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SUMMARY OF QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS (QSEHRAS)

The 21st Century Cures Act ("Cures Act"), enacted on December 13, 2016, amended Section 9831 of the Internal Revenue Code ("Code") to permit small employers to adopt stand-alone health reimbursement arrangements ("HRAs") for their employees without incurring excise taxes under the Affordable Care Act ("ACA"). These HRAs are referred to as "qualified small employer health reimbursement arrangements" or "QSEHRAs." The Internal Revenue Service ("IRS") issued Notice 2017-67 to provide guidance on the rules that apply to QSEHRAs.

Background

Many small employers historically paid the premiums for the health plan coverage that their employees purchased on the market or, more recently, on the Health Insurance Marketplace ("Marketplace"), on a pre-tax basis. Some small employers also reimbursed out-of-pocket medical expenses, such as deductibles or co-payments, for their employees on a pre-tax basis. This type of reimbursement arrangement is referred to as a "health reimbursement arrangement" or "HRA" and has been a very common, long-standing practice for small employers.

Beginning in 2013, the IRS issued a series of notices concluding that these types of stand-alone HRAs[1] are group health plans that fail to comply with the applicable market reforms under the ACA. Since they did not (and could not) comply with the ACA, employers adopting a stand-alone HRA were subject to an excise tax of $100 per day ($36,500 a year) per affected participant. In Notice 2015-17, the IRS issued transition relief from these excise taxes for small employers through June 30, 2015.

Significantly, employers with only a single full-time employee could continue to adopt a stand-alone HRA for that employee, under an exception to the group health plan rules for plans that have less than two participants who are current employees.[2] For example, a church whose minister is the only full-time employee can reimburse the minister's premiums for coverage purchased in the individual market or on the Marketplace on a pre-tax basis without incurring excise taxes. This same exception also applies to "retiree-only" stand-alone HRAs because they do not cover any employees.

Summary of Cures Act

The Cures Act creates a statutory exception to the IRS's prior guidance by excluding a QSEHRA from the definition of group health plan. The rules described in this Summary

[1] Stand-alone HRAs are HRAs that are not integrated with an employer sponsored group health plan.
[2] Code Section 9831(a)(2). Although the exception provides only that the plan cannot cover more than one participant who is a current employee, an employer could only have one full-time employee in order to take advantage of this exception and not violate the nondiscrimination rules applicable to group health plans.

apply to QSEHRAs, as set forth in Code Section 9831 and explained in Notice 2017-67. Notice 2017-67 provides guidance in a question-and-answer format that includes 79 questions on various aspects of QSEHRAs. This Summary does not cover all matters discussed in the guidance, but covers topics most relevant to church employers.

Eligible Employers

Only eligible employers can establish a QSEHRA. An eligible employer must meet the following two criteria:

1. **The employer is not subject to the ACA employer mandate.** The employer (taking into account all employers in the same controlled group) cannot be a large employer for purposes of the ACA employer mandate. In other words, the employer must have had fewer than 50 full-time employees or full-time employee equivalents in the prior calendar year.

2. **The employer does not offer any group health plan.** The employer (and all employers in the same controlled group) cannot offer a group health plan to any of its employees (regardless of whether or not eligible for the QSEHRA).

CANNOT be offered	CAN be offered
• Major medical plans • HRAs, including amounts accumulated from prior years if current employees have continued access • Health flexible spending accounts (FSAs), including amounts carried over from prior years if current employees have continued access • Excepted benefits, such as limited scope dental and vision plans and employee assistance plans (EAPs)	• Retiree-only group health plans, including retiree-only HRAs • Health savings accounts (HSAs) [3]

[3] To be eligible to participate in a HSA, an individual must be covered under a high deductible health plan ("HDHP"). An eligible employer could not offer the HDHP, since it is a group health plan. Accordingly, an employee would have to secure HDHP coverage through a spouse, the individual market, or the Marketplace in order to participate in the employer's HSA.

An employer that offers a group health plan for part of the year is disqualified for any month during which the plan was offered at least one day that month. If an employer becomes a large employer during a calendar year, it ceases to be an eligible employer on the January 1 of the next year (*i.e.*, the time at which the employer becomes subject to the ACA employer mandate).

Eligible Employees

The QSEHRA must be provided to all eligible employees of the employer. An eligible employee includes all employees of the employer, ***except*:**

1. Employees who have not completed 90 days of service.

2. Employees who have not attained age 25.

3. Part-time employees whose customary weekly employment is less than 25 hours, and part-time employees whose customary weekly employment is less than 35 hours if other employees performing similar work for that employer have substantially more hours.

4. Seasonal employees whose customary annual employment is less than 7 months, and seasonal employees whose customary annual employment is less than 9 months if other employees performing similar work for that employer work substantially more months.

5. Employees covered by a collective bargaining agreement.

6. Nonresident aliens with no U.S. source income.

If an employee is an excludable employee, the employer must provide the QSEHRA to the employee the day immediately following the day that the employee is no longer an excludable employee. An employee cannot waive a QSEHRA.

Employer Funded

The QSEHRA must be funded solely by the employer. Salary reduction contributions by employees are not permitted.

Proof of Minimum Essential Coverage

The QSEHRA may only provide reimbursements to an eligible employee after the eligible employee provides proof of coverage that qualifies as "minimum essential coverage" ("MEC"). MEC includes most types of health care coverage, whether provided by an employer (including COBRA), an individual policy, or through a government-sponsored program. However, MEC does not include coverage consisting solely of excepted benefits, such as standalone vision and dental plans or workers' compensation coverage, and coverage limited to a specified disease or illness. Proof of

MEC must also be provided for any individual whose expenses will be reimbursed under the QSEHRA, such as a dependent.

An initial and annual proof of coverage is required and may be provided under either of the following methods:

1. A document from a third party, such as an insurer, showing that the employee and the individual have coverage (*e.g.*, an insurance card or explanation of benefits) **and** an attestation by the employee that the coverage is MEC.

2. An attestation by the employee stating that the employee and the individual have MEC, the date coverage began, and the name of the provider of the coverage.

The employer may rely on the employee's attestation unless the employer has actual knowledge to the contrary.

Following the initial (or annual) submission of proof of coverage, with each new request for reimbursement of an expense incurred during the same plan year, the employee must attest that the individual whose expense is being reimbursed continues to have MEC. This attestation should be included on the reimbursement form.

Permitted Benefit Statutory Limit

The QSEHRA provides a **permitted benefit** to eligible employees – the maximum amount of the payment or reimbursement available to each employee. The permitted benefit cannot exceed statutory dollar limits that are indexed for inflation.[4]

	2022	2023
Self-only coverage	$5,450	$5,850
Family coverage	$11,050	$11,800

Unused permitted benefits from one year can be carried-over to the next year, but the carryover amount is counted against the statutory limit for permitted benefits in effect for that later year. Therefore, if the carryover amount from a prior year plus the current year's permitted benefit exceed the current year's statutory limit, some portion of the carryover is forfeited.[5]

The statutory dollar limits are prorated for the number of months that an eligible employee is provided a QSEHRA. However, if an employee receives reimbursements

[4] These limits are typically published in November of the immediately preceding year.
[5] Notice 2017-67, Q/A-29.

from a QSEHRA that equal the statutory limit and later terminates employment before the end of the plan year, the QSEHRA will not be treated as violating the statutory limit.[6]

Same Terms Requirement

The QSEHRA must be provided on the same terms to all eligible employees of the employer. This means that the QSEHRA must be operated on a uniform and consistent basis for all eligible employees. However, this requirement is not violated simply because different employees provided the same permitted benefit submit different expenses for reimbursement.

The permitted benefit under the HRA may vary in accordance with the variation in the cost of insurance coverage in the relevant individual health insurance market due to:

- the age of the employee or his or her family members, as applicable, or
- the eligible employee's number of family members.

The "baseline" insurance policy used to determine this permitted variation must be MEC, the same policy for all eligible employees, and available for purchase by at least one eligible employee.[7]

Examples of designs that *do not violate* the same terms requirement

- A QSEHRA that provides for reimbursements up to a single dollar amount regardless of whether the eligible employee has self-only or family coverage.[8]
- A QSEHRA that provides for reimbursements up to the self-only or family dollar limits or to an equal percentage of each limit.[9]
- A QSEHRA that provides for reimbursements based on the prior year's statutory limits.[10]
- A QSEHRA that determines the permitted benefit based on the employee's family size and age on the first day of the plan year, even if the size of the family changes during the plan year.[11]
- A QSEHRA that limits reimbursements to certain types of medical expenses, such as insurance premiums or cost-sharing expenses, unless the limitation effectively limits the QSEHRA's availability to all eligible employees.[12]
- A QSEHRA that provides for a carryover of unused benefit amounts from a prior

[6] Notice 2017-67, Q/A-31.
[7] Notice 2017-67, Q/A-13.
[8] Notice 2017-67, Q/A-14.
[9] Notice 2017-67, Q/A-15.
[10] Notice 2017-67, Q/A-26.
[11] Notice 2017-67, Q/A-17.
[12] Notice 2017-67, Q/A-21.

plan year.[13]

- A QSEHRA that makes reimbursements available ratably on a month-by-month basis, rather than making the full amount of the annual permitted benefit available at the beginning of the year.[14]

Examples of designs that *violate* the same terms requirement

- A QSEHRA that limits the permitted benefit provided to two eligible employees who are married to the amount that would be provided to one employee.[15]
- A QSEHRA that offers eligible employees a choice between two different permitted benefit options (for example, reimbursement of premium only or reimbursement of non-premium medical expenses).
- A QSEHRA that is only available to the eligible employees of one eligible employer in a controlled group of employers.[16]
- A QSEHRA that provides a different permitted benefit for eligible employees than that provided for a category of excludable employees.[17]

Substantiation Requirement

The QSEHRA may only reimburse expenses of the employee or his or her family members[18] that are **qualified medical expenses** as defined in Code Section 213(d) (see table on following page for examples). All claims for reimbursements must be substantiated to ensure that a particular payment is a reimbursement of a qualified medical expense.

An employee may satisfy the substantiation requirements by complying with the substantiation requirements that apply for purposes of health FSA reimbursements.[19] Generally, this requires the employee to provide information to document the expense, the date incurred, and the provider. Self-certification is not permitted.

If a QSEHRA mistakenly permits a reimbursement to an eligible employee for a qualified medical expense that has not been substantiated – or for an expense that is not a qualified medical expense – all payments to all employees under the QSEHRA

[13] Notice 2017-67, Q/A-23.
[14] Notice 2017-67, Q/A-50.
[15] Notice 2017-67, Q/A-19.
[16] Notice 2017-67, Q/A-24.
[17] Notice 2017-67, Q/A-15.
[18] A family member is any individual for whom the employer's reimbursement of medical expenses would be excluded from the employee's gross income under Code Section 105(b), which generally include the employee, the employee's spouse, the employee's children until the end of year in which they reach age 26, and the employee's tax dependents.
[19] *See* Treas. Reg. § 1.125-6.

(whether substantiated or not) on or after the date of the mistaken reimbursement become taxable. To avoid this result, the mistaken reimbursement must be timely repaid with after-tax funds, generally by March 15 of the year following the year in which the error was identified.[20]

Examples of qualified medical expenses[21]

- Premium payments, including premiums of an employee's family member who is covered by a separate policy than the employee[22]
- Over-the-counter drugs[23]
- Transportation to get medical care
- Cost-sharing payments (deductibles, co-payments, coinsurance)
- Medical equipment, supplies, and diagnostic devices
- Qualified long-term care services

A QSEHRA may never reimburse eligible employees with a taxable payment of unused permitted benefits at the end of the year (a "cash-out").[24]

Written Notice

The employer must provide a written notice to each eligible employee at least 90 days before the beginning of the year (or for a new employee, on or before the date the employee is eligible) that states the following:[25]

1. The amount of the employee's permitted benefit under the QSEHRA for the year. The notice can include each available permitted benefit, or the permitted benefit for which that employee is eligible. For new employees that will receive a prorated benefit, their initial notice should include the prorated benefit or information necessary to calculate it. The notice must include the date that the QSEHRA is first provided to the eligible employee.

2. A statement that the eligible employee must inform the Marketplace of his or her permitted benefit if the employee is applying for a premium tax

[20] Notice 2017-67, Q/A-45.
[21] See IRS Publication 502 for more information.
[22] Reimbursement of premium is taxable to the extent that the premium was paid on a pre-tax basis, for example, under a group health plan sponsored by the employer of the eligible employee's spouse. Notice 2017-67, Q/A-48.
[23] Notice 2017-67, Q/A-54. Prior to January 1, 2020, over-the-counter (OTC) drugs could be reimbursed, but the reimbursement was taxable to the employee unless the OTC drugs were prescribed or were insulin. Effective January 1, 2020, reimbursements for all over-the-counter (OTC) drugs are not taxable.
[24] Notice 2017-67, Q/A-46.
[25] Notice 2017-67, Q/A-38. This Q/A includes an example of a written notice that satisfies these requirements.

credit. The notice must state that the amount of the permitted benefit may affect eligibility for and the amount of any premium tax credit, and that the employee should retain the written notice because it may be needed to calculate the premium tax credit on the employee's individual tax return.

3. A statement that if the employee is not covered under MEC for any month, the employee may be subject to an individual penalty[26] and reimbursements under the QSEHRA will be included in gross income.

Employers who fail to provide timely written notices are subject to a penalty of **$50 per employee** up to a maximum of $2,500 per calendar year.[27]

Written notices may be provided electronically to the extent the employer complies with the IRS rules for electronic disclosure.[28]

Tax Reporting and Withholding

The employer must report the permitted benefit available to each eligible employee in box 12 of Form W-2 using code FF (without regard to actual reimbursements).[29] The amount reported should exclude any permitted carryovers because those amounts were reported in a prior year.

If an employer varies the permitted benefit based on age or the number of family members, and an employee does not provide proof of MEC and receives no payments under the QSEHRA, the employer will report the highest value permitted benefit that the QSEHRA provides (unless the employee later provides proof of MEC and establishes eligibility for a lesser value permitted benefit).[30]

The permitted benefits provided to an eligible employee under the HRA for qualified medical expenses will not be included in his or her taxable income, except in certain circumstances outlined below.

Taxable Reimbursements	Taxation and Reporting
• Reimbursements were mistakenly made for one or more months in which the employee did not have MEC.	• Report the amount in box 1, Wages, tips, and other compensation. • Do not report the amount in box 3, Social security wages, or box 5,

[26] The individual penalty under the ACA was reduced to $0 after the end of 2018. Although this statement remains a requirement under the QSEHRA rules, it may be confusing to participants to include reference to the individual penalty in light of the subsequent change in the law. Employers may wish to add a parenthetical (currently, $0) with respect to the individual penalty.
[27] Notice 2017-67, Q/A-34.
[28] Notice 2017-67, Q/A-36; *see* Treas. Reg. § 1.401(a)-21.
[29] Notice 2017-67, Q/A-57.
[30] Notice 2017-67, Q/A-58.

Taxable Reimbursements	Taxation and Reporting
	Medicare wages and tips. • The amount is excluded from wages for purposes of federal income tax withholding. • The permitted benefit reported in box 12 using code FF remains the same.
• Premiums were paid on a pre-tax basis for group health plan coverage sponsored by the employer of the employee's spouse.	• Report the amount in box 1, Wages, tips, and other compensation. • Report the amount in box 3, Social security wages, and box 5, Medicare wages and tips. • The amount is subject to wages for purposes of federal income tax withholding. • The permitted benefit reported in box 12 using code FF remains the same.

Marketplace Premium Tax Credits

An eligible employee participating in a QSEHRA can purchase individual coverage on a Marketplace, but coverage under a QSEHRA will impact the employee's eligibility for or amount of a premium tax credit (PTC).

1. If the QSEHRA constitutes "affordable" coverage, the employee will not be eligible for a PTC.

2. If the QSEHRA does not constitute "affordable" coverage, the PTC for which the employee would have otherwise qualified will be reduced by the amount of the permitted benefit.

A QSEHRA is treated as providing **affordable coverage** for a month if the excess of the monthly premium for the self-only second lowest cost silver plan over 1/12 of the employee's permitted benefit under the QSEHRA does not exceed 1/12 of 9.5% (adjusted annually)[31] of the employee's household income.[32] For this purpose, the permitted benefit for self-only coverage provided by the employer is used to determine

[31] 9.78% applied for 2020, 9.83% applied for 2021, and 9.61% applies for 2022. The percentage is indexed annually.
[32] Code Section 36B(c)(4)(A).

affordability, regardless of whether the permitted benefit provided to a particular eligible employee is for self-only or family coverage.

EXAMPLE 1

For 2023, assume an employer provides a QSEHRA with a self-only permitted benefit of $4,800 and a family permitted benefit of $9,600. An employee has a spouse and a dependent. The employee enrolls in a Marketplace plan that covers all three family members and is provided an $9,600 permitted benefit. The annual premium for the second-lowest cost self-only silver plan offered by the employee's Marketplace is $7,200. The employee's household income is $24,000, and 9.12% of household income equals $2,188.80.

Even though the employee receives the family permitted benefit of $9,600, the self-only permitted benefit of $4,800 is used to determine whether the QSEHRA constitutes affordable coverage for the employee.

- Monthly premium for Marketplace coverage: 1/12 x $7,200 = $600
- 1/12 of self-only permitted benefit: 1/12 x $4,800 = $400
- Excess of monthly premium over 1/12 permitted benefit: $600 - $400 = $200
- 1/12 of 9.12% of household income: 1/12 x 9.12% x $24,000 = $182.40
- $200 excess monthly premium > $182.40 affordability threshold

The QSEHRA does not constitute affordable coverage for the employee for any month of 2023. The employee may be allowed a PTC for 2023 for coverage for the employee and the employee's family.

If the QSEHRA does not constitute affordable coverage, then the PTC available to the employee is reduced by 1/12 of the permitted benefit for each month.[33] For this purpose, the permitted benefit for the type of coverage (self-only or family coverage) in which the employee was enrolled for the year is used to calculate the PTC reduction.[34]

EXAMPLE 2

Assume the same facts as Example 1, in which the employee was determined to be eligible for a PTC because the QSEHRA did not constitute affordable coverage.

The PTC available to the employee will be reduced each month by 1/12 of the permitted benefit related to the coverage in which the employee is enrolled and which is reported on the employee's Form W-2 (in this case, family coverage).

The employee's PTC reduction is $800 per month, which is 1/12 of the family permitted benefit [1/12 x $9,600].

[33] Code Section 36B(c)(4)(B).
[34] Notice 2017-67, Q/A-66.

An eligible employee is required to provide the amount of his or her permitted benefit when applying for coverage on the Marketplace. The written notice provided by the employer will assist the employee in providing this information.

PCORI Fees

A QSEHRA is considered an applicable self-insured health plan subject to the Patient-Centered Outcomes Research Institute (PCORI) fee under Code Section 4376. This tax is reported and paid using Form 720, which is filed annually by July 31. The PCORI fee is a temporary fee that was originally set to expire in 2019. Following a 10-year extension that was passed in 2019, the fee is applicable with respect to plan years ending before October 1, 2029.[35]

Interaction with HSA Requirements

Employees and their family members who are covered by a QSEHRA are not eligible to make or receive contributions to a health savings account (HSA) if the QSEHRA provides disqualifying coverage for HSA purposes.[36]

- If the QSEHRA reimburses for any medical expenses, including cost sharing expenses, it is disqualifying coverage, and covered individuals are not HSA-eligible.

- If the QSEHRA limits reimbursements to premium payments only, it is not disqualifying coverage, and the QSEHRA does not impact HSA eligibility.

Failure to Satisfy QSEHRA Requirements

If an arrangement fails to be a QSEHRA, it will constitute a group health plan that is subject to the requirements under the Code applicable to group health plans, including the ACA coverage mandates. Any violation of the Code's requirements for group health plans is subject to a $100 excise tax per affected participant per day.[37]

The following failures will cause an arrangement to not be a QSEHRA:

1. The arrangement is not provided by an eligible employer.

2. The arrangement is not provided on the same terms to all eligible employees.

[35] Notice 2017-67, Q/A-74. The PCORI fee is adjusted annually. For plans that end on or after October 1, 2022, and before October 1, 2023, the PCORI rate per covered individual is $3.00. For plans ending in the previous 12-month period, the PCORI rate per covered individual is $2.79.
[36] Notice 2017-67, Q/A-75, 76; *see also* Code Section 223.
[37] Code Section 4980D.

3. The arrangement reimburses medical expenses without first requiring proof of MEC.

4. The arrangement reimburses medical expenses that are not substantiated or before they are substantiated.

5. The arrangement provides a permitted benefit in excess of the statutory dollar limits.

In addition, an arrangement designed to reimburse expenses other than medical expenses (even if it also reimburses for medical expenses) is neither a QSEHRA nor a group health plan. Accordingly, all payments under such arrangement would be includible in the employee's gross income and wages.

A failure to comply with the written notice requirement does not disqualify the QSEHRA, but instead subjects the employer to the $50 per employee penalty.

Effective Date

The Cures Act is effective for years beginning after December 31, 2016. Accordingly, an eligible employer could establish a QSEHRA as early as January 1, 2017. Certain transition relief applied with respect to QSEHRAs, and to stand-alone HRAs in effect prior to January 1, 2017, which has since expired. The guidance under Notice 2017-67 remains generally applicable to QSEHRAs.

Impact on Existing Exceptions

The Cures Act does not change the existing exception for employers who have only one full-time employee for whom they reimburse premiums on a pre-tax basis or who reimburse premiums or medical expenses for retirees only. An employer who can meet this exception can continue these arrangements without satisfying the requirements for a QSEHRA.[38]

This publication is intended for general information purposes only and does not and is not intended to constitute legal advice. The reader must consult with legal counsel to determine how laws or decisions discussed herein apply to the reader's specific circumstances.

[38] Code Section 9831(a)(2). See also 75 Fed. Reg. 37188, 37190-37191 (June 28, 2010) (discussing the exemption from the requirements of the Code and ERISA relating to the Affordable Care Act for plans with fewer than two current employees in the context of a standalone HRA for retirees).