The Affordable Care Act and the Reconciliation Act amended the provisions of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. Specifically, PHS § 2711 generally prohibits group health plans and health insurance issuers offering group or individual health insurance coverage from imposing lifetime or annual limits on the dollar value of health benefits.

The Affordable Care Act requires health plans offered in the individual and small group markets, both inside and outside of Affordable Insurance Exchanges, to include a core package of items and services, known as Essential Health Benefits (“EHB”). EHB must include items and services within at least the following 10 categories and each is subject to PHS § 2711 prohibiting limits:

| 1. Ambulatory patient services | 6. Prescription drugs |
| 2. Emergency services           | 7. Rehabilitative and habilitative services and devices |
| 3. Hospitalization             | 8. Laboratory services |
| 4. Maternity and newborn care  | 9. Preventive and wellness services and chronic disease management |
| 5. Mental health and substance use disorder services, including behavioral health treatment | 10. Pediatric services, including oral and vision care |

The interim final regulations\(^1\) issued June 20, 2010, provide that the PHS § 2711 no limit rules do not apply to health Flexible Spending Accounts (FSAs), Medical Savings Accounts (MSAs) under IRC § 220 and Health Savings Accounts (HSAs) under IRC § 223. Both MSAs and HSAs generally are not treated as group health plans because the amounts available under the plans are available for both medical and nonmedical expenses. Furthermore, annual contributions to MSAs and HSAs are subject to specific statutory provisions that require that the contributions be limited.

However, PHS § 2711 no limit rules do apply to a Health Reimbursement Arrangement (HRA), and its compliance is based on the HRA type. Generally, an HRA is an arrangement\(^2\) that: (1) is paid for solely by the employer and not provided pursuant to salary reduction election or otherwise under a § 125 cafeteria plan; (2) reimburses the employee for medical care expenses [as defined by IRC § 213(d)] incurred by the employee and the employee’s spouse and

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dependents (as defined in § 152); and (3) provides reimbursements up to a maximum dollar amount for a coverage period and any unused portion of the maximum dollar amount at the end of a coverage period is carried forward to increase the maximum reimbursement amount in subsequent coverage periods.

The regulations identify two types of HRAs. The first type is an "Integrated-HRA". This is an HRA which is integrated with other coverage as part of a group health plan and the other coverage alone would comply with the requirements of PHS § 2711. The fact that benefits under the HRA by itself are limited does not violate PHS § 2711 because the combined benefit satisfies the requirements.

The second type is a "Stand-Alone HRA". This form of an HRA is not integrated with other coverage as part of a group plan and other coverage would not comply with the requirements of PHS § 2711 except for HRAs that are limited to retirees. This means that a Stand-Alone HRA that covers active employees and provides any EHB is subject to the PHS § 2711 no limits requirement. For all practical purposes, employers that have been offering Stand-Alone HRAs will abandon such arrangements since it is unlikely that any employer will grant an employee unlimited coverage for any EHB under an HRA.

On January 24, 2013, the Department of Labor posted the eleventh FAQs about Affordable Care Act Implementation. Under the section "Compliance of Health Reimbursement Arrangements with Public Health Service Act (PHS Act) section 2711", the DOL states:

1. Integration with non-Individual Plans Only. 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. This effectively hampers one defined contribution approach for employers intending to use HRAs as a funding mechanism beginning in 2014.

2. Integrate or Not Integrate. 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. Any HRA that credits additional amounts to an individual when the individual is not enrolled in primary coverage meeting the requirements of PHS Act section 2711 provided by the employer will fail to comply with PHS Act section 2711.

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3 The exemption from the requirements of ERISA and the IRC relating to the Affordable Care Act for plans with fewer than two current employees means that the retiree-only HRA is generally not subject to the rules in PHS Act section 2711 relating to annual limits.

4 http://www.dol.gov/ebsa/faqs/faq-aca11.html
3. Consistency. Whether or not an HRA is integrated, unused amounts credited before January 1, 2014, under the terms of an HRA in effect on January 1, 2013, may be used beginning in 2014 to reimburse medical expenses in accordance with those terms without causing the HRA to fail to comply with PHS Act section 2711. If the HRA terms in effect on January 1, 2013, did not prescribe a set amount or amounts to be credited during 2013 or the timing for crediting such amounts, then the amounts credited may not exceed those credited for 2012 and may not be credited at a faster rate than the rate that applied during 2012.

The information provided under the FAQ should not be a surprise and is consistent with the intent of the Affordable Care Act. We anticipate future guidance on the use of HRA, but it is not likely that Stand-Alone HRA will play a meaningful role in a defined contribution approach to providing health benefits going forward.