

2014

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Recommended Citation

Richard R. Bennett *The Changing Face of Health Reimbursement Arrangements: Affordable Care Act Implications for HRAs*, 27 Loy. Consumer L. Rev. 156 (2014).

Available at: <http://lawcommons.luc.edu/lclr/vol27/iss1/5>

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THE CHANGING FACE OF HEALTH REIMBURSEMENT ARRANGEMENTS: AFFORDABLE CARE ACT IMPLICATIONS FOR HRAS

*Richard Ryan Bennett**

I. INTRODUCTION

Since the implementation of the Patient Protection and Affordable Care Act (“ACA”) in 2010¹, employers and employees alike have seen major changes not only to the way their group plan health care is organized, but also to some of the tax benefits they previously utilized.² As federal agencies continue to develop regulations and strategies to further implement the ACA, there have been substantial changes to health reimbursement arrangements (“HRAs”).³ An HRA is a health arrangement account, to which an employer can make tax-

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¹ *Patient Protection and Affordable Care Act*, PUB. L. NO. 111-148, 124 STAT. 119 (2010) [hereinafter “ACA”].

² Mary Agnes Carey, *The Sign-Up Deadline is March 31: A Consumer Guide*, KAISER HEALTH NEWS (Mar. 21, 2014), <http://www.kaiserhealthnews.org/stories/2012/march/22/consumer-guide-health-law.aspx>; e.g., I.R.C. §4980D (setting forth the \$100/day per employee penalty for the failure of any group health plan to comply with chapter 100 group health plan requirements).

³ U.S. DEPT. OF LABOR, FAQs ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART XI (2013), available at <http://www.dol.gov/ebsa/faqs/faq-aca11.html> [hereinafter IMPLEMENTATION FAQs]; see also, Dan Drummond, *Standalone Health Reimbursement Arrangements Fail to Comply with Obamacare for Employee Coverage*, GUNNCHAMBERLAIN, P.L. (Jun. 4, 2014), available at <http://www.gunnchamberlain.com/2014/06/standalone-health-reimbursement-arrangements-fail-to-comply-with-obamacare-for-employee-coverage>, (explaining that HRA plans that fail to meet the integration requirements under the ACA will result in a penalty to the employer of \$100 a day per employee, cumulatively an annual \$36,500 penalty per employee).

deductible contributions.⁴ The HRA in turn provides tax-excludable reimbursements to employees for a variety of medical expenses allowed under Section 213(d) of the Internal Revenue Code (the “Code”).⁵ The ACA tasks the Department of Labor (“DOL”), Health and Human Services (“HHS”), and the Treasury (collectively the “Departments”) with implementing select changes to HRAs.⁶ Key changes include the prohibition of standalone HRAs, which reimburse employees for individual market premiums, and any HRAs that is not “integrated” with an ACA-compliant group health plan.⁷

This Note focuses largely on the explicit restriction of an employer’s ability to offer an HRA to its employees, which would otherwise reimburse them for the cost of obtaining their own individual coverage on the market.⁸ The Departments’ rationale behind this decision is poorly reasoned, since minor regulatory tweaks and legislative amendments could simultaneously alleviate the concerns presented by the Departments, while also allowing the return of the popular individual coverage reimbursing HRA model.⁹

⁴ *Application of Market Reform and Other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain Other Employer Healthcare Arrangements*, 2013-40 I.R.B. 287 (2013), available at <http://www.irs.gov/pub/irs-drop/n-13-54.pdf> [hereinafter NOTICE 2013-54]; I.R.C. §213 (d).

⁵ NOTICE 2013-54, *supra* note 4.

⁶ IMPLEMENTATION FAQs, *supra* note 3, at 1.

⁷ NOTICE 2013-54, *supra* note 4, at 4; see also *Affordable Care Act Changes for Health Reimbursement Arrangements*, WAGeworks COMPLIANCE BRIEFING CENTER, 2 (2013), available at http://www.getwageworks.com/compliance/RegulatoryUpdates/ACA_HRA.html [hereinafter WAGeworks] (noting that an HRA set up in conjunction with a group health care plan is specifically allowed only if the underlying plan is “ACA-compliant”).

⁸ WAGeworks, *supra* note 7, at 2.

⁹ Letter from Randel K. Johnson, Senior Vice President, Labor, Immigration, & Employee Benefits U.S. Chamber of Commerce & Katie Mahoney, Executive Director, Health Policy U.S. Chamber of Commerce, to Secretary Kathleen Sebelius, Dep’t of Health and Human Services, Secretary J. Jack Lew, Dep’t of the Treasury, & Acting Secretary Seth D. Harris, Dep’t of Labor (May 20, 2013), available at <https://www.uschamber.com/sites/default/files/legacy/comments/HRA%20FAQ%20-%20USCC%20comments.pdf>. at 3. [hereinafter Chamber of Commerce Letter]; *Accord.*, Robert Bloink & William H. Byrnes, *Are HRAs on the Chopping Block Under the Affordable Care Act?*, THINKADVISOR (Feb. 5, 2013), available at <http://www.thinkadvisor.com/2013/02/05/are-hras-on-the-chopping-block-under-the-affordabl> (describing HRAs, prior to the restrictive regulations, as a popular and “valuable tool that provided flexible health benefits before the ACA”).

This Note will first address the technical background of an HRA by examining the benefits derived by both employers and employees. Part II will review the ACA's regulatory implementation, and how it has morphed the face of HRAs. The rationale behind these changes, as well as the position in favor of continuing to allow HRAs to reimburse individual coverage, will be explored in Part III. Finally, Part IV of this Note will argue that HRA plans must continue, and will address the Departments' concerns through a combination of regulatory modifications and legislative amendments.

II. BACKGROUND: CREATION AND FUNCTION OF HRAS

HRAs were formally constructed in IRS Notice 2002-45, which set forth that an HRA is a medical reimbursement arrangement between an employer and employee that can also cover the employee's eligible dependents or spouse.¹⁰ The employer has the sole ability to make contributions to the HRA, which are then issued as reimbursements to the employee.¹¹ These reimbursements are allowed only for medical expenses not covered by other forms of insurance, as specified in Section 213(d) of the Code, and the reimbursements are generally excludible from the employee's gross income.¹² Another common practice, now restricted by the ACA, allows the employee to obtain individual healthcare coverage on the market, and the HRA then subsequently reimburses the employee for the expense.¹³

HRAs are generally classified as employer-sponsored "group health plans," and typically provide the same benefits to all employees enrolled in that particular employer's HRA.¹⁴ The HRA

¹⁰ *Health Reimbursement Arrangements, Part III – Administrative, Procedural, and Miscellaneous*, 2002-28 I.R.B. 93 [hereinafter NOTICE 2002-45].

¹¹ *Id.*

¹² *Id.*; I.R.C. §213(d) (setting forth the definition of the term medical care, which means any amount paid "for the diagnosis, cure, mitigation, treatment, or prevention of disease," or for the "purpose of affecting any structure or function of the body," transportation for essential medical care, "qualified long-term care services," or insurance premiums).

¹³ NOTICE 2002-45, *supra* note 10, at 2; see FED. TAX COORDINATOR, ¶ H-1349.14 (2d.), at 33 (2014) (explaining that, "...an employer-sponsored HRA cannot be integrated with individual market coverage or with an employer plan that provides coverage through individual policies, and will violate § 2711 if it does so").

¹⁴ *Health Reimbursement Arrangements*, FED. TAX COORDINATOR, ¶ H-1349 (2d.), at 1 (2014); see also FED. TAX COORDINATOR, ¶ H-1325.23 (2d.), at 32.2

can also extend coverage to the medical expenses of the employee's spouse or dependents.¹⁵ Importantly, HRAs allow for any unused portion of the HRA to cumulatively rollover into the next year, alleviating the potential pressure from the employee to exhaust the account at the end of each year.¹⁶ From an employer's perspective, one major incentive for establishing an HRA is the tax deduction the employer can take for contributions to the HRA. Section 419 of the Code allows deductions for "welfare benefit funds;"¹⁷ however, the deduction is not permitted unless the medical expense claimed falls into one of the permitted categories set forth in Section 213(d) of the Code. These categories range from the diagnosis and treatment of disease to transportation for essential care services.¹⁸

Approximately between only 20 to 50 percent of American employees utilize their health care annually.¹⁹ Thus, an HRA allows an employer to individually determine which type of coverage best

(2014) (defining that "...an employer payment plan under which an employer reimburses employees for an employee's substantiated individual insurance policy premiums. . . is considered to be a group health plan").

¹⁵ NOTICE 2002-45, *supra* note 10, at 2.

¹⁶ FED. TAX COORDINATOR, ¶ H-1349.14, *supra* note 10, at 36. (stating that, "Whether or not an HRA is integrated with other group health plan coverage, unused amounts credited before Jan. 1, 2014. . . 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 § 2711"); NOTICE 2002-45, *supra* note 10, at 2.

¹⁷ I.R.C. §419; NOTICE 2002-45, *supra* note 10, at 13; *see also* Myra J. Green, *Consumer-Directed Health Plans: A Health Plans Strategy*, American Health Lawyers Association Conference Seminar Materials, AHLA PAPERS P05140307 (May 14, 2003) (explaining that where an HRA which is funded with "hard-dollar amounts" actually set aside by the employer, the employer would be able to take an immediate deduction, whereas if the HRA is set up similarly to that of a line of credit, in which where employee expenses are "paid using employer funds if and when they occur," then the employer may only take a deduction when those funds are actually paid out).

¹⁸ NOTICE 2002-45, *supra* note 10, at 2; I.R.C. §213 (d).

¹⁹ TASC TOTAL ADMINISTRATIVE SERVICES, *Health Reimbursement Arrangement* (2014), available at <https://www.tasconline.com/biz-resource-center/plans/health-reimbursement-plan/> [hereinafter TASC]; *see also* Robin A. Cohen, Whitney K. Kirzinger, & Renee M. Gindi, *Healthcare Access and Utilization Among Young Adults Aged 19-25: Early Release of Estimates From National Health Interview Survey January-September 2011*, Division of Health Interview Statistics, NAT'L CTR. FOR HEALTH STATISTICS (May 2012) (presenting statistical data for the 19-25 year old age bracket which indicates that only 19.9 percent of "not poor" respondents had an emergency room visit in the past 12 months, and 73.0 percent had at least one doctor visit in the past 12 months).

fits the needs and demographics of their employees.²⁰ Aside from tax deductions and more efficient programs, employees generally perceive HRAs positively, due to the fact that they are often custom tailored to meet the needs of the employees, rather than being a one-size-fits-all group health plan.²¹

The employer will often pair the HRA with a High Deductible Health Plan (“HDHP”).²² Under this arrangement, employees receive two key benefits: a lower premium on their coverage from the HDHP and the ability to use the tax-advantaged HRA funds to reimburse eligible medical expenses incurred before the HDHP deductible is met.²³ HRAs are typically considered a substantial perk for employees, as well as a way to attract and retain talent, which benefits employers and employees alike.²⁴ These benefits include tax advantages, flexibility of coverage and design, and rollover contributions.²⁵

III. AFFORDABLE CARE ACT REGULATORY IMPLEMENTATION

In an effort to provide regulatory guidance for employer compliance with the ACA, the Departments have issued a series of notices and technical releases that directly address an employer’s permitted use of HRAs under the ACA.²⁶ These regulations extend

²⁰ TASC, *supra* note 19, at 1.

²¹ *Id.*, at 2; *see also* INTERNAL REVENUE SERVICE (I.R.S.), TAXPAYER INFORMATION PUBLICATION, PUBLICATION 969, HEALTH SAVINGS ACCOUNTS AND OTHER TAX-FAVORED HEALTH PLANS (January 22, 2014), *available at* <http://www.irs.gov/publications/p969/ar02.html> (explaining that, “Employers have complete flexibility to offer various combinations of benefits in designing their plan”).

²² TASC, *supra* note 19, at 2.

²³ *Id.*

²⁴ *Id.*; *see Health Reimbursement Arrangement*, FBMC BENEFITS MANAGEMENT, *available at* <http://www.fbmc.com/LearningCenter/TaxFavoredBenefits/HRA.aspx#employees> (claiming that the primary reasons employees like HRAs are: (1) the fact that HRAs are completely funded by the employer, (2) funds left over in the plan at the end of the year roll over into the next year, and (3) HRAs can also sometimes be used “in conjunction with both Medical Flexible Spending Accounts and Health Savings Accounts”) [hereinafter FBMC BENEFITS].

²⁵ FBMC Benefits, *supra* note 24, at 1.

²⁶ NOTICE 2013-54, *supra* note 4, at 1; U.S. DEP’T OF LABOR, *Technical Release 2013-03, Application of Market Reform and other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain Other Employer Healthcare Arrangements* (Sept. 13, 2013), *available at*

past mere implementation measures, and have transformed the HRA landscape entirely.²⁷ IRS Notice 2013-54, released in September 2013, indicates that because HRAs are considered “group health plans,” they are subject to the ACA rules, or the “market reforms,” governing such arrangements.²⁸ However, pursuant to Section 9831(a)(2) of the Code, the market reforms do not apply to a group health plan for employers with fewer than two participants on the first day of the plan’s year.²⁹ The market reforms are also inapplicable to the “excepted benefits” set forth in Section 9832(c) of the Code, thus excluding a handful of insurance and compensation plans.³⁰

Notice 2013-54 also addresses two ACA market reforms which have the most operative impact on HRAs: Public Health Service Act Sections 2711 (“Section 2711”) and 2713 (“Section 2713”).³¹ Section 2711 requires that a group health plan must not set an annual dollar limit on the amount of “essential health benefits” that a coverage plan provides.³² This limit applies specifically to “essential health benefits,” and makes an express exception for the establishment of annual limits on health benefits that are not classified as “essential” under Section 1302(b) of the ACA.³³ Section

<http://www.dol.gov/ebsa/pdf/tr13-03.pdf> (providing the DOLs nearly verbatim, slightly streamlined version of IRS Notice 2013-54); IMPLEMENTATION FAQs, *supra* note 3, at 1.

²⁷ Nancy K. Campbell, *Non-Integrated Health Reimbursement Arrangements (Whatever They Are Called) Are Subject to \$36,500 Per-Participant Per-Year Penalty*, SNELL AND WILMER BENEFITS BLOG (Mar. 19, 2014), available at <http://www.swlaw.com/blog/employee-benefits/2014/03/19/non-integrated-health-reimbursement-arrangements-whatever-they-are-called-are-subject-to-36500-per-participant-per-year-penalty/> (stating that the specific regulatory guidance in IRS Notice 2013-54 is “not good news for most HRAs, also called medical expense reimbursement plans (“MERPs”).

²⁸ NOTICE 2013-54, *supra* note 4, at 1.

²⁹ *Id.* at 3; I.R.C. §9831 (setting forth the general exceptions for market reforms).

³⁰ I.R.C. §9832(c)(1) (specifying the following excepted benefits: any combination of accident and/or disability income insurance, liability insurance supplements, liability insurance, workers’ compensation, automobile medical payment insurance, credit-only insurance, on-site medical clinic coverage, and a miscellaneous category for any similar insurance specified in other regulations); see NOTICE 2013-54, *supra* note 4, at 3.

³¹ NOTICE 2013-54, *supra* note 4, at 3.

³² *Id.* at 3-4.

³³ See also ACA, *supra* note 1, at § 1302(b) (setting forth the following non-exhaustive list of “essential health benefits:” ambulatory patient services,

2711 is the market reform that places substantial restrictions on HRAs by mandating that no group health plan contain an annual limit on essential benefits, as the various forms of existing HRAs effectively did by only providing a fixed contribution to the employee's HRA account every year.³⁴ Additionally, as described in Notice 2013-54, Section 2713 requires all non-grandfathered group health plans to provide "certain preventative services without imposing any cost-sharing requirements for these services."³⁵

A. Integration

The Departments' new technical terminology associated with HRA planning is "integration."³⁶ For an HRA to be valid under Section 2711's annual limit prohibition, it must be qualified as "integrated" with an underlying ACA-compliant group health plan that does not have the type of annual limit described in Section 2711.³⁷ The DOL explicitly indicates that a group health plan that complies with the annual limit prohibition, but which the employer then pairs with an HRA that does set annual limits (such as through a fixed annual contribution cap), is considered fully integrated with the

emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavior health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventative and wellness services and chronic disease management, and pediatric services, including oral and vision care); NOTICE 2013-54, *supra* note 4, at 3.

³⁴ NOTICE 2013-54, *supra* note 4, at 4; *see generally* FBMC BENEFITS, *supra* note 24, at 2 (explaining that the seven major forms of HRAs are: (1) medical, which is required to be paired with a health plan, often a HDHP, (2) stand-alone [which were expressly prohibited by Notice 2013-54], (3) limited purpose, which may reimburse only dental and vision medical expenses and can run concurrently with an HSA, (4) post-deductible, which is tied to a HDHP, but unlike the medical HRA, does not begin reimbursing the employee until the HDHP deductible has been met, (5) suspended, which can occur when the employee derives similar reimbursement benefits from another mutually exclusive employee-benefits program, and all accrued funds become available after retirement, (6) funded, which is similar to a suspended HRA, except that the funds are placed into a Trust account, and (7) retiree, in which the HRA funds are available only once certain conditions are met and the employee retires or terminates employment).

³⁵ NOTICE 2013-54, *supra* note 4, at 3.

³⁶ *Id.* at 4 (specifying that "integration" as a requirement for an HRA is being applied in direct coordination with the DOL and HHS, and that all three agencies are issuing "substantially identical" guidance).

³⁷ IMPLEMENTATION FAQs, *supra* note 3, at 1; *see* 29 CFR 2590.715-2711.

underlying ACA-compliant plan.³⁸ This is justified because the combined, aggregate benefit satisfies the Section 2711 requirements.³⁹ Notice 2013-54 further interprets the integration standard by clarifying that, in terms of complying with the annual dollar limit prohibition, an employer-sponsored HRA is not technically integrated with ACA-compliant market coverage if the HRA itself is used to purchase individual coverage on the market.⁴⁰ This effectively sets a boundary for HRA usage; if the HRA is itself subject to an annual dollar limit but simultaneously reimburses an employee who obtains his own individual coverage, the Departments would classify that as non-integrated, and therefore prohibited, under Section 2711.⁴¹ The practical impact of this is that if an employer previously reimbursed an employee for obtaining individual coverage through an HRA, 2014 regulations will terminate the HRA, and therefore the employee reimbursement.⁴² This is an unnecessary elimination of a system which both employees and employers found convenient as well as beneficial.

Notice 2013-54 also requires that all employees must actually be enrolled in the group plan for an HRA to be considered integrated with a group plan complying with the annual limit prohibition.⁴³ An HRA providing reimbursement to an employee who is not enrolled in an underlying plan that meets the annual limit prohibition will be considered non-compliant with Section 2711.⁴⁴ This requirement compels employers to make sure that all employees are covered under a group health plan that does not have an annual dollar limit

³⁸ *Id.* at 2.

³⁹ *Id.* at 1; *see* 75 FR 37188, at 37190-37191. (containing the exact language of the preamble which the Implementation FAQs draw on, which essentially permits HRAs with annual restrictions on the grounds that they are largely auxiliary at that point, since the underlying group health plan already meets the annual limit requirement).

⁴⁰ NOTICE 2013-54, *supra* note 4, at 4; IMPLEMENTATION FAQs, *supra* note 3, at 2 (stating that, in response to the common implementation question of whether an HRA may be used to reimburse the purchase price of individual premiums by the employee, “. . . an employer-sponsored HRA cannot be integrated with individual market coverage or with an employer plan that provides coverage through individual policies and therefore will violate PHS Act section 2711”).

⁴¹ *Id.* at 4.

⁴² *Id.* at 3.

⁴³ *Id.* at 4.

⁴⁴ *Id.* (stating that “the Departments intend to issue guidance providing that . . . any HRA that credits additional amounts to an individual, when that individual is not enrolled in primary coverage meeting the annual dollar limit prohibition. . .” [fails to comply with Section 2711] (Emphasis added)).

before doling out portions of the HRA, as the receipt of an HRA reimbursement by an employee who is not covered by the underlying compliant plan renders the whole setup legally inoperable.⁴⁵ Along with the requirement that the underlying group plan be ACA-compliant, integration requires that: (1) the employer-provided group health plan must offer benefits considered “excepted benefits”; (2) an employee must be allowed to permanently opt out of the HRA and waive future reimbursements; and (3) in the event of termination of employment, the employee must have the option to either forfeit or waive future payments from the existing accrued HRA.⁴⁶ In light of these additional three requirements, along with the requirement that an employer provide an ACA-compliant group health plan, Notice 2013-54 effectively relegates HRAs to a more auxiliary position by requiring that they only be used for additional benefits above and beyond the minimum ACA requirements on the underlying employer-provided group health plan.⁴⁷

Additionally, Notice 2013-54 interprets the preventative services requirement set forth in Section 2713 to require that for an HRA to be considered integrated, the underlying group health plan, which the HRA supplements, must offer the preventative services required by Section 2713.⁴⁸ As with the annual dollar limit prohibition⁴⁹, the HRA remains completely dependent upon the underlying group health plan.⁵⁰ If the group health plan fails to meet either the Section 2711 or 2713 requirements, the HRA will not be integrated and the entire arrangement will fail.⁵¹ Failure to properly

⁴⁵ *Id.*

⁴⁶ *New Rules for Health Reimbursement Accounts Under the ACA: Update from the VEHI*, Vermont Education Health Initiative (Nov. 2013), available at http://www.vehi.org/media/doc/HRAs_under_ACA_update_November_2013.pdf; I.R.C. §9832(c)(1), *supra* note 30 (listing the “excepted benefits”).

⁴⁷ NOTICE 2013-54, *supra* note 4, at 4.

⁴⁸ *Id.* at 6; see *Employer Health Care Arrangements*, VANASEK INSURANCE SERVICES (May 30, 2014), <http://www.vanasekinsurance.com/weblog/general/employer-health-care-arrangements.html>, (reviewing the preventative services requirement in Notice 2013-54 as a “requirement to provide certain preventative care without cost sharing”); see also 29 CFR 2590.715-2713 (setting forth the regulations for 2713, which broadly require coverage and prevent cost-sharing requirements for any immunizations, preventative care, office visits, and certain health care services provided to women).

⁴⁹ See 29 CFR 2590.715-2711.

⁵⁰ See NOTICE 2013-54, *supra* note 4, at 6.

⁵¹ NOTICE 2013-54, *supra* note 4, at 6; see Campbell, Nancy K., *supra* note 27, at 1. (summarizing the two integration tests set forth in Notice 2013-54 as: (1) “the

comply is detrimental to the employer, as the penalty for non-compliance is a fee of \$100 each day, per employee receiving healthcare benefits from an HRA which is non ACA-compliant.⁵²

B. Unusual Situations

The Departments have also addressed the issues that arise in certain unusual situations.⁵³ For example, the Departments have addressed situations where an employee is offered coverage that complies with the annual limit prohibition in Section 2711, elects not to enroll in that coverage, and then receives reimbursements from an HRA provided by the employer.⁵⁴ The Departments explained that the HRA in this scenario is not integrated unless the employee actually accepted (or already possessed) Section 2711-compliant coverage.⁵⁵ Hence, where an employer offers an employee a Section 2711-compliant plan with no annual limits and the employee actually refuses the plan but then receives payments from an HRA also offered by the employer, the HRA would be considered non-integrated, since the employee did not accept the underlying insurance policy.⁵⁶

Notice 2013-54 also reviews a situation in which an employee is enrolled in a group health plan that is properly integrated with an HRA, the coverage from the underlying group health plan ceases, and

‘minimum value not required method,’ requir[ing that the] HRA only reimburse only co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, or reimburse medical care other than essential health benefits,” and (2) the “minimum value required method,” which does not have the use restrictions of the first method, but imposes a mandatory “minimum-value” on non-HRA-coverage. Both tests require a permanent opt-out waiver for participants in the HRA. Since neither test requires that the HRA be sponsored by the same employer, “an employer may ‘integrate’ its HRA with another employer’s non-HRA coverage. Both methods require that employees be allowed to permanently opt-out of HRA coverage and, upon termination of employment either forfeit their HRA balance or permanently opt-out of coverage”).

⁵² Drummond, *supra* note 3, at 1 (explaining that, effectively, the only way for an employer-sponsored plan to include an HRA is to make the HRA effectively “supplemental” to ACA-compliant group coverage).

⁵³ IMPLEMENTATION FAQs, *supra* note 3, at 2.

⁵⁴ *Id.* (stating that the Departments, “*intend* to issue guidance under PHS Act section 2711 providing that an employer-sponsored HRA may be treated as integrated with other coverage only if the employee receiving the HRA is actually enrolled in that coverage” (Emphasis added)).

⁵⁵ *Id.* at 2.

⁵⁶ *Id.* at 3; see NOTICE 2013-54, *supra* note 4, at 4.

the employee still wants to use existing funds in the HRA that remain from the prior integration.⁵⁷ In this case, the employee would be permitted to use the remaining funds in the HRA, since the contributions the employer made were accumulated before the HRA became non-integrated.⁵⁸ This makes sense from a public policy perspective: if an employee accrued employer contributions in his HRA while it was integrated, but the arrangement subsequently becomes non-integrated through the subtraction of his group health plan, he should still reasonably have access to the funds built up in the HRA while it was integrated.⁵⁹ It is clear that the Internal Revenue Service (the “IRS”) does not think that the loss of a health care plan’s integration status should deprive the beneficiary of his prior integrated accrued benefits.⁶⁰

Another HRA complication arises when an employee is covered under a coverage configuration that would otherwise be considered integrated, but the group health plan with which the HRA is integrated does not provide all the essential health benefits that ACA Section 1302(b) requires.⁶¹ The second crucial fact in this hypothetical is that the HRA itself instead provides those essential health benefits but unlike the Section 2711-compliant group health plan, has an annual dollar limit.⁶² These facts raise the question of whether the Departments will view this paired arrangement, in the

⁵⁷ NOTICE 2013-54, *supra* note 4, at 9; *see also* Klinger, Lisa, *New Guidance Addresses Effect of ACA on HRAs, Health FSAs & Premium Reimbursement Accounts*, LEAVITT GROUP (Sept 20, 2013), <https://news.leavitt.com/health-care-reform/new-guidance-addresses-effect-of-aca-on-hras-health-fsas-and-premium-reimbursement-accounts/> (explaining that Notice 2013-54’s FAQ 5 expressly permits an employee who accumulated HRA funds under an integrated plan to continue to use those funds once the integration has ceased, without being “deemed noncompliant”).

⁵⁸ NOTICE 2013-54, *supra* note 4, at 9 (specifying, however, that the use of residual reimbursement funds must be “in accordance with the terms of the HRA”).

⁵⁹ I.R.C. 36B; NOTICE 2013-54, *supra* note 4, at 9; *see* Klinger, *supra* note 57, at 4 (explaining that, in this particular scenario, the ramifications of using the HRA accumulation once it has become non-integrated will work to the disadvantage of the employee, since “an employee who has unused HRA amounts available will *not* be eligible for a premium tax credit to buy individual insurance in the Marketplace”).

⁶⁰ *See* NOTICE 2013-54, *supra* note 4, at 9.

⁶¹ 42 U.S.C.A. §18022(b); NOTICE 2013-54, *supra* note 4, at 9.

⁶² NOTICE 2013-54, *supra* note 4, at 9 (setting forth the hypothetical in which an employee’s group health plan does not provide the ACA § 1302(b) essential health benefits, but the HRA instead does, “but limits the coverage to the HRA’s maximum benefit”); ACA § 1302(b), *supra* note 33.

aggregate, as meeting the ACA requirements.⁶³ According to the IRS, such an HRA would be considered non-integrated, and would not be allowed.⁶⁴ However, such a situation is unlikely to arise, since the market reforms in the ACA require that all non-grandfathered group health plans provide those essential health benefits.⁶⁵

Notice 2013-54 also expressly states that the Treasury Department and the IRS are aware that some employers would prefer to create standalone retiree-only HRAs.⁶⁶ This type of HRA is only offered to retired employees, who can then proceed to obtain reimbursements as a non-retired employee would, including reimbursement for the purchase of individual health insurance.⁶⁷ The Departments have indicated that this would “constitute an eligible employer-sponsored plan under Code § 5000A(f)(2), and therefore . . . would constitute minimum essential coverage under Code Section 5000A.”⁶⁸ The Departments further indicate that in general, market reforms do not apply to a retiree-only HRA, and therefore, market reforms will not impair an employer’s decision to offer such a plan.⁶⁹ However, one drawback of a retiree-only HRA is that the Code Section 36B premium tax credit would no longer be available for any month in which the retiree is covered by the HRA.⁷⁰ Instead, the employee would receive the HRA benefits in lieu of being eligible for the Section 36B credit.⁷¹

⁶³ NOTICE 2013-54, *supra* note 4, at 9.

⁶⁴ *Id.*; see Klinger, *supra* note 47, at 1-2.

⁶⁵ ACA §1302(b), *supra* note 33; see Klinger, *supra* note 57, (explaining the low likelihood of this situation as a result of the default essential health benefits requirements imposed on all “non-grandfathered, small-group insured plan[s]”); NOTICE 2013-54, *supra* note 4, at 9.

⁶⁶ NOTICE 2013-54, *supra* note 4, at 12.

⁶⁷ *Id.*

⁶⁸ *Id.*; see also I.R.C. §5000A(f)(2) (setting forth the category of “eligible employer-sponsored plan[s]”); NOTICE 2013-54, *supra* note 4, at 12.

⁶⁹ NOTICE 2013-54, *supra* note 4, at 12; see also Catherine Creech & Helen Morrison, *PPACA Guidance Clarifies Rules for HRAs, Health FSAs, and Other Accountable Plans*, AMERICAN INSTITUTE OF CPAS (Jan. 1, 2014), available at <http://www.aicpa.org/PUBLICATIONS/TAXADVISER/2014/JANUARY/Pages/clinic-story-04.aspx> (explaining that, “HRAs covering only retirees are not subject to the PPACA market reform rules because plans with fewer than two current employees are excepted.” By virtue of the fact that a retiree plan effectively only applies to a single individual, the scope of the ACA is limited).

⁷⁰ NOTICE 2013-54, *supra* note 4, at 12; see I.R.C. §36B (setting forth the “Premium assistance credit amount,” as well as specifying the applicable percentages and qualifications).

⁷¹ NOTICE 2013-54, *supra* note 4, at 12; see 26 I.R.C. §36B.

Taken as a whole, the regulations the Departments set forth modify the following three forms of HRAs: standalone HRAs, standalone retiree-only, and individual coverage reimbursement HRAs.⁷² Standalone HRAs, which do not reimburse employees for individual market premiums, do not meet the Section 2711 annual dollar limit prohibition and therefore must be terminated when the present accrued balance is exhausted.⁷³ Standalone retiree-only HRAs, which reimburse a retiree for either individual coverage premiums or Section 213(d) expenses, are removed from the market reforms and are therefore not effected by the ACA.⁷⁴ HRAs which reimburse employees for the cost of individual coverage premiums, in conjunction with a Section 2711 and Section 2713-compliant group health plan, are permitted.⁷⁵ While on its face this distinction might not seem to be warranted or even necessary, the Departments offered several explanations for the differentiation during a meeting with the Chamber of Commerce.⁷⁶

III. RATIONALE AND IMPACT

The Chamber of Commerce directly addresses what it correctly describes as the “HRA prohibition” in a May 20, 2013, letter to Secretary Kathleen Sebelius at the Department at the Health and Human Services, Secretary Jack Lew at the DOL, and Acting Secretary William Harris at the Treasury Department.⁷⁷ The Chamber of Commerce references a meeting that took place between the Departments and the Chamber of Commerce, along with several of its member companies.⁷⁸ The Chamber of Commerce, speaking in its letter for a wide cross-section of American business, accurately hones

⁷² WAGWORKS, *supra* note 7, at 2.

⁷³ NOTICE 2013-54, *supra* note 4, at 4.

⁷⁴ WAGWORKS, *supra* note 7, at 2; *see* Creech, *supra* note 58, at 2.

⁷⁵ WAGWORKS, *supra* note 7, at 2; *see 4 Things to Know About HRAs and Health Reform in 2014*, EMPLOYEE HEALTH BENEFITS AND INSURANCE BLOG (Jan. 16, 2014), <http://www.zanebenefits.com/blog/bid/307266/4-Things-to-know-about-HRAs-in-2014> (explaining that, “An Integrated HRA is an HRA linked with a high deductible group health insurance plan. The Integrated HRA is offered only to those at the company who take the group health insurance plan as it is a supplement to help with deductible costs”).

⁷⁶ Chamber of Commerce Letter, *supra* note 9, at 3.

⁷⁷ *Id.* at 2.

⁷⁸ *Id.* at 1.

in on the Departments' prohibition on using HRA reimbursements to purchase individual market coverage, and claims that it may have broader negative implications than anticipated.⁷⁹ The Departments directly addressed the common practice of using HRA reimbursements to allow employees to purchase individual health coverage, and the Chamber of Commerce expresses concern that this is, in effect, an overly broad regulation that requires immediate nullification.⁸⁰ The Chamber of Commerce claims that, based on this meeting, the Departments view any employer subsidy⁸¹ given to an employee for the purchase of an individual health plan violates the ACA's annual dollar limit prohibition.⁸² The Chamber of Commerce suggests the Departments' position is overly broad because placing such restrictive controls on HRAs may create unnecessary and unintended consequences, and is inconsistent with the ACA's overall goal of expanding health care availability and affordability.⁸³

One major problem with applying the annual dollar limit to HRAs is that many businesses, especially smaller business operations and nonprofit organizations, have entered into prior multi-year contractual agreements to reimburse their employees for the expense of obtaining individual insurance coverage.⁸⁴ While not technically HRAs, the IRS interpreted them to be tax-free within the meaning of Section 106 of the Code.⁸⁵ The Chamber of Commerce suggests that

⁷⁹ *Id.* at 2; (contextualizing their member base by explaining that that the U.S. Chamber of Commerce is "the largest business federation in the world," with over 96 percent of members being small businesses with under 100 employees, 70 percent of which being businesses with under 10 employees, but also having members from virtually every facet of corporate business); *see generally* IMPLEMENTATION FAQs, *supra* note 3, at 2.

⁸⁰ Chamber of Commerce Letter, *supra* note 9, at 2.

⁸¹ The Departments exclude retiree-only subsidies from this alleged violation. Chamber of Commerce Letter, *supra* note 9, at 2.

⁸² *Id.*

⁸³ *Id.* at 2-4.

⁸⁴ *Id.* at 3; *E.g.*, Letter from Dan Busby, President, Evangelical Council for Financial Accountability, to Mark Iwry, George Bostick, William Wilkins, IRS (Jun. 17, 2014), *available at* <http://www.ecfa.org/Documents/News/061714%20ECFA%20Comments%20on%20Notice%202013-54.pdf> (explaining that by eliminating pre-tax medical reimbursement for healthcare expenses, Notice 2013-54 "disproportionately affects church and nonprofit workers," by eliminating the pre-tax arrangements which best served the tight financial budget of a church or nonprofit organization. The authors emphasize that smaller churches and nonprofits cannot afford the cost of providing group health plans, which is an expense that for-profit corporations can afford).

⁸⁵ REV. RUL. 61-146, 1961-2 CB 25; Chamber of Commerce Letter, *supra*

many small business owners who entered into such contracts are unaware that the Section 2711 annual limit prohibition will apply to their existing, legally enforceable arrangements.⁸⁶ This complication runs afoul the public policy notion which supports churches, small business owners, and nonprofit organizations, by placing them in a difficult position between ACA regulations and multi-year healthcare contracts locked into annual 2014 budgets.⁸⁷ This also counters the primary objective of the ACA, which “aims to increase the number of Americans covered by health insurance and decrease the cost of health care.”⁸⁸

The Chamber of Commerce claims there is no justification for interpreting Section 2711 to prohibit the use of an HRA to reimburse the cost of obtaining ACA-compliant individual coverage.⁸⁹ To counter, the Departments provided three reasons for this interpretation at the Chamber of Commerce’s meeting. First, the Departments claim that although an HRA that subsidizes the employee’s purchase of an individual ACA-compliant policy may collectively avoid the annual limit prohibition, the individual components are not independently compliant with the annual limit rule.⁹⁰ Hence, the Departments rely on the mere technicality that an HRA is not a “group health plan” and as an essential component of integration it cannot be separately viewed as being compliant with the annual limit prohibition.⁹¹ The Chamber of Commerce suggests that this is merely a definitional problem and an HRA which reimburses

note 9, at 3; I.R.C. §106.

⁸⁶ Chamber of Commerce Letter, *supra* note 9, at 3.

⁸⁷ *Id.*; see Bostick, et al., *supra* note 84, at 2 (explaining that most churches and nonprofit organizations have already “set their budgets and employee compensation for 2014 when Notice 2013-54 was announced..”. The ECFA emphasized the need for an extension of the IRS regulations set forth in Notice 2013-54 until January 1, 2015, in order to “allow smaller religious and other employers the time necessary to revise budgets and determine suitable employee compensation”).

⁸⁸ *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S.Ct. 2566, 2580 (2012).

⁸⁹ Chamber of Commerce Letter, *supra* note 9, at 3.

⁹⁰ *Id.*; see also Christopher E. Condeluci, *How Will HRAs Be Impacted By PPACA? What Are “Integrated” and “Stand-Alone” HRAs?*, VENABLE, LLP (Sept. 11, 2013), <http://www.mondaq.com/unitedstates/x/262142/Employee+Benefits+Compensation/How+Will+HRAs+Be+Impacted+By+PPACA> (surmising, before the release of Notice 2013-54, that, “. . .an integrated HRA is an HRA that is offered as a component of a group health plan where the employee actually enrolls in the underlying group health plan”).

⁹¹ Chamber of Commerce Letter, *supra* note 9, at 3.

employees for obtaining individual ACA-compliant coverage could easily be collectively viewed as compliant in the aggregate – a definitional modification the Chamber of Commerce characterizes as “easily accommodate[d].”⁹²

Second, the Departments claim that allowing employers to provide subsidies for individual health insurance policies “would encourage employers with sicker-than-average workforces to abandon the group insurance market.”⁹³ The Departments allege that many employers will often not provide group health insurance without the HRA restrictions.⁹⁴ However, as the Chamber of Commerce points out, the ACA does not require employers to provide health insurance by law; rather, the ACA threatens non-compliant employers with a tax-penalty.⁹⁵ Relying upon national surveys which indicate employers will abandon group health insurance and take the penalties if it makes economic sense, the Chamber of Commerce claims, “the inability of employers to subsidize individual insurance is not likely to materially influence that decision [but] it is more likely to cause the worst possible result for employees – the loss of both group coverage *and* employer subsidies.”⁹⁶ In essence, by the nature of the ACA’s pecuniary penalty for non-compliance, many employers may choose to simply take the penalty over providing a group health plan.⁹⁷ This choice undermines the ACA’s focus on consumer access to affordably

⁹² *Id.* (characterizing this accommodation as a solution which “. . . treat[s] the aggregate as a group health plan”).

⁹³ *Id.*; see Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Healthcare Reform by Dumping Sick Employees?*, 97 Va. L. Rev. 125 (2011) (claiming that, “. . . employer dumping will prove attractive to employers not simply because it can reduce healthcare costs, but because it can do so while protecting the interests of all employees”); see also Christina Merhar, *8 Ways HRAs Help A Small Business Grow*, EMPLOYEE HEALTH BENEFITS AND INSURANCE BLOG (May 21, 2013), <http://www.zanebenefits.com/blog/bid/292663/8-Ways-HRAs-Help-a-Small-Business-Grow> (explaining that traditionally, “. . . until recently there weren’t state risk pools in every state, so for some employees coverage under an employer sponsored plan was their best (if not only) option for coverage”).

⁹⁴ *Id.*

⁹⁵ *Id.* at 4.

⁹⁶ Chamber of Commerce Letter, *supra* note 9, at 4; see also *2014 Affordable Care Act Survey Results*, BROWN AND BROWN BENEFIT ADVISORS (2014), http://www.advisorsbb.com/pdf/knowledge_hcreform_31_3358685589.pdf, (reporting that when asked the question, “Are you considering any of the following options for 2014 or beyond?” 19 percent of surveyed business owners selected the option labeled, “Dropping coverage and paying penalty.”).

⁹⁷ Chamber of Commerce Letter, *supra* note 9, at 4.

priced health care and enrollment in the system, and the HRA restriction only threatens employees with the loss of any employer-derived benefit.⁹⁸ In theory, an employer who takes the tax penalty without providing health insurance to employees will make a contribution towards the government-subsidized market. However, the resulting burden on the employee to enroll in an individual, publically-issued insurance plan is still substantial.⁹⁹

The Departments' third and most serious reason for the HRA restrictions is the possibility of double dipping.¹⁰⁰ Doubling up on tax benefits is a situation which the Departments, particularly the Treasury Department, wish to avoid with good reason.¹⁰¹ In such a scenario, allowing employees to use HRA funds, which are both tax-excludible for the employee and generally tax deductible for the employer, would overlap with federally subsidized coverage on the health care exchanges.¹⁰² However, as the Chamber of Commerce points out, this most serious concern could easily be addressed through enacting additional regulations by simply making mutually exclusive the tax benefit from the income-excluded HRA reimbursements and the federal subsidy on the exchange market.¹⁰³

⁹⁸ *Id.*

⁹⁹ See generally Merhar, *supra* note 93, at 4 (explaining that HRAs are a useful tool for removing small businesses from the health care business. A smaller business has limited resources, and so managing the health care plan often falls to the owner. The now-prohibited standalone HRA was particularly effective at removing small business management from the realm of health care technicalities, “[allowing] employees to make smart health insurance decisions for themselves,” and reallocating the management or owner’s valuable time back into growing the business).

¹⁰⁰ Chamber of Commerce Letter, *supra* note 9, at 4; *Contra*, *HRA Frequently Asked Questions*, BLUE CROSS BLUE SHIELD OF TENNESSEE, available at <https://www.bcbst.com/health-plans/group/consumer-directed/hra-faq.shtml> (explaining the other type of HRA double dipping, in which an employee is covered by a spouse’s coverage, but also seeks a reimbursement from his own HRA for the exact same medical expense. This type of “double dipping” is already prohibited, but it is distinctly different from the “double dipping” being assessed here, which deals with tax benefits); see REV. RUL. 2002-03; see REV. RUL. 2002-80.

¹⁰¹ Joe Carlson, *IRS Moves Against Double-Dipping on Tax Perks for Health Insurance*, MODERN HEALTHCARE (May 27, 2014), available at <http://www.modernhealthcare.com/article/20140527/NEWS/305279947#>, at 1 (characterizing preventing this type of “double-dipping” as something the IRS wants and needs to prevent).

¹⁰² Chamber of Commerce Letter, *supra* note 9, at 4.

¹⁰³ *Id.*; see also., Carlson, *supra* note 101 (explaining that the long held view is

The Chamber of Commerce goes a step further and claims using the annual limit prohibition as a restriction on HRAs is a manipulation of the ACA which was not explicitly prohibited by the ACA itself.¹⁰⁴ This manipulation, which the ACA did not itself prescribe, the Chamber of Commerce asserts, “likely exceeds the Departments’ rule-making authority.”¹⁰⁵

The Chamber of Commerce strongly advises the Departments to turn course and lift the HRA restrictions by using a “balanced approach” which would allow HRAs to subsidize individual coverage while also contributing to the ACA’s goal of making health care more affordable.¹⁰⁶ In addition, lifting the HRA restriction by allowing employer subsidies for individual coverage will increase the likelihood that more Americans will be covered instead of encouraging employers to take the tax penalty which would unreliably require the employees to go to the public exchange.¹⁰⁷ To address the double-dipping concern, the Chamber of Commerce proposes amending Section 36B(c)(2)(A)(ii) of the Code to preclude federal subsidies off the state exchange by simply making such subsidies available only if the taxpayer paid for the individual coverage.¹⁰⁸ One counterargument the Departments raised is that reversing course at this point might encourage employers to cancel group health plans they established in anticipation of the HRA restrictions.¹⁰⁹ The Chamber of Commerce suggests the best way to prevent “harmful employer backpedaling” is to issue cautionary guidance which strongly asserts that “cherry-picking” will not be

that, “tax consultants have been aggressively hunting for ways to combine the tax write-offs that come with traditional group coverage with the subsidies available to buy coverage through an insurance exchange. . .” These two categories have long been viewed as two separate worlds, and Carlson indicates that preventing “double dipping” is the spirit of, and possibly the primary motivation behind, issuing Notice 2013-54).

¹⁰⁴ Chamber of Commerce Letter, *supra* note 9, at 4.

¹⁰⁵ *Id.*

¹⁰⁶ *Id.* (setting forth that a “balanced approach” is not only attainable in this case, but reasonable).

¹⁰⁷ *Id.*

¹⁰⁸ I.R.C. §36B(c)(2)(A)(ii) (setting forth the current language, which states that, “the premium for coverage under such plan for such month is paid by the taxpayer (or through advance payment of the credit under subsection (a) under section 1412 of the Patient Protection and Affordable Care Act”)); Chamber of Commerce Letter, *supra* note 9, at 4.

¹⁰⁹ Chamber of Commerce Letter, *supra* note 9, at 4.

tolerated.¹¹⁰ “Cherry-picking” in this context is a term which refers to a situation in which an employer offers group health plans to healthy employees but offers subsidies for its unhealthy employees to obtain their own individual coverage elsewhere on the public exchange.¹¹¹ The Chamber of Commerce concludes by commenting that even if the Departments are unwavering in their position, they should still extend the HRA restrictions to the latest point at which an employer can comply without breaching the terms of a multi-year contract as described previously.¹¹²

IV. REGULATORY SOLUTIONS

While the Chamber of Commerce has advocated for a reversal of the HRA restrictions, as of mid-2014, these proposed changes have yet to take effect.¹¹³ Consistent with the Chamber of Commerce’s suggestions, a combination of regulatory and legislative action is required to alleviate the Departments’ concerns.¹¹⁴ At the same time, it is still possible to reintroduce HRAs used solely for the reimbursement of obtaining individual coverage on the market.

The Departments’ concern regarding the definitional objection to aggregating HRAs with group health plans that comply with Section 2711 can be addressed through a legislative amendment. An HRA, or an employer subsidy, then-used for obtaining ACA-compliant coverage, is a compartmentalized and technically separate and distinct process according to the Departments.¹¹⁵ The HRA and the group plan it purchases must be viewed as individual components and the HRA itself does therefore not conform to the annual limit rule.¹¹⁶

¹¹⁰ *Id.*

¹¹¹ *Id.* at 4-5.

¹¹² *Id.* at 5; e.g., Stephen H. Cooper, *Church Alliance Comments Re: Notice 2013-54*, CHURCH ALLIANCE (Apr. 10, 2014) (requesting a one year postponement on the regulatory guidance in Notice 2013-54, and indicating that this deferment is justified by church and nonprofit organizations’ “common” reliance on employer payment plans. Also specifically “. . .urges the Departments to allow employer payment plans to be “integrated” with the group health plan of another employer”).

¹¹³ Chamber of Commerce Letter, *supra* note 9, at 4-5 (urging immediate reversal of course, or at least a one-year postponement of these regulations).

¹¹⁴ *Id.* at 5.

¹¹⁵ *Id.* at 4.

¹¹⁶ *Id.* at 3 (explaining the Departments’ method of treating the HRA and the individual coverage that it purchases as two individual “group health plans” before potential aggregation).

If the Departments are concerned about legislative intent and opine it was Congress' intent to view these components separately, then the most effective response is to amend Section 2711 to specifically permit aggregation of individual ACA-compliant coverage purchased in the market using the reimbursement from the non-compliant-HRA.¹¹⁷ The Chamber of Commerce's logical leap supporting aggregation is that the definitional objection the Departments raised is effectively irrelevant, since obtaining individual ACA-compliant coverage and being reimbursed through the HRA accomplishes the same overall goal of increasing health care enrollment.¹¹⁸ Allowing an express exception in Section 2711 would in fact *further* the overarching goal of the ACA by encouraging employers to take advantage of a tax-deductible HRA plan, instead of pigeonholing employers into either providing a group health plan, or worse, taking the penalty and without providing health coverage to their employees.¹¹⁹ In addition, the Chamber of Commerce suggested a "balanced approach" by the Departments would designate an HRA that is to be used for individual coverage reimbursement to be "earmarked" for only that specific purpose.¹²⁰ By adopting the Chamber of Commerce's recommendations in this regard, the Departments' definitional objection can be easily rectified.

The Departments also raised the possibility that employers with a sicker-than-average stock of employees would cancel its group health coverage entirely and send them all to the individual market.¹²¹ As the Chamber of Commerce pointed out, an employer might elect to pay the penalty and the individual public market would still absorb the sick employees.¹²² This can be effectively addressed through further regulatory rulemaking that offers zero flexibility when an employer is found to have engaged in cherry-picking.¹²³

Cherry-picking is already illegal under Section 510 of the

¹¹⁷ NOTICE 2013-54, *supra* note 4, at 9-12; Chamber of Commerce Letter, *supra* note 9, at 3; ACA §2711, *supra* note 33.

¹¹⁸ Chamber of Commerce Letter, *supra* note 9, at 4 (emphasizing the overall goal of the ACA).

¹¹⁹ *Id.*

¹²⁰ *Id.* (explaining that earmarking the HRA for individual coverage reimbursement would automatically cause it to be aggregated and effectively exempt from the annual dollar limit prohibition).

¹²¹ *Id.*

¹²² *Id.*

¹²³ *Id.* (stating that the Departments should "caution that cherry-picking initiatives will not be tolerated").

Employee Retirement Income Security Act (“ERISA”).¹²⁴ Instead of issuing strict guidance or a cautionary statement, as the Chamber of Commerce suggested, the Departments should construct a very stringent set of additional disciplinary regulations that identify HRA-motivated cherry-picking plans and impose harsh sanctions on violators. For example, as an additional sanction to discourage cherry-picking, the IRS could prevent an employer from being able to file for the tax deduction on HRA contributions for a period of several years. This, however, may run contrary to the obligation of multi-year contracts which provide employees a legally enforceable guarantee of coverage.¹²⁵ Stiff regulations are nonetheless justified by the Treasury Department as necessary to discourage cherry-picking and selectively dumping sick employees onto the market – an act that strongly resembles a bad-faith abuse of HRA flexibility.¹²⁶ Unyielding regulations which deprive the employer of the HRA deduction for a set period of time following a finding of cherry-picking is one such way to ensure compliance.

To alleviate the concern of double-dipping by preventing an employee from obtaining tax-advantaged funds from an HRA and subsequently using them in conjunction with a federally subsidized state exchange, a simple modification to Section 36B(c)(2)(A)(ii) of the Code is required.¹²⁷ The Chamber of Commerce’s proposed modification to Section 36B of the Code, “could preclude federal subsidies because it makes them available *only if the taxpayer paid for the coverage*” (Emphasis added).¹²⁸ In essence, by providing the HRA subsidy to cover the employee’s cost of obtaining individual coverage, the employee would immediately become ineligible for the federal subsidy, which is an automatic correction device that prevents any double-dipping of subsidies.¹²⁹ The reasons for restricting HRAs

¹²⁴ 29 U.S.C.A. §1140 (“It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan. . .”); see Vicki Johnson, *Section 510 of ERISA – Generally*, EMPLOYEE BENEFITS LAW (2008); *Id.* at 5.

¹²⁵ See Bostick, *supra* note 87, at 2; Chamber of Commerce Letter, *supra* note 9, at 4.

¹²⁶ Chamber of Commerce Letter, *supra* note 9, at 4; see Carlson, *supra* note 101, at 2 (claiming, in regards double-dipping with an HRA, there are “people who keep trying to figure out how to use money from one in the other”).

¹²⁷ Chamber of Commerce Letter, *supra* note 9, at 4.

¹²⁸ I.R.C. §36B; *Id.* (proposing, in footnote 3, that, “. . . This could preclude subsidies because the employer has paid some or all of the cost of coverage”).

¹²⁹ Chamber of Commerce Letter, *supra* note 9, at 4.

can thus all be reasonably tackled and resolved by using a combination of legislative and regulatory tools.

V. CONCLUSION

The ACA aims to expand health care coverage and American enrollment while simultaneously reducing the cost of health care and improving access to coverage. Although successful in theory, the regulatory implementation of the ACA drastically restricted HRA availability, particularly as a way for employers to offer employees a reimbursement for their individual coverage premiums. In effect, this restriction will discourage employers from providing tax-advantaged HRAs to their employees, and may indeed push employers to offer no group health coverage, instead electing to simply take the penalty – a clear unintended consequence of the ACA.

Yet, while the Departments offer some substantial justifications for this restriction (for example, tax double-dipping or cherry-picking), these concerns can be easily and adequately addressed. Through a combination of legislative amendments and regulatory corrections, it is possible to reinstate the individual premium reimbursement HRA without suffering any of the drawbacks of which the Departments warned. Employers and their employees will again be able to enjoy the tax benefits that that type of HRA offers, and it will come at little expense to the taxpayers. However, as the Departments have yet to turn on the course to HRA restriction, for the foreseeable future, employers will have to comply by only offering integrated HRAs.