a maximum dollar amount for the year.
- A **health FSA** is used by an employer to reimburse employees for medical expenses. Typically Health FSAs are funded from the employee's income through a salary reduction agreement (the employee funds the account with pre-tax dollars); however, employers can provide additional health FSA contributions excluded from taxable income, above (or in lieu of) the employee's salary reduction amount.
- An **Employer Payment Plan** was used by an employer to directly pay an employee's premiums or reimburse an employee who paid premiums for a non-employer sponsored health insurance plan (i.e., an individual plan or policy), using nontaxable dollars. *EPPs are no longer permitted.*

Many employers offered their employees HRAs, Employer Payment Plans and health FSAs prior to the ACA. Employer Payment Plans were common among local churches for coverage of employees who were not covered in annual conference or denominational plans (for example, part-time clergy and many lay employees). In the UMC, full-time clergy employees were typically covered through a traditional group health plan (usually the annual conference plan).

Important: Employers, e.g., local churches, may still pay for ***group*** health plan coverage with dollars that are not considered taxable income to the covered clergy or lay employees. This generally applies to annual conference health plans and small group market health plans.

The Dilemma

Many employers would like a way to offer employees nontaxable dollars with which employees could purchase individual coverage through the Marketplace or in the individual private market, without the employer establishing its own group health plan (or allowing the employer to cease providing a group health plan). Employers would also like to continue offering their employees HRAs or health FSAs to supplement their group health coverage (for example, by covering employees' cost-sharing obligations such as co-payment, co-insurance and annual deductible).

Stand-alone FSAs appear to be prohibited by the September 2013 Guidance for use as a potential strategy to help employees who purchase Marketplace coverage manage their out-of-pocket costs.

The ACA creates some barriers to these approaches (stand-alone FSAs and offering employees money to purchase coverage) by applying the Market Reforms to group health plans, notably the Annual Limit Rule and Preventive Service Rule. A group health plan that offers only a fixed or limited annual dollar amount or does not cover preventive services would violate these requirements and thus be prohibited. (**Exception**: The September 2013 Guidance indicated that a group plan that covers only retirees would not be subject to the Market Reforms and therefore would be permitted.[5])

The Market Reforms, however, do not apply to "excepted benefits," which include accident-only or disability coverage; certain vision, dental or long-term care benefits; and certain health FSAs. Health FSAs are excepted benefits (and therefore *not* subject to the Market Reforms) if:

- the employer also offers other group health coverage to the employees; *and*
- the maximum FSA benefit payable does not exceed certain limits[6].

Minimum Essential Coverage

Excepted benefits do not qualify as "minimum essential coverage" (MEC) for purposes of the ACA's individual mandate. The individual mandate requires every American to have health insurance that qualifies as minimum essential coverage or else pay a penalty tax. Thus an employee who *has* only excepted benefits coverage would have to pay the ACA penalty for failing to have minimum essential coverage.

On the other hand, an employee who is *offered* only excepted benefit coverage by his or her employer may qualify for premium tax credits (PTCs) through the Marketplace (the federal subsidy to reduce the premium cost of individual Marketplace coverage)[7].

Additionally, the employer that offers only excepted benefit coverage may be subject to the employer shared responsibility penalty for failing to provide minimum essential coverage. However, the employer shared responsibility penalty (also called the employer mandate) applies only to "applicable large employers" with 50 or more full-time equivalent employees. Many UMC local churches are exempt from this penalty because they have fewer than 50 eligible employees.

Whether HRAs, Employer Payment Plans, or health FSAs are considered "group health plans" or "excepted benefits" becomes an important question for determining whether these offerings qualify as minimum essential coverage, i.e., whether they meet the individual mandate (employee's obligation to have MEC) and the employer mandate (employer's obligation to offer MEC).

The current Guidance expands on **earlier guidance** issued by the Departments in January 2013 and discussed **here**, which defined HRAs as group health plans subject to the Market Reforms. When an HRA is integrated with an underlying group health plan that covers Preventive Services and does not have annual dollar limits, the HRA is permissible. However, stand-alone HRAs violate the Market Reforms and would subject the plan sponsor to daily penalties[8]. *(See Prohibited Arrangements in this document for more details.)*

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[5] The exemption from the requirements of the ACA is limited to plans with fewer than two "current employees."

[6] The total payable from a health FSA for any year cannot be more than twice the participant's salary-reduction election for that year (or, if greater, the participant's salary-reduction election for that year plus $500).

[7] Individuals who have "minimum essential coverage" through an employer plan, typically a group health plan, are prohibited from qualifying for a PTC through the ACA Marketplace. Because HRAs are considered employer group health plans, stand-alone HRAs, where permitted (for retirees), disqualify covered individuals from PTC eligibility.

[8] Penalties under Code §4980D for violations of ACA Market Reforms are $100 per day for each affected individual (employee and covered dependents).

PTCs and Affordable, Minimum Essential Coverage

HRA funding may be considered to determine whether an employee who is offered employer coverage is eligible for PTCs because their employer coverage is either *inadequate* (does not meet minimum essential coverage standards) or *unaffordable*[9].

- HRA amounts newly made available during a plan year that the employee may use to pay premiums of an integrated group plan are counted for determining affordability of an employer plan.
- Amounts that can only be used for cost-sharing can be considered for determining minimum value[10] of the employer plan.

However, if an employee actually *enrolls in* an HRA, the employee is *ineligible* for a PTC because he or she has MEC. This same exception applies to health FSAs, Section 125 (Cafeteria) plans and Employer Payment Plans—employees who enroll in any of these plans become *ineligible* for PTC.

Prohibited Arrangements

The Guidance makes clear that stand-alone HRAs for active employees and Employer Payment Plans *cannot be used to purchase or reimburse premiums for individual health plans* (either Marketplace plans or private market individual policies).

In addition, HRAs that are stand-alone, rather than integrated into a group health plan, would violate both the Annual Limit Rule and Preventive Services Rule. Employer Payment Plans would similarly violate both rules. This violation accounts for the prohibition against stand-alone HRAs and Employer Payment Plans for active employees under the Guidance.

Acceptable HRAs

An employer may offer an HRA only when the HRA is "integrated" with an underlying group health plan. For example, consumer-driven health plans (CDHPs) in HealthFlex are integrated with the HRAs offered through the Plan—and therefore are permitted under ACA. Most consumer-driven plans and high-deductible plans maintained by annual conferences that have an associated HRA will also be integrated and permitted.

Interestingly, an employer can offer an HRA when the HRA is integrated with another employer's group health plan (such as the employer of an employee's spouse). However, such an HRA would not count toward the affordability or Minimum Value of the other employer's plan for purposes of determining the employee's eligibility for a PTC. If an employer offers an HRA to purchase health coverage offered by another employer, the employee must be given the option of opting out of the HRA at least annually and upon termination of employment (forfeiting any remaining benefits), so that the employee may then opt for a PTC in the Marketplace instead (if otherwise eligible based on taxable income).

The Guidance provides two integration methods for HRAs—one that does not require Minimum Value and one that does.

[9] Employer-provided health coverage under ACA is not generally "affordable" if it costs the employee more than 9.5% of his or her taxable income for individual coverage.

[10] Minimum value under the ACA means that the employer "plan's share of the total allowed costs of health benefits provided under the plan is less than 60 percent of such costs." Minimum value is explained further **here**.

Method 1 (Minimum Value not required: An HRA is integrated with a group health plan if:

- The employer offers a group health plan (other than the HRA) to the employee that does not consist solely of excepted benefits;
- The employee receiving the HRA is actually enrolled in a group health plan (other than the HRA) that does not consist solely of excepted benefits. This can be the plan of another employer or a former employer (non-HRA group coverage);
- The HRA is available only to employees who are enrolled in "non-HRA group coverage," regardless of whether the employer sponsors the non-HRA group coverage;
- The HRA is limited to reimbursement of one or more of the following: co-payments, co-insurance, deductibles and premiums under the non-HRA group coverage, as well as medical care defined under §213(d) of the Tax Code that is not "essential health benefits"; and
- Under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA at least once a year. Upon termination of employment, 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. (The opt-out feature is required because benefits provided by the HRA are minimum essential coverage under the ACA and will disqualify the individual from claiming PTC.)

Method 2 (Minimum Value required): Alternatively, an HRA that is not limited with respect to reimbursements as required under the first integration method can be integrated with a group health plan if:

- The employer offers a group health plan to the employee that provides Minimum Value;
- The employee receiving the HRA is actually enrolled in a group health plan that provides Minimum Value, regardless of whether the employer sponsors the plan (non-HRA Minimum Value group coverage);
- The HRA is available only to employees who are actually enrolled in "non-HRA Minimum Value group coverage," regardless of whether the employer sponsors the non-HRA Minimum Value group coverage; and
- Under the terms of the HRA, 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, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out and waive future HRA reimbursements.

Note that under the Method 2, the items that can be reimbursed through the HRA are not limited as they are under Method 1. The Guidance also explains that unused amounts that were credited to an HRA while the HRA 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—whether or not an HRA is integrated with other group health plan coverage. Therefore, terminated employees, employees who retire or employees who opt out of the group plan may still be reimbursed from an HRA through a "spend-down" or "run-out" period. However, an HRA balance during the run-out period would disqualify the covered individual from a PTC in the Marketplace.

The simplest way for a plan sponsor to ensure its HRA is integrated is to require its employees to participate in its own group health plan in order to also participate in the HRA. Alternatively, an employer might amend its HRA to prevent reimbursement of an employee's claim if the employee is not actually enrolled in group health coverage that satisfies the integration test. If the employee loses coverage, the plan sponsor could argue that any reimbursement made by the HRA should simply be treated as taxable income to the employee under this latter approach.

The Guidance is not entirely clear whether the integrated HRA could provide a temporary "opt-out" right to employees. Conceivably, a temporary opt-out right would allow an employee to choose whether to opt out of HRA coverage on an annual basis. The employee could not obtain reimbursements in the year that he or she opted out, yet the HRA balance from previous years would be frozen instead of forfeited. Arguably, the employee could be eligible for PTCs in any year during which he or she "opted out" of the HRA coverage. Under such an

arrangement, the employee could then opt back into the HRA in future years and obtain access to HRA funds for reimbursements.

The Guidance's discussion of retiree-only HRAs, however, suggests that a temporary opt-out may not be allowed. With regard to retiree-only HRAs, the Departments took the position that HRA coverage would constitute MEC (and therefore disqualify the retiree from PTCs) for any month in which funds remain in the HRA. An important aspect of both integration methods is that they do not require that the HRA and the coverage with which it is integrated share the same plan sponsor (employer). An HRA can satisfy the integration tests provided that the employee is enrolled in *any* group health plan that meets the requirements of the test—not necessarily a group health plan sponsored by his or her employer. This would allow an employee to enroll in group health plan coverage through his or her spouse and still be eligible to enroll in an integrated HRA through his or her own employer. However, in order for the employer to be sure its own HRA continues to meet one of the integration tests above and is therefore ACA-compliant, the employer must monitor the other plan in which the employee is enrolled and regularly verify whether its employee continues to actually be enrolled in the other plan[11]. An employer with multiple employees choosing to enroll in spouses' plans would need to monitor compliance of multiple other plans.

Retiree-Only HRAs

Stand-alone "retiree-only"[12] HRAs constitute eligible employer-sponsored plans. Therefore, retiree-only HRAs constitute minimum essential coverage for any month in which any funds remain in the HRA (including amounts retained in the HRA after the employer has ceased making contributions). Although the retiree-only HRA coverage would satisfy the ACA's individual mandate because it is MEC, covered individuals would not be eligible for PTCs because the HRA is employer-provided coverage. This means that pre-65 retirees—who are typically not Medicare-eligible except due to disability—will not be eligible for the PTC for any month that the HRA has a balance.

The Guidance limits the usefulness of retiree-only HRAs, which some plan sponsors had envisioned using to help pre-65 retirees purchase Marketplace coverage. Although not entirely clear under Guidance issued to date, it appears that plan sponsors may be able to offer retirees an annual enrollment option under which a retiree could choose whether or not to have coverage under the retiree-only HRA for a given year (i.e., receive reimbursements). However, any time the retiree "dis-enrolled" from the HRA for a year, the remaining HRA balance would be forfeited and unavailable for future use even if the retiree opts back in later. This would prevent HRA balances from accumulating over time (rolling over year to year if the retiree opts out during that time).

Employer Payment Plans

Employer Payment Plans are "group health plans under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy…or arrangements under which the employer uses its funds to directly pay the premium for an individual health insurance policy covering the employee when the employer payments are excluded from the employee's taxable income." Employer Payment Plans are prohibited beginning January 1, 2014 for any individual health insurance policy (whether purchased through the ACA Marketplace or in the private market).

On the other hand, Employer Payment Plans can be paired with other *group* health coverage to comply with the ACA's Market Reforms. In addition, an Employer Payment Plan for retirees-only, like other retiree-only health plans, is not subject to the ACA's Market Reforms. Retiree-only Employer Payment Plans may be used to purchase non-employer-sponsored health coverage, including individual policies—but will disqualify the retiree from obtaining a subsidy through the ACA Marketplace.

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[11] Employers can rely on employees' attestations about their coverage under another employer's non-HRA group health plan (including its minimum value, if applicable) and the nature of their expenses under that plan (that is, limited to co-pays and other permitted costs in the case of a non-minimum-value group plan).

[12] Under the ACA, a "retiree-only plan" is a plan that does not cover any more than one current employee.

Cafeteria Plans and Premium-Only Section 125 Plans

Effective January 1, 2014, employees are not permitted to pay for ACA Marketplace individual insurance on a pre-tax basis through their employer's Cafeteria Plan or Premium-Only Section 125 Plan (POP). The ACA amended the Code so that Marketplace-based individual coverage may not be offered as a "qualified benefit" subject to the preferential tax treatment of Code Section 125.

It appears that the only way for an employer to offer a tax-favored arrangement for ACA Marketplace coverage for active employees is through the SHOP, which applies only to small employers (fewer than 50 full-time equivalent employees in 2014). The ACA added Code section 125(f), which generally prohibits pre-tax payment of an employee's share of individual policies purchased through the Marketplace. There is one exception—for policies purchased through the SHOP Marketplace. In general, SHOPs are only available to small businesses. You can read more about the SHOP **here.**

Since employees will not have access to an employer's Cafeteria Plan when purchasing individual Marketplace coverage (not through SHOP), this will in effect increase the employee's effective cost for this coverage by taxing the amount paid for premiums. Employers should consider this fact and communicate it to employees if they intend to educate employees about their coverage options.

Health FSAs

Health FSAs are not subject to the Market Reforms if they offer only excepted benefits. Health FSAs are considered excepted benefits if the employer independently offers a group health plan and employer contributions to the FSA do not exceed certain limits[13]. If an employer offers a health FSA that does not qualify as excepted benefits—for example, in the absence of a group health plan—the health FSA must satisfy the Preventive Services Rule. A health FSA is not subject to the Annual Limit Rule if it is offered through a Section 125 (Cafeteria) Plan. Most employers' health FSAs currently qualify for this exception.

Health Savings Accounts (HSAs) Not Affected

The Guidance does not affect HSAs, which generally are not group health plans under the ACA. HSAs may reimburse qualified medical expenses, including premiums for COBRA continuation coverage, for any health coverage while the account holder is unemployed. If the account holder (the plan participant) is age 65 or older, HSAs may reimburse qualified medical expenses including premiums for any health insurance other than a Medicare supplemental plan, e.g., supplemental dental or vision plans, or individual policies for individuals over age 65 who do not qualify for Medicare.

Employee Assistance Programs (EAPs)

Employee assistance programs (EAPs) are welfare programs that provide employees with access to referral or counseling services for problems such as alcoholism, drug abuse, financial issues or legal issues. The Guidance also offers some insight regarding the treatment of EAPs under the ACA's Market Reforms and whether EAPs qualify as minimum essential coverage for purposes of the individual mandate and PTCs.

The Guidance clarifies that an EAP is an "excepted benefit" (provided it does not offer significant medical care or treatment benefits). Therefore, EAPs:

- are not considered minimum essential coverage, and
- do not disqualify the employee from eligibility for a premium tax credit.

Employers may use a reasonable, good faith interpretation of whether an EAP provides "significant benefits in the nature of medical care or treatment." It is likely that many employers will conclude that their EAPs are excepted benefits under these guidelines.

[13] The total payable from a health FSA for any year cannot be more than twice the participant's salary-reduction election for that year (or, if greater, the participant's salary-reduction election for that year plus $500).

The Bottom Line

The bottom line is that it will be nearly impossible to use nontaxable or before-tax dollars through an employer to purchase individual medical coverage (individual plans or policies) in the individual market within or outside of the ACA Marketplace (exchanges) for active employees.

For retirees covered through an employer-provided HRA, the Guidance prevents the covered retirees from benefiting from the tax-favored treatment of employer coverage *and* qualifying for the ACA's PTCs at the same time.

On the other hand, employers can increase compensation (taxable dollars) to assist employees who will no longer have access to EPPs or other plans terminated by employers with purchasing individual coverage (coverage outside of a group health plan). Employers also can offer tax-free excepted benefits (such as EAPs, dental and vision plans) to employees. Excepted benefits do not count as MEC, but also do not negate an employee's eligibility for PTCs. Employers also can use deferred compensation arrangements [e.g., 403(b) plans, etc.] as a complementary approach to relying on the ACA Marketplaces.

What Guidance May Mean for Annual Conferences

Annual conferences will not be able to use stand-alone HRAs or Employer Payment Plans to help clergy or lay employees purchase individual health plans or policies through the ACA Marketplaces or in the private market. In fact, the ACA makes it difficult for employers to provide tax-favored financial assistance to employees to purchase individual policies, except through the SHOP Marketplace. There are ways to provide taxable assistance, but added taxable dollars will likely increase clergy household taxable income (MAGI) and cause available PTCs to be diminished. Taxable cash solutions may bring added costs to clergy [self-employment (SECA) taxes], local churches [added payroll (FICA) taxes], and the Connection [increased conference and denominational average compensation (CAC and DAC), which would drive up costs of retirement and welfare benefits plans].

Many annual conferences are considering the concept of a "private exchange." HRAs and Employer Payment Plans are still permitted under limited circumstances, provided they meet the requirements described above, to be coupled with group health coverage offered by an employer. Many private exchanges are built around fully-insured large group plans or self-funded plans. These designs should be able to work with integrated HRAs, Employer Payment Plans and Cafeteria Plans. A HealthFlex Exchange is available as of January 2016.

Also, stand-alone HRAs are allowed for retiree-only health plans. They must satisfy the requirements described above, and they disqualify covered retirees from the PTCs in the ACA Marketplace (keeping in mind that PTCs are not available to Medicare-covered retirees). But, the retirees can use the HRA funds to purchase individual plans in the ACA Marketplace, on the private market or in the Medicare supplement market if they are Medicare-eligible.

HRAs are allowed if they are integrated with a conference's group health plan (like the HRAs coupled with the HealthFlex consumer-driven health plan). However, plan sponsors of integrated HRAs may need to quickly amend their plans to add the required opt-out feature described above.

In separate guidance (covered **here**), the Departments confirmed that retiree medical coverage (through an HRA or other plan) is considered MEC only if a retiree actually *enrolls* in that coverage. Mere eligibility for retiree health coverage will not keep pre-65 retirees from obtaining coverage through the ACA Marketplace and qualifying for PTCs.

If an annual conference offers a health FSA to groups that are not also offered its group health plan, (e.g., part-time clergy, deacons or lay employees at local churches), *the conference will need to take steps quickly to amend its FSA or group health plan so that the FSA is offered only to participants who are also offered the group health plan*. This eligibility change was effective for the plan year starting January 1, 2014.

What Guidance May Mean for Local Churches

Local churches that rely on stand-alone HRAs or Employer Payments Plans to cover lay employees, deacons or part-time clergy should terminate those plans. Continuing stand-alone HRAs risks ACA and payroll tax penalties to the local church and adverse tax consequences to the employees. Local churches that wish to continue providing financial assistance to help employees purchase individual health plans or policies through the ACA Marketplace or the private market still have a few options:

1. A local church (if it is a small employer) can simply increase the employee's taxable wages, as long as the employee is not required to be paying for individual health insurance or medical expenses incurred. [As discussed earlier, this option also increases the employee's taxes and the church's payroll (FICA) taxes.]
2. A local church can establish a payroll practice of forwarding post-tax employee wages to a health insurance issuer at the direction of an employee, if the practice meets the following criteria:
   - No contributions are made by an employer or employee organization.
   - Participation in the program is completely voluntary for employees.
   - The employer collects premiums through payroll deduction and remits them to the insurer without endorsing the program.
   - The employer receives no consideration (e.g., cash) other than reasonable compensation for administrative services rendered to collect the premiums.
3. A small employer local church can adopt plans through the SHOP Marketplace for employees and provide a tax-free contribution toward coverage.

Lay employees at local churches should not be provided a health FSA unless they have also been offered access to an employer group health plan, e.g., a small group market plan, SHOP plan or an annual conference plan that is sponsored, adopted or "participated in" by the local church.

For More Information

The General Board continues to monitor federal health care reform and provide applicable information for annual conferences, local churches and other UMC employers, as well as information for individuals. Check the General Board's **health care reform web page** frequently for updates.

If you have questions or would like additional information, please send your inquiries to **healthcarereform@gbophb.org**. General information about health care reform is available from the federal government at **www.healthcare.gov**.