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HIGHLIGHTS OF THIS ISSUE

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These synopses are intended only as aids to the reader in identifying the subject matter covered. They may not be relied upon as authoritative interpretations.

EMPLOYEE PLANS

Announcement 2017–15, page 534.

Announcement 2017–15 provides relief to victims of Hurricane Maria and the recent California wildfires. It permits easier access to funds held in workplace retirement plans and in IRAs, for periods beginning in September and October 2017 and ending March 15, 2018. The relief provided in the announcement is in addition to the relief already provided by the IRS pursuant to several recent news releases.

Notice 2017–67, page 517.

This notice provides guidance on the requirements for providing a qualified small employer health reimbursement arrangement (QSEHRA) under section 9831(d) of the Internal Revenue Code, the tax consequences of the arrangement, and the requirements for providing written notice of the arrangement to eligible employees.

Finding Lists begin on page ii.

The IRS Mission

Provide America's taxpayers top-quality service by helping them understand and meet their tax responsibilities and enforce the law with integrity and fairness to all.

Introduction

The Internal Revenue Bulletin is the authoritative instrument of the Commissioner of Internal Revenue for announcing official rulings and procedures of the Internal Revenue Service and for publishing Treasury Decisions, Executive Orders, Tax Conventions, legislation, court decisions, and other items of general interest. It is published weekly.

It is the policy of the Service to publish in the Bulletin all substantive rulings necessary to promote a uniform application of the tax laws, including all rulings that supersede, revoke, modify, or amend any of those previously published in the Bulletin. All published rulings apply retroactively unless otherwise indicated. Procedures relating solely to matters of internal management are not published; however, statements of internal practices and procedures that affect the rights and duties of taxpayers are published.

Revenue rulings represent the conclusions of the Service on the application of the law to the pivotal facts stated in the revenue ruling. In those based on positions taken in rulings to taxpayers or technical advice to Service field offices, identifying details and information of a confidential nature are deleted to prevent unwarranted invasions of privacy and to comply with statutory requirements.

Rulings and procedures reported in the Bulletin do not have the force and effect of Treasury Department Regulations, but they may be used as precedents. Unpublished rulings will not be relied on, used, or cited as precedents by Service personnel in the disposition of other cases. In applying published rulings and procedures, the effect of subsequent legislation, regulations, court decisions, rulings, and procedures must be considered, and Service personnel and others concerned are cautioned against reaching the same conclusions in other cases unless the facts and circumstances are substantially the same.

The Bulletin is divided into four parts as follows:

Part I.—1986 Code.
This part includes rulings and decisions based on provisions of the Internal Revenue Code of 1986.

Part II.—Treaties and Tax Legislation.
This part is divided into two subparts as follows: Subpart A, Tax Conventions and Other Related Items, and Subpart B, Legislation and Related Committee Reports.

Part III.—Administrative, Procedural, and Miscellaneous.
To the extent practicable, pertinent cross references to these subjects are contained in the other Parts and Subparts. Also included in this part are Bank Secrecy Act Administrative Rulings. Bank Secrecy Act Administrative Rulings are issued by the Department of the Treasury's Office of the Assistant Secretary (Enforcement).

Part IV.—Items of General Interest.
This part includes notices of proposed rulemakings, disbarment and suspension lists, and announcements.

The last Bulletin for each month includes a cumulative index for the matters published during the preceding months. These monthly indexes are cumulated on a semiannual basis, and are published in the last Bulletin of each semiannual period.

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Part III. Administrative, Procedural, and Miscellaneous

Qualified Small Employer Health Reimbursement Arrangements

Notice 2017–67

PURPOSE

This notice provides guidance on the requirements for providing a qualified small employer health reimbursement arrangement (QSEHRA) under section 9831(d) of the Internal Revenue Code (Code), the tax consequences of the arrangement, and the requirements for providing written notice of the arrangement to eligible employees.

BACKGROUND

The 21st Century Cures Act (Cures Act), P.L. 114–255, 130 Stat. 1033, was enacted on December 13, 2016. Section 18001 of the Cures Act amends the Code, the Employee Retirement Income Security Act of 1974 (ERISA), and the Public Health Service Act (PHS Act), to permit an eligible employer to provide a QSEHRA to its eligible employees.[1]

Pursuant to section 9831(d)(1), a QSEHRA is not a group health plan, and as a result, is not subject to the group health plan requirements that apply under the Code, ERISA and, with one exception, the PHS Act.[2] Generally, payments from a QSEHRA to reimburse an eligible employee's medical expenses are not includible in the employee's gross income if the employee has coverage that provides minimum essential coverage (MEC) as defined in section 5000A(f).[3] For this purpose, "medical expenses" means expenses for medical care, as defined in section 213(d) (which includes premiums for other health coverage, such as individual health insurance policies).

The Cures Act provides that a QSEHRA is an arrangement that meets the following criteria:

(a) The arrangement is funded solely by an eligible employer, and no salary reduction contributions may be made under the arrangement;

(b) The arrangement provides, after the eligible employee provides proof of coverage, for the payment or reimbursement of the medical expenses incurred by the employee or the employee's family members[4] (in accordance with the terms of the arrangement);

(c) The amount of payments and reimbursements described in paragraph (b) of this section for any year does not exceed $4,950 ($10,000[5] for an arrangement that also provides for payments or reimbursements of medical expenses of the eligible employee's family members (family coverage)); and

(d) The arrangement is generally provided on the same terms (the "same terms requirement") to all eligible employees of the eligible employer.

To be an eligible employer that may provide a QSEHRA, the employer must not be an applicable large employer (ALE), as defined in section 4980H(c)(2) and the regulations thereunder (and, thus, may not be an employer that, generally, employed at least 50 full-time employees, including full-time equivalent employees, in the prior calendar year), and must not offer a group health plan (as defined in section 5000(b)) to any of its employees. Pursuant to section 4980H(c)(2), an employer whose workforce increases to 50 or more full-time employees during a calendar year will not become an ALE before the first day of the following calendar year.

In addition, Executive Order 13813 (82 Fed. Reg. 48385, Oct. 17, 2017), directed the Secretaries of the Treasury, Labor, and Health and Human Services to consider revising guidance, to the extent permitted by law and supported by sound policy, to increase the usability of health reimbursement arrangements (HRAs), expand employers' ability to offer HRAs to their employees, and to allow HRAs to be used in conjunction with non-group coverage. The guidance provided in this notice addresses each of those objectives. The Treasury Department (Treasury) and the Internal Revenue Service (IRS) anticipate that the Departments will issue additional guidance in the future in response to Executive Order 13813.

GUIDANCE

This guidance includes sections on the following topics:

- A. Eligible employer
- B. Eligible employee
- C. Same terms requirement
- D. Statutory dollar limits
- E. Written notice requirement
- F. MEC requirement
- G. Proof of MEC requirement
- H. Substantiation requirement
- I. Reimbursement of medical expenses
- J. Reporting requirement
- K. Coordination with PTC
- L. Failure to satisfy the requirements to be a QSEHRA
- M. Interaction with HSA requirements
- N. Effective date

A. Eligible employer

Under section 9831(d)(3)(B)(ii), "eligible employer" means an employer that does not offer a group health plan (including a health reimbursement arrangement (HRA) or a health flexible spending arrangement (FSA)) to any of its employees. A group health plan includes a plan that

[1]On December 20, 2016, the Department of Labor, the Department of the Treasury, and the Department of Health and Human Services (collectively, the Departments) issued FAQs About Affordable Care Act Implementation (Part 35), Q&A–3 (https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-35.pdf) concerning the Cures Act. That guidance continues to apply.

[2]A QSEHRA continues to be treated as a group health plan under the PHS Act for purposes of part C of title XI of the Social Security Act.

[3]MEC is defined in section 5000A(f) and the regulations thereunder. See Appendix A to this notice for a list of examples of plans and arrangements that are MEC, as provided in the 2016 Instructions for Form 8965, Health Coverage Exemptions (and Instructions for Figuring Your Shared Responsibility Payment).

[4]For purposes of this notice, "family member" of an eligible employee means any individual for whom an employer's reimbursement of the individual's medical expenses would be excluded from the eligible employee's gross income under section 105(b).

[5]Section 9831(d)(2)(D)(ii) provides that both statutory dollar limits are adjusted for inflation beginning after 2016. This adjustment increased the $10,000 limit to $10,050 for a QSEHRA provided in 2017; the adjustment did not increase the $4,950 limit for 2017. The adjusted limits for 2018 are $5,050 for self-only coverage and $10,250 for family coverage.

provides only excepted benefits described in section 9831(c) (for example, a vision or dental health plan that qualifies as an excepted benefit) if that plan is offered by an employer to its employees.

If an employer endorses a particular policy, form, or issuer of individual health insurance, the coverage may constitute a group health plan. However, providing employees with information about the Affordable Insurance Exchange, also called a Health Insurance Marketplace (Marketplace), or the premium tax credit (PTC) under section 36B, is not an endorsement of a particular policy, form, or issuer of health insurance.

***Question 1*:** Does an employer fail to be an eligible employer if it offers a group health plan to former employees (for example, retirees)?

***Answer 1*:** No. For purposes of the QSEHRA requirements, former employees are not treated as employees. As a result, offering a group health plan to former employees does not cause the employer to fail to be an eligible employer.

***Question 2*:** Does an employer fail to be an eligible employer if it provides current employees with continued access to amounts that were accumulated in an HRA in prior years or carryover amounts in an FSA?

***Answer 2*:** Yes, but an employer does not fail to be an eligible employer if it suspends access to amounts accumulated in an HRA in previous years (such that they cannot be used for any purpose) during the period a QSEHRA is provided to its eligible employees.

***Question 3*:** Does an S corporation fail to be an eligible employer if, separate from a QSEHRA, it reimburses the health insurance policy premiums of a 2-percent shareholder (as defined in section 1372(b)) who is an employee?

***Answer 3*:** No. But see Q&A–9 regarding the status of an owner as an eligible employee.

***Question 4*:** Does an employer fail to be an eligible employer for any month during which it offers a group health plan?

***Answer 4*:** Yes. An employer is not an eligible employer for any month during which the employer offers a group health plan to its employees that would provide coverage on any day of the month. Thus, for example, in the case of a non-calendar year group health plan, the employer is not an eligible employer for those months of a calendar year during which the group health plan is offered.

***Question 5*:** If one employer in a group of employers that are treated as a single employer under section 414(b), (c), (m), or (o) offers its employees a group health plan, may any other employer in the group be an eligible employer?

***Answer 5*:** No.

***Question 6*:** Does an employer fail to be an eligible employer if it contributes to an employee's health savings account (HSA), including permitting an employee to make pre-tax contributions to the HSA, by salary reduction, through a cafeteria plan?

***Answer 6*:** No.

***Question 7*:** When does an employer fail to be an eligible employer if it provides a non-calendar year QSEHRA and becomes an ALE?

***Answer 7*:** The employer fails to be an eligible employer as of January 1 of the year it becomes an ALE. That is, if an employer increases in size during the current year so that it employs an average of at least 50 full-time employees (and full-time equivalent employees) on business days during the current year, then it is an ALE on January 1 of the next year and ceases to be an eligible employer on that date. Although the employer may no longer provide the QSEHRA as of the date it becomes an ALE (even if the QSEHRA were provided on a non-calendar plan year basis), the QSEHRA may have a run-out period for medical expenses incurred during the months of the prior year during which the QSEHRA was provided. For purposes of this notice, a "run-out period" is a period following the coverage period for submitting a claim for reimbursement of medical expenses incurred during the coverage period.

B. Eligible employee

Under section 9831(d)(3)(A), ''eligible employee'' means any employee of an eligible employer, except that the terms of a QSEHRA may exclude employees who have not completed 90 days of service with the employer, employees who have not attained age 25 before the beginning of the plan year, part-time or seasonal employees, employees covered by a collective bargaining agreement if health benefits were the subject of good faith bargaining, and employees who are nonresident aliens with no earned income from sources within the United States.

***Question 8*:** What are the definitions of "part-time employees" and "seasonal employees" for purposes of determining whether an employee may be excluded from being an eligible employee under the terms of a QSEHRA?

***Answer 8*:** For purposes of determining whether an employee may be excluded from being an eligible employee under the terms of a QSEHRA, "part-time employees" and "seasonal employees" have the meanings set forth in § 1.105–11(c)(2)

(iii)(C) of the Income Tax Regulations:

> Part-time employees whose customary weekly employment is less than 35 hours, if other employees in similar work with the same employer (or, if no employees of the employer are in similar work, in similar work in the same industry and location) have substantially more hours and seasonal employees whose customary annual employment is less than 9 months, if other employees in similar work with the same employer (or, if no employees of the employer are in similar work, in similar work in the same industry and location) have substantially more months. Notwithstanding the preceding sentence, any employee whose customary weekly employment is less than 25 hours or any employee whose customary annual employment is less than 7 months may be considered as a part-time or seasonal employee.

***Question 9*:** May an eligible employer provide a QSEHRA to retirees, other former employees, or non-employee owners?

***Answer 9*:** No. A QSEHRA may only be provided to employees. A 2% shareholder who is otherwise an employee is not an employee for purposes of a QSEHRA. See section 1372. An arrangement provided to former employees is a group health plan within the

meaning of section 5000(b).[6]

***Question 10*:** When must an eligible employer provide a QSEHRA to an eligible employee who previously was excluded under one or more categories of excludable employees referenced in section 9831(d)(3)(A)?

***Answer 10*:** If the employee is otherwise an eligible employee, the eligible employer must provide a QSEHRA to the employee no later than the day immediately following the date the employee is no longer in any category of excludable employees under the terms of the plan.

***Question 11*:** May an eligible employee waive participation in a QSEHRA?

***Answer 11*:** No. Section 9831(d)(2)(A)(ii) requires that the eligible employer provide, rather than offer, a QSEHRA on the same terms to all eligible employees.

C. Same terms requirement

Under section 9831(d)(2)(A)(ii), a QSEHRA is an arrangement that is provided on the same terms to all eligible employees of the eligible employer. In addition, under section 9831(d)(2)(C), the maximum amount of payments or reimbursements that may be made under the arrangement during the year to a particular employee (the permitted benefit) may vary from employee to employee based only on the age of covered individuals or the number of individuals covered in accordance with the variation in the price of an insurance policy in a relevant individual health insurance market. This insurance policy (the baseline policy) must be the same insurance policy with respect to all eligible employees.

***Question 12*:** Does an arrangement fail to satisfy the same terms requirement if it is not operated on a uniform and consistent basis with respect to all eligible employees?

***Answer 12*:** Yes. To satisfy the same terms requirement, the arrangement must be operated on a uniform and consistent basis with respect to all eligible employees. However, an arrangement does not fail to be operated on a uniform and consistent basis merely because different eligible employees who are provided the same permitted benefit are reimbursed different amounts because they submitted different expenses for reimbursement.

Example 1. *Facts*: In 2017, Employer provides an arrangement that only reimburses premiums up to a self-only permitted benefit of $4,950 and a family permitted benefit of $10,050. Employee A purchases self-only coverage with an annual premium of $3,450 and is reimbursed $3,450. Employee B purchases family coverage with an annual premium of $9,000 and is reimbursed $9,000. Employee C purchases self-only coverage with an annual premium of $6,000 and is reimbursed $4,950.

Conclusion: The arrangement does not fail to satisfy the same terms requirement.

Example 2. *Facts*: An employer provides an arrangement the terms of which state that one category of employees may be reimbursed for all medical expenses, but that another category of employees may only be reimbursed for premiums for individual health insurance policies.

Conclusion: The arrangement fails to satisfy the same terms requirement.

***Question 13*:** What type of insurance policy in the relevant individual health insurance market may be used as the baseline policy for determining permissible variations in the permitted benefit based on age or number of family members?

***Answer 13*:** The baseline policy must be both MEC and available for purchase by at least one eligible employee.

***Question 14*:** Does an arrangement fail to satisfy the same terms requirement if it provides for reimbursements up to a single dollar amount regardless of whether an eligible employee has self-only or family coverage?

***Answer 14*:** No.

***Question 15*:** Does an arrangement fail to satisfy the same terms requirement if it provides for reimbursements up to the self-only and family statutory dollar limits or up to an equal percentage of the statutory dollar limits without referring to a baseline policy?

***Answer 15*:** No.

Example. *Facts*: In 2017, Employer provides an arrangement with a self-only permitted benefit of $3,960 (80% of the 2017 statutory dollar limit of $4,950 for self-only coverage) and a family permitted benefit of $8,040 (80% of the 2017 statutory dollar limit of $10,050 for family coverage).

Conclusion: The arrangement does not fail to satisfy the same terms requirement. (Although this example illustrates an arrangement that does not refer to a baseline policy and does not fail to satisfy the same terms requirement, there may be other arrangements that also do not fail to satisfy the same terms requirement.)

***Question 16*:** Does an arrangement that varies the permitted benefit based on the number of family members fail to satisfy the same terms requirement if it provides a self-only permitted benefit to an eligible employee who enrolls in self-only coverage without regard to whether the employee has a family member that has MEC under one or more separate policies?

***Answer 16*:** Yes. To the extent that an arrangement covers medical expenses of family members of eligible employees, the same terms requirement is satisfied only if the permitted benefit is based on the number of family members that have MEC without regard to whether they have a single policy or multiple policies.

Example. *Facts*: Employer provides an arrangement with a self-only permitted benefit and a family permitted benefit that is larger than the self-only permitted benefit. Employee enrolls in self-only coverage; Employee's spouse enrolls in a different plan or policy that provides MEC. Employer provides Employee with a self-only permitted benefit.

Conclusion: The arrangement fails to satisfy the same terms requirement.

***Question 17*:** Does an arrangement fail to satisfy the same terms requirement merely because it determines an eligible employee's permitted benefit based on the employee's family size and age on the first day of the plan year?

***Answer 17*:** No. An arrangement that determines an eligible employee's permitted benefit based on the employee's family

[6]Provided the arrangement meets the general exception set forth in section 9831(a)(2) that on the first day of the plan year the plan has less than two participants who are current employees, the arrangement would not be subject to the market reforms and other requirements of chapter 100.

size and age on the first day of the plan year does not fail to satisfy the same terms requirement merely because the determination is made as of the first day of the plan year and the arrangement does not provide for a change in permitted benefits if the employee changes coverage during the plan year due to a change in personal circumstances (for example, the employee marries, divorces, or adopts a child during the plan year).

Example. *Facts*: Employer provides an arrangement with a self-only permitted benefit and a family permitted benefit. Employee is enrolled in self-only coverage on January 1 and has no family members. In July, Employee enrolls in family coverage. Employer provides Employee with a self-only permitted benefit for the entire plan year.

Conclusion: The arrangement does not fail to satisfy the same terms requirement.

***Question 18*:** What rounding rules may an eligible employer use in order for the QSEHRA's permitted benefit to comply with the same terms requirement?

***Answer 18*:** The eligible employer may set the permitted benefit by rounding amounts in increments of $50 to the nearest whole dollar amount that does not exceed the applicable statutory dollar limit.

***Question 19*:** Does an arrangement fail to satisfy the same terms requirement if it limits the permitted benefit provided to two or more eligible employees covered under the same family health insurance policy (for example, if two eligible employees are married to each other) to the permitted benefit that would be provided to one eligible employee?

***Answer 19*:** Yes. To satisfy the same terms requirement, a QSEHRA provided to two or more eligible employees of the same eligible employer must provide separate permitted benefits (which will be subject to separate statutory dollar limits) to each employee without regard to whether the employees are covered under separate health insurance policies or a single family policy. Notwithstanding the previous sentence, a QSEHRA may not provide duplicative reimbursements of a single medical expense.

Example. *Facts*: In 2017, Employer provides an arrangement that reimburses all medical expenses with a self-only permitted benefit of $3,960 and a family permitted benefit of $8,040. The permitted benefit for eligible employees that are covered under a single family health insurance policy is collectively limited to one shared family permitted benefit of $8,040. Employee A, Employee B, and Employee C are covered under one family health insurance policy with a $10,000 premium. The arrangement collectively reimburses a total amount of $8,040 to Employee A, Employee B, and Employee C.

Conclusion: The arrangement fails to satisfy the same terms requirement. Employee A, Employee B, and Employee C are each entitled to a permitted benefit of $8,040. (However, reimbursements with respect to the $10,000 premium are limited to $10,000 among the employees.)

***Question 20*:** Does an arrangement fail to satisfy the same terms requirement if eligible employees are offered a choice between two different permitted benefit options (for example, the QSEHRA only reimburses employees for premiums or the QSEHRA only reimburses employees for non-premium medical expenses)?

***Answer 20*:** Yes.

***Question 21*:** Does an arrangement fail to satisfy the same terms requirement if it limits reimbursements for all eligible employees to one or more of the following: (a) insurance premiums, (b) cost-sharing expenses that are medical expenses, or (c) certain other medical expenses specified under the arrangement?

***Answer 21*:** Generally, no. A QSEHRA may limit reimbursements to certain medical expenses, but the arrangement will fail to satisfy the same terms requirement, if, under the facts and circumstances, the arrangement's limitation of reimbursements causes the arrangement not to be effectively available to all eligible employees.

***Question 22*:** Does an arrangement fail to satisfy the same terms requirement if it reimburses premiums for Medicare or Medicare supplement (Medigap) policies?

***Answer 22*:** No. However, an arrangement that limits reimbursements to only premiums for Medicare or Medigap policies may fail to satisfy the same terms requirement if the reimbursements would not be effectively available to all eligible employees.

***Question 23*:** Does an arrangement fail to satisfy the same terms requirement if it allows for carryover of unused benefit amounts (the carryover amount) from a prior plan year?

***Answer 23*:** No. A difference in permitted benefits that is due only to the availability of a carryover amount from a prior plan year does not cause a QSEHRA to fail to satisfy the same terms requirement. Note that the sum of the carryover amount and the permitted benefit amount under the QSEHRA for the later year cannot exceed the statutory dollar limit in that later year. See Q&A–29.

Example. *Facts*: Employer provides a QSEHRA with a permitted benefit of $2,000. The QSEHRA allows eligible employees to use carryover amounts from the prior plan year. Employee A receives $500 in reimbursements from the QSEHRA, leaving a carryover amount of $1,500. Employee B receives $2,000 in reimbursements from the QSEHRA, leaving no carryover amount. In the following plan year, Employee A has a permitted benefit of $3,500 ($2,000 plus the $1,500 carryover amount). Employee B has a permitted benefit of $2,000.

Conclusion: The QSEHRA does not fail to satisfy the same terms requirement.

***Question 24*:** Does an arrangement fail to satisfy the same terms requirement if it is only available to the eligible employees of one eligible employer in a group of employers that are treated as a single employer under section 414(b), (c), (m), or (o)?

***Answer 24*:** Yes. If a group of eligible employers are treated as a single employer under section 414(b), (c), (m), or (o), each employer in the group must provide a QSEHRA to all eligible employees. Moreover, each employer's QSEHRA must be provided on the same terms (for example, with the same amounts of permitted benefits).

***Question 25*:** Does an arrangement fail to satisfy the same terms requirement if it provides a different permitted benefit for a category of employees that may be excluded as eligible employees?

***Answer 25*:** Yes. Although an eligible employer is not required to provide a QSEHRA to employees in a category described in any clause of section 105(h)(3)(B), if a QSEHRA is provided to employees in an excludable category, those employees must be provided the QSEHRA on the same terms as all employees to whom the QSEHRA is provided. Further, an employer that provides a group

health plan to current employees in an excludable category is not an eligible employer.

***Question 26*:** Does an arrangement fail to satisfy the same terms requirement if the permitted benefits are determined based on the prior year's statutory dollar limits?

***Answer 26*:** No. For purposes of the same terms requirement, because indexed amounts for a calendar year are not expected to be published before October of the immediately preceding year (and the written notice must be provided to eligible employees at least 90 days before the beginning of the year), it is permissible for each year's permitted benefits to be determined based on the prior year's statutory dollar limits. Thus, for example, for a QSEHRA designed to satisfy the same terms requirement using proportional amounts of the statutory dollar limits, it is permissible to use the 2017 indexed limits to determine permitted benefits for 2018, even if the result would not be proportional to the dollar limits as those limits are indexed for 2018.

D. Statutory dollar limits

Under section 9832(d)(2)(B)(iii), a QSEHRA may not provide reimbursements that exceed the statutory dollar limits. The statutory dollar limits are indexed for inflation for years after 2016. The indexed dollar limits for 2017 are $4,950 for self-only coverage and $10,050 for family coverage. In the case of an individual who is not covered by a QSEHRA for the entire year, section 9831(d)(2)(D)(i) requires the statutory dollar limits to be prorated to reflect the number of months that the individual is covered by the QSEHRA.

***Question 27*:** What are the statutory dollar limits for a QSEHRA provided for 2018?

***Answer 27*:** For 2018, the maximum permitted benefit for self-only coverage is $5,050 and for family coverage is $10,250. See Rev. Proc. 2017–58. The statutory dollar limits for a calendar year are determined based on information that is not expected to be available until September of the immediately preceding year. As a result, the statutory dollar limits for a calendar year are not expected to be published before mid-October of that immediately preceding year. A QSEHRA may comply with the statutory dollar limits by relying on the indexed dollar limits for the immediately preceding year to determine the permitted benefits for the current year. However, if an arrangement provided for the current year assumes statutory dollar limits in excess of the actual indexed amounts for the current year, the arrangement will fail to be a QSEHRA. For a QSEHRA that varies the permitted benefit based on the statutory dollar limits, see Q&A–26 regarding the use of the prior year's statutory dollar limits to satisfy the same terms requirements.

***Question 28*:** How are the statutory dollar limits for a non-calendar year QSEHRA determined?

***Answer 28*:** The statutory dollar limits are prorated based on the number of months in each portion of the two calendar years in which the QSEHRA is provided. However, as a practical matter, it is unlikely that the eligible employer will have sufficient information three months before the beginning of the non-calendar plan year to allow the employer to provide accurate information in the written notice. Therefore, the QSEHRA may use the statutory dollar limits applicable on the first day of the plan year for the entire plan year. If an arrangement assumes statutory dollar limits in excess of the actual indexed dollar limits for the applicable year, the arrangement will fail to be a QSEHRA.

***Question 29*:** If a QSEHRA allows for the use of carryover amounts from a prior plan year, may an eligible employee's carryover amount be added to the newly available amount to provide a total permitted benefit that exceeds the applicable statutory dollar limit?

***Answer 29*:** No. An eligible employee's total permitted benefit, taking into account both carryover amounts and newly available amounts, may not exceed the applicable statutory dollar limit.

***Example*.** *Facts*: Employer provides a QSEHRA with a permitted benefit of $3,000. The QSEHRA allows for the use of carryover amounts from the prior plan year. Employee receives $500 in reimbursements from the QSEHRA for the year, leaving a carryover amount of $2,500. In the following year, the applicable statutory dollar limit is $5,050.

Conclusion: Employee is limited to a permitted benefit of $5,050 in the second year (the $3,000 newly available amount plus $2,050 of the $2,500 carryover amount).

***Question 30*:** How are the statutory dollar limits determined for a newly eligible employee (for example, a newly hired employee) who is first provided a QSEHRA on a day other than the first day of the calendar year?

***Answer 30*:** The statutory dollar limits are prorated to reflect the actual number of months that an eligible employee is provided the QSEHRA when the QSEHRA is provided for a period that does not include all months of the year. For this purpose, an eligible employee is treated as having been provided a QSEHRA for the entire month if the employee is eligible for reimbursements from the QSEHRA for expenses incurred on any day of that month.

***Example*.** *Facts*: In 2017, Employer provides a calendar year QSEHRA. The self-only permitted benefit is $4,950 and the family permitted benefit is $10,050. Employee becomes an eligible employee on August 6, 2017. The QSEHRA provides Employee with either a self-only permitted benefit of $2,050 ($4,950 x 5/12, rounded) or a family permitted benefit of $4,150 ($10,050 x 5/12, rounded). The prorated statutory dollar limit for family coverage is $4,187.50. As explained in Q&A–18, rounding to an amount in excess of the statutory dollar limit is not permitted.

Conclusion: The QSEHRA does not fail to satisfy the statutory dollar limit.

***Question 31*:** If an eligible employee receives reimbursements from a QSEHRA that equal the applicable statutory dollar limit but later terminates employment before the end of the plan year so the employee was not covered by the QSEHRA for the entire year, does the QSEHRA satisfy the statutory dollar limit?

***Answer 31*:** Yes. Because the arrangement satisfied the statutory dollar limit at the time the expenses were incurred and reimbursed, the arrangement is treated as satisfying the statutory dollar limit for the calendar year. If the eligible employee receives a reimbursement before the employee's termination that would be in excess of the prorated statutory dollar limit except for the fact that it is payable under the terms of the QSEHRA as described in the preceding sentence, then the reimbursement that would otherwise have exceeded the prorated statutory dollar limit is not taxable. However, to the extent a QSEHRA allows medical expenses in-

curred before termination of employment to be submitted during a run-out period after termination of employment, the QSEHRA may not reimburse medical expenses in excess of the prorated statutory dollar limit.

***Question 32*:** May a QSEHRA be provided for a period that is less than 12 months in total and begins after January 1?

***Answer 32*:** Yes. However, section 9831(d)(2)(D)(i) requires the statutory dollar limit for the applicable year to be prorated to reflect the number of months that the QSEHRA is provided.

***Example*.** *Facts*: Employer provides a QSEHRA with a short plan year beginning August 1, 2017, and ending on December 31, 2017. The QSEHRA is designed to provide permitted benefits at 100% of the statutory dollar limit. For the short 2017 plan year, the QSEHRA provides permitted benefits of $2,050 for self-only coverage (5/12 x $4,950 = $2,062.50, rounded to $2,050) and $4,150 for family coverage (5/12 x $10,050 = $4,187.50, rounded to $4,150).

Conclusion: The QSEHRA does not fail to satisfy the statutory dollar limit.

***Question 33*:** How do the statutory dollar limits apply if an eligible employee receives a QSEHRA from more than one eligible employer in a calendar year?

***Answer 33*:** If an eligible employee is provided more than one QSEHRA from separate eligible employers that are not members of a group of employers that are treated as a single employer under section 414(b), (c), (m), or (o), each employer may provide the employee with a permitted benefit up to the applicable statutory dollar limit. (However, no expense may be reimbursed more than once.)

***Question 34*:** May a mistaken reimbursement from a QSEHRA in excess of the statutory dollar limit be corrected if the eligible employee timely repays the excess reimbursement?

***Answer 34*:** Yes. If an eligible employee timely repays with after-tax funds an excess reimbursement that was made by mistake, the QSEHRA will be treated as satisfying the statutory dollar limit. For this purpose, timely repayment does not include repayments made after the earlier of (a) March 15 of the year following the year in which the excess reimbursement was made, or (b) in the case of an eligible employer whose federal income tax return is under examination for the taxable year during which the excess reimbursement was made, the date the eligible employer receives written notification from the examining agent(s) specifically citing the excess reimbursement as an issue under consideration.

E. Written notice requirement

Section 9831(d)(4) requires an eligible employer who provides a QSEHRA to its eligible employees to furnish a written notice (the written notice) to each eligible employee at least 90 days before the beginning of each year or, for an employee who is not eligible to participate at the beginning of the year, the date on which the employee is first eligible to participate in the QSEHRA. Section 6652(o) provides a penalty of $50 per employee (up to a maximum of $2,500 per calendar year per eligible employer) for failure to provide the written notice.

The Cures Act provides a transition rule under which an eligible employer will not be treated as failing to furnish the written notice if the notice is provided no later than 90 days after the date of enactment of the Cures Act. Notice 2017–20, 2017–11 IRB 1010, released February 27, 2017, provides that the period for furnishing the initial written notice for a QSEHRA beginning in 2017 is extended to at least 90 days following the issuance of further guidance concerning the written notice. This notice constitutes such guidance. Employers that furnished the written notice to their eligible employees before the publication of this notice were permitted to determine the contents of the written notice using a reasonable good faith interpretation of the Cures Act.

***Question 35*:** When is an eligible employer required to furnish the initial written notice to its eligible employees with respect to a QSEHRA provided during 2017 or 2018?

***Answer 35*:** An eligible employer that provides a QSEHRA during 2017 or 2018 must furnish the initial written notice to its eligible employees by the later of (a) February 19, 2018, or (b) 90 days before the first day of the plan year of the QSEHRA. The penalties under section 6652(o) apply to any employer that does not furnish the initial written notice by that date. Thus, an employer that provided a QSEHRA before the release of this notice and has not previously furnished the written notice must furnish the written notice by February 19, 2018. For some employees, the information in the notice will be necessary to complete their individual tax returns even if the information is not available when they are making decisions about health coverage, and the information will alert them to potential tax consequences. In addition, employers are encouraged to provide employees with information regarding the QSEHRA as soon as possible to allow employees to make informed decisions about health coverage, even if that information is less than the full notice required to satisfy the written notice requirement that will be provided at a later date.

***Question 36*:** May an eligible employer use an electronic medium (for example, email) to furnish the written notice to its eligible employees?

***Answer 36*:** Yes. An eligible employer may furnish the written notice electronically to its eligible employees if the employer follows the rules for the use of electronic media in § 1.401(a)–21.

***Question 37*:** When must the initial written notice be furnished to a newly eligible employee?

***Answer 37*:** Except as provided in Q&A–35, in the case of a newly eligible employee, the initial written notice must be furnished on or before the first day the employee becomes eligible to participate in the QSEHRA.

***Example*.** *Facts*: A QSEHRA provides that newly hired employees are eligible for reimbursement of expenses incurred beginning the first day of the first month following an employee's date of hire. An employee is hired on the 15th day of the month and receives the initial written notice on the 20th day of the month.

Conclusion: Because the employee was not eligible to participate until the first day of the first month after the employee's date of hire, and the written notice was furnished before that date, the eligible employer timely provided the initial written notice to the

eligible employee.

***Question 38*:** What information must be included in the written notice?

***Answer 38*:** The written notice must include the information described below, and may include other information, as long as the additional information does not conflict with the following required information:

(a) A statement of the amount of each permitted benefit for which the employee might be eligible. To the extent the permitted benefit varies based on the number of family members covered under the arrangement or their ages, the written notice for an employee may include either each available permitted benefit, or the permitted benefit for which that employee is eligible. In the case of a newly eligible employee whose permitted benefit has been prorated, the written notice must either (i) include the prorated permitted benefit for which that employee is eligible, or (ii) state that the amounts are prorated based on months of coverage and provide the information necessary to calculate the prorated amount (for example, the permitted benefit amounts and the first month the employee will become eligible to participate in the QSEHRA). The notice must include the date on which the QSEHRA is first provided to the eligible employee.

(b) A statement that the eligible employee must inform any Marketplace to which the employee applies for advance payments of the PTC (APTC) of the amount of the permitted benefit. The written notice must state that the amount of the permitted benefit may affect the eligibility for and amount of any PTC and that the employee should retain the written notice because it may be needed to calculate the PTC on the employee's individual income tax return.

(c) A statement that if the eligible employee does not have MEC for any month, the employee may be liable for an individual shared responsibility payment under section 5000A for that month, and reimbursements under the QSEHRA for expenses incurred in the month will be includible in gross income.

***Example*.** *Facts*: In 2017, Employer provides a QSEHRA with a self-only permitted benefit of $3,960 and a family permitted benefit of $8,040. These dollar amounts are the maximum amounts for which an eligible employee in each category may be reimbursed; the amount each employee is actually reimbursed depends on the expenses submitted by the employee for reimbursement. The first month of eligibility begins on January 1. Employer timely provides the following written notice to its eligible employees:

"Your permitted benefit for 2017 is $3,960 if you have self-only coverage or $8,040 if any members of your family also have coverage. (These amounts are prorated by month if you are not eligible on the first day of the year.) Your permitted benefit applies to medical expenses incurred on or after January 1 (your eligibility date)."

"You are required to inform any Marketplace to which you apply for advance payments of the premium tax credit about the amount of your permitted benefit. The amount of your permitted benefit may affect your eligibility for a premium tax credit and will reduce the amount of the premium tax credit for which you are eligible. You should retain this written notice because it may be needed to calculate the premium tax credit on your individual income tax return."

"If you do not have minimum essential coverage for any month, you may be liable for an individual shared responsibility payment under section 5000A of the Internal Revenue Code, and all of the reimbursements you receive under this arrangement for expenses incurred in that month will be includible in your gross income. For a list of examples of plans and arrangements that are minimum essential coverage, you may refer to the Instructions for IRS Form 8965, which are available on the IRS website."

An employee hired after the beginning of the year receives the same written notice except the first paragraph includes the newly eligible employee's initial eligibility date.

Conclusion: Employer satisfies the written notice requirements.

***Question 39*:** Must an eligible employer directly provide to a Marketplace any information about a QSEHRA that it provides to its eligible employees?

***Answer 39*:** No.

F. MEC requirement

Under section 106(g), payments or reimbursements from a QSEHRA are not treated as paid or reimbursed under employer-provided coverage for medical expenses under an accident or health plan for purposes of sections 106 and 105 if, for the month in which the medical care is provided, the individual does not have MEC.

***Question 40*:** What are the tax consequences for an eligible employee who mistakenly received reimbursements from a QSEHRA with respect to medical care provided during one or more months in the year when the individual to whom the care was provided did not have MEC?

***Answer 40*:** To the extent medical care was provided (or incurred) during one or more months when the individual for whom the expenses were incurred did not have MEC, the amount of the reimbursements of those expenses mistakenly paid from the QSEHRA is included in the gross income of the eligible employee who was provided the QSEHRA. See Q&A–62 regarding information reporting requirements related to the reimbursement.

G. Proof of MEC requirement

Under section 9831(d)(2)(B)(ii), a QSEHRA may only provide reimbursements to an eligible employee after the eligible employee provides proof of coverage. Consistent with section 106(g), such coverage must qualify as MEC.

***Question 41*:** What satisfies the requirement that a QSEHRA only provide reimbursements after the eligible employee provides proof of coverage?

***Answer 41*:** Before a QSEHRA can reimburse an expense for any plan year, the eligible employee must first provide proof that the eligible employee and (if different) the individual whose expense will be reimbursed has MEC for the month during which the expense was incurred. This proof must consist of either (a) a document from a third party (for example, the insurer) showing that the employee and the individual have coverage (for exam-

ple, an insurance card or an explanation of benefits) and an attestation by the employee that the coverage is MEC; or (b) 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. See Appendix B for model attestation language. The initial proof of MEC must be provided with respect to each individual whose expenses are eligible for reimbursement before the first reimbursement of an expense of that individual. An eligible employer may rely on the employee's attestation unless the employer has actual knowledge that the individual whose expense is submitted does not have MEC. Additionally, following this initial proof of coverage, with each new request for reimbursement of an incurred expense for the same plan year, at a minimum, the employee must attest that the employee and the individual whose expense is being reimbursed continue to have MEC (for example, as part of the form for requesting reimbursement). Receipt of the documentation described above satisfies a QSEHRA's requirement that the QSEHRA reimburse medical expenses only after the employee provides proof of coverage.

***Question 42*:** Does the requirement that an eligible employee provide proof of MEC apply separately to each year the QSEHRA is provided?

***Answer 42*:** Yes. An eligible employee must provide initial proof of MEC as described in Q&A–41 at least annually for all individuals for whom the employee intends to seek payments or reimbursements for medical expenses incurred during a year in order to receive payments or reimbursements from the QSEHRA. In addition, following an initial submission of proof of coverage, with each new request for reimbursement of an incurred expense for the same plan year, at a minimum, the employee must attest that the individual whose expense is being reimbursed continues to have MEC.

***Question 43*:** May a QSEHRA reimburse an eligible employee on a taxable basis if the employee fails to provide proof of MEC for the individual for whom the employee seeks payments or reimbursements?

***Answer 43*:** No.

H. Substantiation requirement

Section 18001(a)(8) of the Cures Act provides that the Secretary of the Treasury may issue substantiation requirements as necessary to carry out the exception from group health plan requirements for QSEHRAs. Section 105(b) excludes from gross income employer reimbursements for medical expenses, including expenses reimbursed by a QSEHRA. Section 1.105–2 provides that this income exclusion applies only to amounts paid to reimburse the taxpayer for expenses incurred by the taxpayer for medical care and not for amounts that the taxpayer would be entitled to receive irrespective of whether such an expense was incurred. Therefore, to ensure that a particular payment is a reimbursement of a medical expense, all claims for expense reimbursements must be substantiated.

***Question 44*:** How may an eligible employee substantiate medical expenses to receive a reimbursement from a QSEHRA?

***Answer 44*:** The eligible employee may satisfy the substantiation requirements by complying with the substantiation requirements for FSAs as proposed at § 1.125–6. If an eligible employer pays an issuer directly for an employee's premium payment or uses the methods for payment of premiums described in Rev. Rul. 61–146, 1961–2 C.B. 25, no additional substantiation is required in relation to these payments. See also Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans.

***Question 45*:** What are the tax consequences if an arrangement mistakenly reimburses medical expenses of an eligible employee who failed to satisfy the substantiation requirements?

***Answer 45*:** If an arrangement mistakenly reimburses an eligible employee for a medical expense that has not been substantiated, the arrangement fails to satisfy the requirements for the payments to be excluded from the employee's income, and all payments to all employees under the arrangement, substantiated and unsubstantiated, on or after the date the mistaken reimbursement was made, become taxable. See also Q&A–72. If an employee timely substantiates or repays an unsubstantiated amount with after-tax funds, the QSEHRA will not be treated as failing to satisfy the substantiation requirements. Similarly, if an arrangement mistakenly reimburses employees for expenses that do not qualify as medical expenses, all payments to all employees under the arrangement, substantiated and unsubstantiated, on or after the date the reimbursement was made, become taxable. If a non-medical expense is mistakenly reimbursed and the employee timely repays the amount with after-tax funds, the arrangement will be treated as not failing the requirement for exclusion under section 105(b). For this purpose, timely substantiation or repayment does not include substantiations or repayments made after the earlier of (a) March 15 of the year following the year in which the error was identified, or (b) in the case of an eligible employer whose federal income tax return is under examination for the taxable year during which the error was identified, the date the eligible employer receives written notification from the examining agent(s) specifically citing the mistaken reimbursement as an issue under consideration.

***Example*.** *Facts*: A QSEHRA reimburses an eligible employee for a medical expense. Upon later internal review, it is determined that the expense was not adequately substantiated. Upon request, the employee provides the missing substantiation by March 15th of the year following the year the substantiation error was identified.

Conclusion: The reimbursement is excluded from the employee's income and wages, and payments to other employees under the arrangement remain excluded from their income and wages.

I. Reimbursement of medical expenses

Section 9831(d)(2)(B)(ii) provides that a QSEHRA is an arrangement that provides, after the eligible employee provides proof of coverage, for the payment of, or reimbursement of, expenses for medical care as defined in section 213(d) that are incurred by an employee or the employee's family members (as determined under the terms of the QSEHRA). Section 105(b) generally excludes from gross income payments by eligible employers to reimburse employees for medical expenses incurred by an employee or mem-

bers of the employee's family.

***Question 46*:** May a QSEHRA reimburse eligible employees with a taxable payment of unused permitted benefits at the end of the year (sometimes referred to as a cash-out)?

***Answer 46*:** No. A cash-out of unused permitted benefits would result in all payments to all eligible employees under the QSEHRA for the year being includible in income and wages because the exclusion under section 105(b) does not apply to amounts the taxpayer would be entitled to receive irrespective of whether the taxpayer incurs medical expenses.

***Question 47*:** May a QSEHRA reimburse health insurance premiums related to an eligible employee's family member if the family member's coverage is a separate policy from the policy covering the employee?

***Answer 47*:** Yes.

***Question 48*:** May a QSEHRA reimburse premiums for coverage under a group health plan sponsored by the employer of the eligible employee's spouse?

***Answer 48*:** Yes. However, the reimbursement is taxable to the extent that the spouse's share of premiums was paid on a pre-tax basis. See Q&A–63 for information regarding the taxation and reporting of the reimbursement.

***Question 49*:** On what date may payments or reimbursements under a QSEHRA first be made to a newly eligible employee?

***Answer 49*:** Payments or reimbursements may be made immediately upon an employee becoming eligible to participate in the QSEHRA, provided the employee has satisfied the other requirements (for example, substantiation) for receiving payments or reimbursements.

***Question 50*:** May a QSEHRA make 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?

***Answer 50*:** Yes. A QSEHRA may provide that any expense incurred during the year may be reimbursed by amounts available during that year after the date the expense was incurred.

Example. *Facts*: Employer provides a QSEHRA with a permitted benefit of $3,000. An eligible employee's available reimbursement on any date during the year is restricted to the number of months elapsed in the year plus the current month multiplied by $250, less any expenses reimbursed as of that date. On January 4, Employee substantiates medical expenses of $4,000. Employee receives $250 in January and an additional $250 in each month for the rest of the year.

Conclusion: The reimbursements do not fail to satisfy the QSEHRA rules.

***Question 51*:** May a QSEHRA impose a deductible or other cost-sharing requirements that must be met before the QSEHRA reimburses medical expenses?

***Answer 51*:** No.

***Question 52*:** May a QSEHRA reimburse medical expenses incurred before the eligible employee is provided the QSEHRA?

***Answer 52*:** No. A QSEHRA may not reimburse medical expenses incurred before the eligible employee is provided the QSEHRA. For this purpose, medical expenses are treated as incurred when the covered individual is provided the medical care that gives rise to the expense, and not when the amount is billed or paid. However, for this purpose, a QSEHRA is permitted to treat a premium expense for a period of coverage as incurred on (a) the first day of each month of coverage on a pro rata basis, (b) the first day of the period of coverage, or (c) the date the premium is paid.

Example 1. *Facts*: Employee pays $6,000 for health insurance coverage from January 1 through June 30, 2018. Employee is first eligible to participate in a QSEHRA on July 1, 2018.

Conclusion: The QSEHRA may not reimburse the $6,000 premium.

Example 2. *Facts*: Employee pays $6,000 on January 1, 2018 for health insurance coverage from January 1 through June 30, 2018. Employee is first eligible to participate in a QSEHRA on March 1, 2018.

Conclusion: The QSEHRA may either (1) reimburse up to $1,000 for each month of coverage between March 1 and June 30, 2018, or (2) reimburse up to $4,000 on March 1, 2018. Alternatively, the QSEHRA is permitted to not reimburse the insurance premium because it was paid before the date Employee first became eligible to participate in the QSEHRA. See Q&A–12 regarding the requirement that an arrangement must be operated on a uniform and consistent basis to satisfy the same terms requirement.

***Question 53*:** May a QSEHRA have a run-out period following the coverage period during which eligible employees may submit claims for medical expenses incurred during the coverage period?

***Answer 53*:** Yes. A QSEHRA may have a run-out period with a deadline on or after the end of the coverage period for submitting a claim for reimbursement of medical expenses incurred during the coverage period. Any run-out period must be provided on a uniform and consistent basis with respect to all eligible employees.

***Question 54*:** May a QSEHRA reimburse expenses for over-the-counter drugs purchased without a prescription?

***Answer 54*:** Yes. A QSEHRA is permitted, but not required, to reimburse expenses for over-the-counter drugs purchased without a prescription. However, these reimbursements are taxable to the eligible employee because section 106(f) permits income exclusion for reimbursements for a medicine or drug only if it is prescribed. See Q&A–64 for information regarding the taxation and reporting of the reimbursements.

***Question 55*:** May an eligible employer provide for an eligible employee to pay the excess of a health insurance premium over the amount paid by the QSEHRA with an after-tax payroll deduction (in contrast to a pre-tax salary reduction) assuming that this payroll practice otherwise satisfies any state law requirements?

***Answer 55*:** Yes. However, if an employer endorses a particular policy, form, or issuer of health insurance, it may constitute a group health plan, in which case the employer would not be an eligible employer that could provide a QSEHRA.

***Question 56*:** May a self-employed taxpayer be allowed a deduction under section 162(l) for a calendar month during which a family member is provided a QSEHRA that would pay or reimburse for premiums or other medical expenses of the taxpayer?

***Answer 56*:** No. The deduction under section 162(l) for amounts paid during the taxable year for insurance that constitutes medical care for the taxpayer and the taxpayer's family members is not available

for any calendar month in which the taxpayer is eligible to participate in any subsidized health plan maintained by any employer of the taxpayer or of the taxpayer's family members. For purposes of section 162(l), coverage under a QSEHRA constitutes participation in a subsidized health plan maintained by an employer.

J. Reporting requirement

Section 6051(a)(15) requires an eligible employee's permitted benefit to be reported on the Form W–2, Wage and Tax Statement.

***Question 57*:** How is an eligible employee's permitted benefit reported on the Form W–2?

***Answer 57*:** The eligible employer must report the amount of payments and reimbursements that the eligible employee is entitled to receive from the QSEHRA for the calendar year in box 12 of the Form W–2 using code FF, without regard to the amount of payments or reimbursements actually received. See Q&A–60 regarding the exclusion of the carryover amount from box 12 of the Form W–2.

Example 1. *Facts*: A QSEHRA provides a permitted benefit of $3,000. Employee receives reimbursements of $2,000 from the QSEHRA.

Conclusion: On the Form W–2, Employer reports a permitted benefit of $3,000 in box 12 using code FF.

Example 2. *Facts*: A QSEHRA provides a permitted benefit of $3,000, prorated by month for employees not eligible for the full year. Employee becomes eligible on May 1 for a permitted benefit of $2,000 ($3,000 x 8/12) for the year.

Conclusion: On the Form W–2, Employer reports a permitted benefit of $2,000 in box 12 using code FF.

***Question 58*:** If an eligible employer provides a QSEHRA that varies based on the number of family members covered under the arrangement or their ages, what amount of permitted benefit is reported on the Form W–2 of an eligible employee who is provided a QSEHRA but receives no payments or reimbursements and provides no proof of MEC?

***Answer 58*:** If the eligible employee receives no payments or reimbursements and provides no proof of MEC, the amount reported is the highest value permitted benefit that the QSEHRA provides. However, if the eligible employee later provides proof of MEC establishing eligibility for a lesser value permitted benefit, the Form W–2 must report this lesser value permitted benefit.

***Question 59*:** How is the permitted benefit provided under a QSEHRA with a non-calendar year plan year reported?

***Answer 59*:** The amount reported is the prorated amount of the permitted benefit for the calendar year (not the plan year, if different) for which the employee is eligible, regardless of whether the employee actually receives payments or reimbursements from the QSEHRA.

Example. *Facts*: Employer provides a non-calendar year QSEHRA that begins on April 1, 2017. (From January 1, 2017 to March 30, 2017, Employer does not provide a QSEHRA.) From April 1, 2017 to March 31, 2018, the QSEHRA provides a permitted benefit of $2,000. From April 1, 2018 to March 31, 2019, the QSEHRA provides a permitted benefit of $3,000.

Conclusion: On the 2017 Form W–2, Employer reports a permitted benefit of $1,500 ($2,000 x 9/12) for calendar year 2017, and, on the 2018 Form W–2, Employer reports a permitted benefit of $2,750 (($2,000 x 3/12) + ($3,000 x 9/12)) for calendar year 2018.

***Question 60*:** If a QSEHRA allows for the use of carryover amounts from prior years, how are the carryover amounts reported?

***Answer 60*:** The permitted benefit reported on the Form W–2 includes only newly available amounts. If the QSEHRA allows for the use of carryover amounts from prior years, those amounts are not included in the amount reported for the current year.

***Question 61*:** How is the permitted benefit reported on the Form W–2 for an eligible employee who is provided a self-only permitted benefit for part of the year and a family permitted benefit for another part of the year?

***Answer 61*:** If the QSEHRA provides that the eligible employee's permitted benefit will be adjusted during the year if the employee enrolls in a different type of coverage, then the amount reported on the employee's Form W–2 is prorated to reflect the change.

Example. *Facts*: Employer provides a QSEHRA with a self-only permitted benefit of $3,960 and a family permitted benefit of $8,040. The QSEHRA provides that the permitted benefit will be adjusted ratably by month if the type of coverage changes during the year. Employee enrolls in self-only coverage from January 1 through July 31 and in family coverage from August 1 to December 31.

Conclusion: On the Form W–2, Employer reports a permitted benefit of $5,660 (($3,960 x 7/12) + ($8,040 x 5/12)).

***Question 62*:** What is reported on the Form W–2 of an eligible employee who received taxable reimbursements as a result of an individual's failure to have MEC for one or more months in the year?

***Answer 62*:** Although a QSEHRA may not reimburse the medical expenses incurred on behalf of an individual who does not have MEC, to the extent an eligible employer discovers that a reimbursement was mistakenly made with respect to medical expenses incurred during a month that the individual whose expense was reimbursed did not have MEC, reporting on the Form W–2 of the eligible employee provided the QSEHRA should be as follows:

(a) The amount of the taxable reimbursement received with respect to expenses incurred during any month or months when the individual whose medical expense was reimbursed did not have MEC is included in the gross income of the eligible employee as other compensation in box 1, Wages, tips, and other compensation.

(b) The taxable reimbursements reported in box 1 are excluded from wages under sections 3121(a)(2)(B) and 3306(b)(2)(B) for purposes of Federal Insurance Contributions Act (FICA) taxes (including social security and Medicare taxes) and Federal Unemployment Tax Act (FUTA) taxes, respectively. Thus, the taxable reimbursements included in box 1 should not be included in box 3, Social security wages, or box 5, Medicare wages and tips.

(c) The taxable reimbursements are also excluded from wages for purposes of

federal income tax withholding. See section 3401(a)(20).

(d) The permitted benefit reported in box 12 using code FF will be the same amount that would have been reported had there been no failure to maintain MEC.

(e) If the employer discovers the lapse in MEC after filing the Form W–2 with the Social Security Administration (SSA) for the calendar year, the employer must furnish the employee a Form W–2c, Corrected Wage and Tax Statement, and file the Form W–2c with SSA.

***Question 63*:** What is reported on the Form W–2 of an eligible employee who received taxable reimbursements related to either (a) over-the-counter drugs purchased without a prescription, or (b) premiums paid on a pre-tax basis for coverage under a group health plan sponsored by the employer of the eligible employee's spouse?

***Answer 63*:** If a QSEHRA provides for taxable reimbursements of either (a) over-the-counter drugs purchased without a prescription, or (b) premiums paid on a pre-tax basis for coverage under a group health plan sponsored by the employer of the eligible employee's spouse, then the amount should be reported on the employee's Form W–2 as follows:

(a) The taxable reimbursements are wages subject to income tax withholding, and are included in box 1.

(b) The taxable reimbursements reported in box 1 are included in wages for purposes of FICA taxes (including social security and Medicare taxes) and FUTA taxes. Thus, the taxable reimbursements included in box 1 must also be included in box 3 and box 5.

(c) The permitted benefit is reported in box 12 using code FF as provided in Q&A–57; the fact that a portion of the permitted benefit is a taxable reimbursement does not change the amount reported in box 12 using code FF.

***Question 64*:** Is an eligible employer that provides a QSEHRA to its eligible employees required to provide Forms 1095–B, Health Coverage, regarding the QSEHRA?

***Answer 64*:** No.

K. Coordination with PTC

Section 36B allows a PTC for certain taxpayers who enroll (or whose family enrolls) in a qualified health plan (QHP) through a Marketplace. A PTC is not available for an individual who is eligible for coverage under an eligible employer-sponsored plan that is MEC, is affordable, and provides minimum value. An eligible employer-sponsored plan is affordable if the employee's required contribution for self-only coverage under the plan does not exceed 9.5 percent (adjusted annually) of the taxpayer's household income.

Under section 36B(c)(2) and §§ 1.36B–2(a) and 1.36B–3(c), a taxpayer who meets certain income and other criteria is allowed a PTC only for months that are coverage months. A coverage month is generally a month for which (a) the taxpayer or a family member of the taxpayer is enrolled in a QHP through a Marketplace and is not eligible for non-Marketplace MEC (for example, Medicaid, Medicare, or employer-sponsored coverage if that coverage is both affordable and provides minimum value), and (b) the premium for the individual's coverage is paid by the unextended due date of the taxpayer's income tax return for the taxable year.

Under section 36B(c)(4)(A), neither an employee nor a family member of the employee has a coverage month if the employee is provided a QSEHRA that constitutes affordable coverage. Section 36B(c)(4)(C) provides that a QSEHRA constitutes 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, as defined in section 9831(d)(3)(C), under the QSEHRA does not exceed 1/12 of 9.5 percent (adjusted annually) of the employee's household income.[7]

Section 36B(c)(4)(B) provides that if an employee is provided a QSEHRA for a coverage month, the PTC otherwise allowable for the month to the taxpayer who claims a personal exemption deduction for the employee is reduced by 1/12 of the employee's permitted benefit (PTC reduction) under the QSEHRA for the year. For purposes of the PTC reduction, the employee's permitted benefit is the maximum permitted benefit (self-only or family, as applicable) available to the employee under the QSEHRA. This amount is reported on the employee's Form W–2.

***Question 65*:** If a QSEHRA provides different amounts of permitted benefits for self-only and family coverage, what amount of permitted benefit reported by the eligible employer in the written notice is used to determine whether the QSEHRA constitutes affordable coverage for an eligible employee and the employee's family members?

***Answer 65*:** The permitted benefit for self-only coverage as reported by the eligible employer in the written notice is used to determine whether the QSEHRA constitutes affordable coverage, regardless of whether the permitted benefit provided to a particular eligible employee is for self-only or family coverage. If the amount of permitted benefit varies based on the age of the employee, the age-applicable self-only coverage amount is used.

***Example*.** *Facts*: For 2018, Employer provides a QSEHRA with a self-only permitted benefit of $3,960 and a family permitted benefit of $8,040. Employee has a spouse and a dependent. Employee enrolls in a QHP that covers all three family members and is provided an $8,040 permitted benefit. The annual premium for the second-lowest cost self-only silver plan offered by Employee's Marketplace is $6,000. Employee's household income is $20,000, and 9.56 percent of household income equals $1,912.

Conclusion: Even though Employee receives the family permitted benefit of $8,040, the self-only permitted benefit of $3,960 is used to determine whether the QSEHRA constitutes affordable coverage for Employee. The QSEHRA does not constitute affordable coverage for Employee for any month of 2018 because 1/12 of the second lowest-cost silver self-only plan (1/12 x $6,000 = $500), minus 1/12 of the self-only permitted benefit (1/12 x $3,960 = $330), equals $170 ($500-$330 = $170), which is greater than 1/12 of 9.56 per-

[7]The affordability safe harbors under § 54.4980H–5(e) only apply for employer liability for assessable payments under section 4980H(b). Eligibility for the PTC is based on an individual's household income.

cent of Employee's 2018 household income (1/12 x $1,912 = $159). Thus, Employee may be allowed a PTC for 2018 for coverage for Employee and Employee's family.

***Question 66*:** What amount of permitted benefit is used to calculate any PTC reduction?

***Answer 66*:** The PTC reduction for an eligible employee who is provided a QSEHRA for a coverage month is 1/12 of the employee's permitted benefit. The maximum permitted benefit for the type of coverage (self-only or family coverage) in which the employee was enrolled for the year, as reported by the eligible employer on the employee's Form W–2, is used to calculate the employee's PTC reduction. Thus, an employee who is provided a permitted benefit for self-only coverage uses the self-only amount to calculate the PTC reduction, and an employee who is provided a permitted benefit for family coverage uses the family amount to calculate the PTC reduction.

Example. *Facts*: Employer provides a QSEHRA with a self-only permitted benefit of $3,960 and a family permitted benefit of $8,040. Employee enrolls in a QHP covering Employee and Employee's three children for 2018. Coverage under the QSEHRA does not constitute affordable coverage for Employee, and Employee is allowed a PTC for each month in 2018 for coverage for Employee and Employee's three children. Employee's Form W–2 reports a permitted benefit of $8,040.

Conclusion: Employee's PTC reduction is $670 each month, which is 1/12 of the $8,040 family permitted benefit under the QSEHRA.

***Question 67*:** If a Marketplace determines that an eligible employee's QSEHRA does not constitute affordable coverage when the employee, or the employee's family member, enrolls in a QHP, does the QSEHRA constitute affordable coverage for a month if it is later determined that the QSEHRA constitutes affordable coverage under the affordability test described in section 36B(c)(4)(C) for that month?

***Answer 67*:** No. If accurate information regarding the permitted benefit is provided to the Marketplace when the eligible employee, or the employee's family member, enrolls in a QHP and the Marketplace determines that the QSEHRA does not constitute affordable coverage, the QSEHRA is treated as not constituting affordable coverage for all months of the year for which the permitted benefit is provided to the employee (or until the Marketplace makes a new determination).

***Question 68*:** If an eligible employee is provided a permitted benefit for self-only coverage for some months of a year and a permitted benefit for family coverage for other months of the year, how is the affordability of the QSEHRA coverage determined? If the QSEHRA does not constitute affordable coverage, how is the PTC reduction determined for the employee?

***Answer 68*:** Regardless of whether an eligible employee is provided a permitted benefit for self-only or family coverage, the permitted benefit for self-only coverage is used to determine whether the QSEHRA constitutes affordable coverage. For the PTC reduction, the prorated self-only permitted benefit is used for the months in which the employee was provided a permitted benefit for self-only coverage, and the prorated family permitted benefit is used for the months in which the employee was provided a permitted benefit for family coverage.

Example. *Facts*: Employer provides a QSEHRA with a self-only permitted benefit of $3,960 and a family permitted benefit of $8,040. Employee enrolls in a self-only QHP from January through August of 2018. In August, Employee marries and enrolls in a family QHP with coverage commencing on September 1, 2018, and continuing through the remaining months of 2018. Under the terms of the QSEHRA, Employee is provided a prorated permitted benefit based on whether Employee is enrolled in self-only or family coverage. Employee's permitted benefit for 2018 is $5,320 ($2,640 for January through August (8/12 x $3,960), plus $2,680 for September through December (4/12 x $8,040)).

Conclusion: To determine whether the QSEHRA constitutes affordable coverage for Employee for each month of 2018, 1/12 of the $3,960 permitted benefit for self-only coverage is used. If the QSEHRA does not constitute affordable coverage for Employee and Employee is allowed a PTC for 2018, Employee's PTC is reduced as follows: for the eight-month period of January through August that Employee was enrolled in self-only coverage, the PTC for each month is reduced by $330 (1/8 of $2,640), and for the four-month period of September through December that Employee was enrolled in family coverage, the PTC for each month is reduced by $670 (1/4 of $2,680).

***Question 69*:** If an eligible employee is provided a permitted benefit under a QSEHRA for some but not all months of a year, how is the affordability of the QSEHRA determined? If the QSEHRA does not constitute affordable coverage, how is the PTC reduction determined for the employee?

***Answer 69*:** If an eligible employee is provided a permitted benefit under a QSEHRA for some, but not all, months of a year, the affordability of the QSEHRA is determined for each month for which a benefit was provided using the prorated permitted benefit amount for self-only coverage. If the QSEHRA does not constitute affordable coverage, the employee's PTC is reduced by the prorated self-only permitted benefit for the months in which the employee was provided a permitted benefit for self-only coverage, and by the prorated family permitted benefit for the months in which the employee is provided a permitted benefit for family coverage. For example, if an eligible employer provided a QSEHRA with a permitted benefit of $3,960 for self-only coverage, an employee who worked for the employer for just four months of the year would be provided a permitted benefit of $1,320 ($3,960 x 4/12 = $1,320), then $330 ($1,320/4 = $330) of the permitted benefit amount is used to determine whether the QSEHRA constitutes affordable coverage for the employee for each of the four months. Similarly, if an employee is provided a permitted benefit for some, but not all, months of a year, the employee must reduce the PTC by a ratable portion of the permitted benefit amount for each month for which a benefit was provided. For example, if an employer provided a QSEHRA with a permitted benefit of $8,040 for family coverage, an employee who worked for the employer for just nine months of the year and who received family coverage would be provided with a permitted benefit of $6,030 ($8,040 x 9/12 = $6,030), then the employee must reduce the PTC by $670 ($6,030/9 = $670) for each of the nine

months the employee worked for the employer.

***Question 70*:** If a QSEHRA allows for the use of carryover amounts from the prior plan year, how do these carryover amounts affect a taxpayer's affordability determination and PTC reduction in the later year?

***Answer 70*:** The carryover amounts do not affect the affordability determination or the PTC reduction in the later year because the carryover amount was already taken into account in both the affordability determination and the PTC reduction in the year the amount was initially available. However, the sum of the carryover amount and the permitted benefit amount under the QSEHRA for the later year cannot exceed the statutory dollar limit. See Q&A–29, regarding the rule that an eligible employee's total permitted benefit, taking into account both carryover amounts and newly available amounts, may not exceed the applicable statutory dollar limit. For purposes of the affordability determination and PTC reduction, if the amount of permitted benefit including carryover amounts from prior years is restricted by the statutory dollar limits, the carryover amounts from prior years are reduced, rather than the initially available amounts.

***Example*.** *Facts*: For 2017 and 2018, Employer provides a QSEHRA with a self-only permitted benefit of $3,960 and a family permitted benefit of $8,040. The QSEHRA allows for the use of carryover amounts in the following year. In 2017 and 2018, Employee enrolls in a self-only QHP; in both years, the Marketplace determines that the QSEHRA does not constitute affordable coverage. Employee receives reimbursements of $3,000 in 2017, leaving an unused amount of $960, which is available to Employee in 2018.

Conclusion: Although Employee may receive reimbursements of $4,920 ($3,960 self-only permitted benefit plus $960 carryover amount) for medical expenses for 2018, only $3,960 in initially available amounts is considered in determining whether the QSEHRA is affordable for Employee for 2018. If Employee claims a PTC for 2018, only $3,960 is considered in determining the amount by which Employee must reduce the monthly PTC.

***Question 71*:** For 2017 or 2018, if APTC is paid on behalf of an eligible employee who was also provided a permitted benefit under a QSEHRA, is the permitted benefit taken into account by Federally-facilitated Marketplaces (FFM) in determining the amount of the APTC?

***Answer 71*:** No. For 2017 and 2018, if APTC is paid on behalf of an eligible employee who is also provided a permitted benefit under a QSEHRA, the permitted benefit is not considered by an FFM when calculating the amount of the employee's APTC; therefore, the employee may have APTC for 2017 or 2018 that exceeds the amount of the employee's allowed PTC (excess APTC). Any employee who receives the benefit of APTC must file Form 8962, Premium Tax Credit, with the employee's federal income tax return to reconcile (compare) the APTC with the PTC for which the employee is eligible. The employee must repay the excess APTC, subject to limitations. To reduce the risk of receiving excess APTC, the employee may reduce the amount of APTC to be paid on the employee's behalf to account for a QSEHRA permitted benefit for 2017 or 2018 by applying a lower APTC amount to the employee's policy through the Marketplace. For example, suppose an employee was determined eligible for and receives APTC in the amount of $400 per month for 2017, and the employee's employer provides the employee with a QSEHRA permitted benefit of $200 per month beginning in July 2017. Because this change in the employee's circumstances could affect the amount of APTC that the employee might have to repay at tax filing and reconciliation, the employee could reduce, in whole or in part, the monthly amount of APTC to be paid on the employee's behalf. While employees may not know the exact amount by which to reduce their APTC, they may reduce it in whole or in part. As noted above, excess APTC must be repaid, within certain limitations, when the employee files and reconciles APTC at tax filing.

L. Failure to satisfy the requirements to be a QSEHRA

If an arrangement fails to be a QSEHRA because one or more of the requirements to be a QSEHRA are not satisfied, the arrangement is a group health plan subject to chapter 100. Any violation of chapter 100 is subject to the excise tax under section 4980D ($100 per affected person per day).[8]

***Question 72*:** What will cause an arrangement to fail to be a QSEHRA?

***Answer 72*:** An arrangement will be a group health plan that is not a QSEHRA if it does not comply with the requirements in section 9831(d), including if (a) it is not provided by an eligible employer (such as an employer that offers another group health plan to its employees), (b) it is not provided on the same terms to all eligible employees, (c) it reimburses medical expenses without first requiring proof of MEC, or (d) it provides a permitted benefit in excess of the statutory dollar limits. An arrangement's failure to be a QSEHRA will not cause any reimbursement of a properly substantiated medical expense that is otherwise excludable from income to be included in the employee's income or wages. Notwithstanding the previous sentence, an arrangement designed to reimburse expenses other than medical expenses (whether or not also reimbursing medical expenses) is neither a QSEHRA nor a group health plan. Accordingly, all payments under such an arrangement are includible in the employee's gross income and wages. An employer's failure to timely provide a compliant written notice does not cause an arrangement to fail to be a QSEHRA, but instead results in the penalty under section 6652(o).

[8]There have been several prior releases on the compliance of HRAs with the group health plan rules of chapter 100: (1) FAQs About Affordable Care Act Implementation (Part XI), issued on January 24, 2013 by DOL (http://www.dol.gov/ebsa/faqs/faq-aca11.html) and HHS (http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html); (2) IRS Notice 2013–54 and DOL Technical Release 2013–03, issued on September 13, 2013; (3) IRS FAQ on Employer Healthcare Arrangements (http://www.irs.gov/Affordable-Care-Act/Employer-Health-Care-Arrangements); (4) FAQs About Affordable Care Act Implementation (Part XXII), issued on November 6, 2014 by DOL (http://www.dol.gov/ebsa/faqs/faq-aca22.html) and HHS (https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-XXII-FINAL.pdf); (5) Notice 2015–17, 2015–14 I.R.B. 845, issued by Treasury and IRS on February 18, 2015; (6) Notice 2015–87, 2015–52 I.R.B. 889, Q&A–1 to Q&A–6, issued by Treasury and IRS on December 16, 2015; and (7) FAQs About Affordable Care Act Implementation (Part 37), issued on January 12, 2017 (http://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-37.pdf). See also 26 CFR 54.9815–2711(d), 29 CFR 2590.715–2711(d), and 45 CFR 147.126(d) (80 FR 72192, Nov. 18, 2015).

***Question 73*:** What are the tax consequences if an arrangement operationally or by its terms either (a) reimburses medical expenses without full substantiation, (b) reimburses medical expenses in advance of receiving substantiation, or (c) reimburses non-medical expenses in addition to reimbursing medical expenses?

***Answer 73*:** If an arrangement operationally or by its terms reimburses eligible employees for expenses (a) that have not been substantiated, (b) that are reimbursed in advance of substantiation, or (c) that are not medical expenses, then the arrangement is neither a QSEHRA nor a group health plan, and all amounts paid under the arrangement are included in every employee's gross income and wages. See also Q&A 45.

Example 1. *Facts*: An arrangement that otherwise satisfies the requirements for a QSEHRA reimburses medical expenses incurred by eligible employees based solely on their verbal statements that the expenses were incurred.

Conclusion: The arrangement is not an accident or health plan, and all amounts paid under the arrangement are included in every eligible employee's gross income and wages.

Example 2. *Facts*: Employer pays its employees on a weekly basis. Employer provides an arrangement that otherwise satisfies the requirements for a QSEHRA. Under the arrangement, 1/52 of the permitted benefit is paid to employees in addition to each eligible employee's weekly salary without regard to whether the employee has incurred any medical expense.

Conclusion: The arrangement is not an accident or health plan, and all amounts paid under the arrangement are included in every eligible employee's gross income and wages.

***Question 74*:** Is a QSEHRA an applicable self-insured health plan subject to the Patient-Centered Outcomes Research Trust Fund (PCORTF) fee under section 4376 for years ending before September 30, 2019?

***Answer 74*:** Yes. Plan sponsors of applicable self-insured health plans must file Form 720, Quarterly Federal Excise Tax Return, annually to report and pay the PCORTF fee; a QSEHRA is an applicable self-insured health plan for this purpose. The Form 720 is due on July 31 of the year following the last day of the policy year or plan year. The fee is applicable with respect to plan years ending before October 1, 2019.

M. Interaction with HSA requirements

Under section 223, individuals who have high deductible health plan (HDHP) coverage and no other disqualifying health coverage may contribute to an HSA. Individuals who are covered by permitted insurance (defined under section 223(c)(3)) or certain disregarded coverage (defined under section 223(c)(1)(B)), in addition to HDHP coverage, remain eligible to contribute to an HSA.

***Question 75*:** Does an individual fail to be an eligible individual under section 223 because the individual is provided a QSEHRA that, by its terms, may reimburse any medical expense, including cost sharing?

***Answer 75*:** Yes.

***Question 76*:** Does an individual fail to be an eligible individual under section 223 because the individual is provided a QSEHRA that, by its terms, may reimburse only premiums?

***Answer 76*:** No.

***Question 77*:** Does an individual fail to be an eligible individual under section 223 because the individual is provided a QSEHRA that, by its terms, may only reimburse expenses that qualify as permitted insurance or disregarded coverage under section 223(c), in addition to reimbursing premiums for health insurance policies?

***Answer 77*:** No.

***Question 78*:** If an employer terminates its group health plan during the calendar year and thereafter provides a QSEHRA, may an HDHP later purchased as individual coverage by an employee take into account, for purposes of the HDHP's deductible, the unreimbursed medical expenses incurred by the employee while covered under the group health plan before termination?

***Answer 78*:** Yes.

N. Effective Date

***Question 79*:** How does the guidance in this notice apply to an eligible employer that provided a QSEHRA to its eligible employees before the date this notice was released?

***Answer 79*:** The guidance in this notice applies to plan years beginning on or after November 20, 2017 (the effective date). QSEHRAs established before that date may rely on these rules. However, if an eligible employer established a QSEHRA and operated it in accordance with a reasonable good faith interpretation of the applicable statutory provisions before the effective date, the employer may continue to operate the QSEHRA according to its terms until the last day of the plan year that began in 2017 so long as the QSEHRA was established before the effective date. In order to have established a QSEHRA before the effective date, the employer must have either (a) taken official action to adopt a QSEHRA before the effective date, (b) provided a QSEHRA to its eligible employees before the effective date, or (c) furnished its eligible employees with a written notice before the effective date.

PUBLIC COMMENTS

This notice generally provides guidance that Treasury and IRS intend to incorporate into proposed regulations. These proposed regulations will provide interested parties an opportunity for comment on the issues addressed in the proposed regulations. However, to assist in development of those proposed regulations, Treasury and IRS request comments on the guidance provided in this notice. Public comments should be submitted no later than January 19, 2018. Comments should include a reference to Notice 2017–67. Send submissions to CC:PA:LPD:PR (Notice 2017–67), Room 5203, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (Notice 2017–67), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC 20044, or sent electronically, via the following e-mail address: *Notice.comments@irscounsel.treas.gov*. Please include "Notice 2017–67" in the subject line of any electronic communication. All material submitted will be available for public inspection and copying.

APPLICABILITY DATE AND RELIANCE PERIOD

Except as otherwise explicitly provided in this notice, the guidance provided in this notice applies for plan years beginning on and after November 20, 2017.

PAPERWORK REDUCTION ACT

The collections of information contained in this notice has been submitted for approval by the Office of Management and Budget for review in accordance with the Paperwork Reduction Act (44 U.S.C. 3507) under control number 1545-0008.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid control number.

The collections of information in this notice are in the section entitled Guidance, subsections E, G, H, I and J. This information is required by the IRS to assure compliance with the new provisions of the 21st Century Cures Act. The likely respondents are employers and employees.

An eligible employee's permitted benefit must be reported on the Form W–2. The reporting burden on the employer will be evaluated at the time of renewal of control number 1545-0008.

The numbers provided in the following paragraphs are estimated numbers because this is the first year with respect to this voluntary provision; the numbers will be adjusted when additional data is available.

With respect to the requirement that an eligible employer furnish eligible employees with an annual written notice, the estimated number of respondents (employers) is 11,000. The estimated number of responses (annual notices) will be 220,000. The estimated annual frequency of responses is annually. Because Notice 2017–67 provides sample language for inclusion in the response, it is estimated that 10 minutes of a human resource professional's time will be required to prepare each response. Therefore, it is expected that employers will incur an estimated annual hour burden of 36,667 hours (estimated responses (220,000) multiplied by estimated frequency (one per year) multiplied by estimated time per response (10 minutes)), for the first year and for subsequent years. The estimated average annual burden associated with furnishing the written notice will be included in the estimated annual burden reported for Form W–2, when the Form W–2 is revised.

With respect to the employee's satisfaction of the attestation and gathering of documentation requirement (collectively, the attestation), the estimated number of respondents (employees) will be 220,000. The estimated annual frequency of responses is two times per year. Because Notice 2017–67 provides model language for inclusion in the response, it is estimated that five minutes of an employee's time will be required to prepare the attestation. Therefore, it is expected that employees will incur an estimated annual hour burden of 36,667 hours (estimated responses (220,000) multiplied by estimated frequency (two per year) multiplied by estimated time per response (five minutes)), for the first year and for subsequent years. The estimated average annual burden associated with the satisfaction of the attestation will be included in the estimated annual burden reported for Form W–2, when the Form W–2 is revised.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

DRAFTING INFORMATION

The principal author of this notice is Karen Levin of the Office of Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this notice contact Ms. Levin or Ronald Rutherford-Triche at (202) 317-5500 (not a toll-free number).

APPENDIX A

Types of Minimum Essential Coverage

Minimum essential coverage means health care coverage under any of the following programs. It does not, however, include coverage consisting solely of excepted benefits. Excepted benefits include stand-alone vision and dental plans, workers' compensation coverage, and coverage limited to a specified disease or illness.

Employer-sponsored coverage:

- Group health insurance coverage for employees under:
  - A plan or coverage offered in the small or large group market within a state,
  - A plan provided by a governmental employer, such as the Federal Employees Health Benefit program, or
  - A grandfathered health plan offered in a group market.
- A self-insured health plan for employees,
- COBRA coverage,
- Retiree coverage, or
- Coverage under an expatriate health plan for employees and related individuals.

Individual health coverage:

- Health insurance purchased directly from an insurance company,
- Health insurance purchased through the Marketplace,
- Health insurance provided through a student health plan,

- Catastrophic coverage, or
- Coverage under an expatriate health plan for non-employees such as students and missionaries.

Coverage under government-sponsored programs:

- Medicare Part A coverage,
- Medicare Advantage plans,
- Most Medicaid coverage,*
- Children's Health Insurance Program (CHIP) coverage,
- Most types of TRICARE coverage,
- Comprehensive health care programs offered by the Department of Veterans Affairs,
- Health coverage provided to Peace Corps volunteers,
- Department of Defense Nonappropriated Fund Health Benefits Program,
- Refugee Medical Assistance, or
- Coverage through a Basic Health Program (BHP) standard health plan.

Other coverage:

- Certain foreign coverage,
- Certain coverage for business owners, or
- Coverage recognized by HHS as minimum essential coverage.**

*Medicaid programs that provide limited benefits generally don't qualify as minimum essential coverage.

**Plans recognized as minimum essential coverage are listed at: www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/minimum-essential-coverage.html, scroll down and click on the link for the list of approved plans.

APPENDIX B

As described in Q&A–42, before reimbursement of an expense by a QSEHRA for any plan year, the eligible employee must first provide proof that the eligible employee and (if different) the individual whose expense will be reimbursed has MEC for the month during which the expense was incurred. This proof may consist of either (a) a document from a third party (for example, the insurer) showing that the eligible employee and the individual have coverage (for example, an insurance card or an explanation of benefits) and an attestation by the employee that the coverage is MEC; or (b) an attestation by the employee stating that the eligible employee and the individual have MEC, the date coverage(s) began, and the name of the provider of the coverage(s). Below is model attestation language for the employee to satisfy the attestation requirement.

Model Attestation for Initial Proof of MEC

Instruction – Complete the following to provide information on your current health coverage.

I am attesting to the following:

I, _____ *(insert name)* _____, am covered under the following health coverage: *(insert name of the health coverage)* _____,

The coverage began on *(insert date coverage began)* _____

The coverage is minimum essential coverage (MEC).

Instruction – Also complete the following if a family member's expenses can be reimbursed from the QSEHRA.

The following family member _____ *(insert name)* _____, is covered under the following health coverage: *(insert name of the health coverage)* _____.

The coverage began on *(insert date coverage began).* _____

The coverage is MEC.

I hereby affirm that the above information is true and accurate.

Signed: _____

Date: _____

Below is model attestation language that an employer can choose to include on a QSEHRA's reimbursement form for the employee to satisfy the requirement to attest that the individual whose expense is being reimbursed continues to have MEC.

Model Attestation for Request for Reimbursement of an Incurred Expense

Instruction – Complete the following for any expenses being reimbursed from the QSEHRA.

I, _____ *(insert name)* _____, am covered under the following health coverage: _____ *(insert name of the health coverage)* _____,

The coverage continues to be minimum essential coverage (MEC). The submitted medical expense has not been previously reimbursed and reimbursement will not be sought for the expense from any other arrangement or health plan.

Instruction – Also, complete the following if a family member's expense is being reimbursed from the QSEHRA.

The following family member _____*(insert name)*_____, is covered under the following health coverage:_____*(insert name of the health coverage)*_____.
The coverage continues to be MEC. The submitted medical expense has not been previously reimbursed and reimbursement will not be sought for the expense from any other arrangement or health plan.
I hereby affirm that the above information is true and accurate.
Signed: _____
Date: _____

Part IV. Items of General Interest

Relief for Victims of Hurricane Maria and the California Wildfires

Announcement 2017–15

Purpose

This announcement provides relief to taxpayers who have been adversely affected by Hurricane Maria and recent wildfires in California ("California Wildfires") and who have retirement assets in qualified employer plans that they would like to use to alleviate hardships caused by these disasters. In addition, this announcement provides relief from certain verification procedures that may be required under retirement plans with respect to loans and hardship distributions. The relief provided under this announcement is in addition to the relief already provided by the Service pursuant to News Releases CA–2017–06, VI–2017–02 and PR–2017–02 under § 7508A of the Internal Revenue Code ("Code") for victims of these disasters, and to any future news releases providing relief related to these disasters. These news releases can be found on *https://www.irs.gov/newsroom/tax-relief-in-disaster-situations*. (For a listing of employee benefit-related acts and deadlines that, under the news releases, were postponed until January 31, 2018, in response to these disasters, see the regulations under § 7508A and Section 8 of Rev. Proc. 2007–56, 2007–2 C.B. 388.) The relief in this announcement is separate and in addition to the relief provided to victims of Hurricane Maria by the Disaster Tax Relief and Airport and Airway Extension Act of 2017, P.L. 115–63.

Background

The laws relating to qualified employer plans impose various limitations on the permissibility of loans and distributions from those plans. For example, § 401(k)(2)(B)(i) of the Code provides that in the case of a § 401(k) plan that is part of a profit-sharing or stock bonus plan, elective deferrals may be distributed only in certain situations, one of which is on account of hardship. Section 403(b)(11) provides similar rules with respect to elective deferrals under a § 403(b) plan. Section 457(d)(1)(A) provides that a plan described in § 457(b) may not permit distributions before the occurrence of certain enumerated events, one being when the participant is faced with an unforeseeable emergency. Certain other types of plans or accounts are not permitted to make in-service distributions (distributions to a participant who is still an employee) even if there is a hardship. For example, in-service hardship distributions are generally not permitted from pension plans or from accounts holding qualified nonelective contributions ("QNECs") described in § 401(m)(4)(C) or qualified matching contributions ("QMACs") described in § 401(k)(3)(D)(ii)(I). However, Rev. Rul. 2004–12, 2004–2 C.B. 478, holds that if amounts attributable to rollover contributions are separately accounted for within a plan, those amounts may be distributed at any time, pursuant to the employee's request. Section 72(p) imposes certain requirements relating to plan loans. Unless those requirements are satisfied, a loan is treated as a distribution under the plan.

In order to make a loan or distribution (including a hardship distribution), a plan must contain language authorizing the loan or distribution. Also, except to the extent a distribution consists of already-taxed amounts, the distribution will be includible in gross income and generally subject to the 10-percent additional tax under § 72(t). Similar rules relating to income inclusion and taxation apply to a distribution from an IRA.

Plan provisions and regulations under certain Code sections establish verification procedures that a plan must follow before loans or distributions can be made from the plan. For example, the regulations under § 401(k) set forth certain criteria an employee must meet in order to receive a hardship distribution. A plan may contain procedures designed to confirm that the criteria have been satisfied.

Relief

As described below, a qualified employer plan will not be treated as failing to satisfy any requirement under the Code or regulations merely because the plan makes a loan, or a hardship distribution for a need arising from Hurricane Maria or the California Wildfires, to an employee or former employee whose principal residence on September 16, 2017, in the case of the U.S. Virgin Islands; September 17, 2017, in the case of Puerto Rico; or October 8, 2017, in the case of California ("Incident Date") was located in one of the areas identified for individual assistance by the Federal Emergency Management Agency ("FEMA") because of the devastation caused by these disasters or whose place of employment was located in one of these areas on that date or whose lineal ascendant or descendant, dependent, or spouse had a principal residence or place of employment in one of these areas on that date. The areas identified for individual assistance by FEMA can be found on FEMA's website at *https://www.fema.gov/disasters*. If additional areas are identified by FEMA for individual assistance because of damage related to these disasters, the relief provided in this announcement will also apply, from the date specified by FEMA as the beginning of the incident period, and that date should be substituted for references to the Incident Date in this announcement. Plan administrators may rely upon representations from the employee or former employee as to the need for and amount of a hardship distribution, unless the plan administrator has actual knowledge to the contrary, and the distribution is treated as a hardship distribution for all purposes under the Code and regulations.

For purposes of this announcement, a "qualified employer plan" means a plan or contract meeting the requirements of § 401(a) (including a plan treated as qualified under § 401(a) on account of an election made pursuant to § 1022(i)(2) of the Employee Retirement Income Security Act of 1974, P.L. 93–406), 403(a) or 403(b), and, for purposes of the hardship relief, that could, if it contained enabling language, make hardship distributions. For purposes of this paragraph, a "qualified employer plan" also means a plan described in § 457(b) maintained by an eligible employer described in

§ 457(e)(1)(A), and any hardship arising from Hurricane Maria or the California Wildfires is treated as an "unforeseeable emergency" for purposes of distributions from such plans. For example, a profit-sharing or stock bonus plan that currently does not provide for hardship or other in-service distributions may nevertheless make hardship distributions related to these disasters pursuant to this announcement, except from QNEC or QMAC accounts or from earnings on elective contributions (see below for plan amendment requirements). A defined benefit or money purchase plan, which generally cannot make in-service hardship distributions, may not make hardship distributions pursuant to this announcement, other than from a separate account, if any, within the plan containing either employee contributions or rollover amounts.

The amount available for hardship distribution is limited to the maximum amount that would be permitted to be available for a hardship distribution under the plan under the Code and regulations. However, the relief provided by this announcement applies to any hardship of the employee, not just the types enumerated in the regulations, and no post-distribution contribution restrictions are required. For example, regulations under § 401(k) provide safe harbor hardship distribution standards under which a hardship is deemed to exist only for certain enumerated events, and, after receipt of the hardship amount, the employee is prohibited from making contributions for at least 6 months. Plans need not follow these rules with respect to hardship distributions for which relief is provided under this announcement.

To make a loan or hardship distribution pursuant to the relief provided in this announcement, a qualified employer plan that does not provide for them must be amended to provide for loans or hardship distributions no later than the end of the first plan year beginning after December 31, 2017. To qualify for the relief under this announcement, a hardship distribution must be made on account of a hardship resulting from Hurricane Maria or the California Wildfires and be made on or after the Incident Date and no later than March 15, 2018. Plan loans made pursuant to this announcement must satisfy the requirements of § 72(p).

In addition, a retirement plan will not be treated as failing to follow procedural requirements for plan loans (in the case of retirement plans other than IRAs) or distributions (in the case of all retirement plans, including IRAs) imposed by the terms of the plan merely because those requirements are disregarded for any period beginning on or after the Incident Date and continuing through March 15, 2018, with respect to loans or distributions to individuals described in the first paragraph under "Relief," above, provided the plan administrator (or financial institution in the case of distributions from IRAs) makes a good-faith diligent effort under the circumstances to comply with those requirements. However, as soon as practicable, the plan administrator (or financial institution in the case of IRAs) must make a reasonable attempt to assemble any forgone documentation. For example, if spousal consent is required for a plan loan or distribution and the plan terms require production of a death certificate if the employee claims his or her spouse is deceased, the plan will not be disqualified for failure to operate in accordance with its terms if it makes a loan or distribution to an individual described in the first paragraph under "Relief" in the absence of a death certificate if it is reasonable to believe, under the circumstances, that the spouse is deceased, the loan or distribution is made no later than March 15, 2018, and the plan administrator makes reasonable efforts to obtain the death certificate as soon as practicable. For purposes of this announcement, "retirement plan" has the same meaning as "eligible retirement plan" under § 402(c)(8)(B).

Taxpayers are reminded that in general the normal spousal consent rules continue to apply, and, except to the extent the distribution consists of already-taxed amounts, any distribution made pursuant to the relief provided in this announcement will be includible in gross income and generally subject to the 10-percent additional tax under § 72(t).

The Department of Labor has advised Treasury and the IRS that it will not treat any person as having violated the provisions of Title I of the Employee Retirement Income Security Act solely because that person complied with the provisions of this announcement.

Definition of Terms

Revenue rulings and revenue procedures (hereinafter referred to as "rulings") that have an effect on previous rulings use the following defined terms to describe the effect:

Amplified describes a situation where no change is being made in a prior published position, but the prior position is being extended to apply to a variation of the fact situation set forth therein. Thus, if an earlier ruling held that a principle applied to A, and the new ruling holds that the same principle also applies to B, the earlier ruling is amplified. (Compare with *modified*, below).

Clarified is used in those instances where the language in a prior ruling is being made clear because the language has caused, or may cause, some confusion. It is not used where a position in a prior ruling is being changed.

Distinguished describes a situation where a ruling mentions a previously published ruling and points out an essential difference between them.

Modified is used where the substance of a previously published position is being changed. Thus, if a prior ruling held that a principle applied to A but not to B, and the new ruling holds that it applies to both A and B, the prior ruling is modified because it corrects a published position. (Compare with *amplified* and *clarified*, above).

Obsoleted describes a previously published ruling that is not considered determinative with respect to future transactions. This term is most commonly used in a ruling that lists previously published rulings that are obsoleted because of changes in laws or regulations. A ruling may also be obsoleted because the substance has been included in regulations subsequently adopted.

Revoked describes situations where the position in the previously published ruling is not correct and the correct position is being stated in a new ruling.

Superseded describes a situation where the new ruling does nothing more than restate the substance and situation of a previously published ruling (or rulings). Thus, the term is used to republish under the 1986 Code and regulations the same position published under the 1939 Code and regulations. The term is also used when it is desired to republish in a single ruling a series of situations, names, etc., that were previously published over a period of time in separate rulings. If the new ruling does more than restate the substance of a prior ruling, a combination of terms is used. For example, *modified* and *superseded* describes a situation where the substance of a previously published ruling is being changed in part and is continued without change in part and it is desired to restate the valid portion of the previously published ruling in a new ruling that is self contained. In this case, the previously published ruling is first modified and then, as modified, is superseded.

Supplemented is used in situations in which a list, such as a list of the names of countries, is published in a ruling and that list is expanded by adding further names in subsequent rulings. After the original ruling has been supplemented several times, a new ruling may be published that includes the list in the original ruling and the additions, and supersedes all prior rulings in the series.

Suspended is used in rare situations to show that the previous published rulings will not be applied pending some future action such as the issuance of new or amended regulations, the outcome of cases in litigation, or the outcome of a Service study.

Abbreviations

The following abbreviations in current use and formerly used will appear in material published in the Bulletin.

A—Individual.
Acq.—Acquiescence.
B—Individual.
BE—Beneficiary.
BK—Bank.
B.T.A.—Board of Tax Appeals.
C—Individual.
C.B.—Cumulative Bulletin.
CFR—Code of Federal Regulations.
CI—City.
COOP—Cooperative.
Ct.D.—Court Decision.
CY—County.
D—Decedent.
DC—Dummy Corporation.
DE—Donee.
Del. Order—Delegation Order.
DISC—Domestic International Sales Corporation.
DR—Donor.
E—Estate.
EE—Employee.
E.O.—Executive Order.
ER—Employer.
ERISA—Employee Retirement Income Security Act.
EX—Executor.
F—Fiduciary.
FC—Foreign Country.
FICA—Federal Insurance Contributions Act.
FISC—Foreign International Sales Company.
FPH—Foreign Personal Holding Company.
F.R.—Federal Register.
FUTA—Federal Unemployment Tax Act.
FX—Foreign corporation.
G.C.M.—Chief Counsel's Memorandum.
GE—Grantee.
GP—General Partner.
GR—Grantor.
IC—Insurance Company.
I.R.B.—Internal Revenue Bulletin.
LE—Lessee.
LP—Limited Partner.
LR—Lessor.
M—Minor.
Nonacq.—Nonacquiescence.
O—Organization.
P—Parent Corporation.
PHC—Personal Holding Company.
PO—Possession of the U.S.
PR—Partner.
PRS—Partnership.
PTE—Prohibited Transaction Exemption.
Pub. L.—Public Law.
REIT—Real Estate Investment Trust.
Rev. Proc.—Revenue Procedure.
Rev. Rul.—Revenue Ruling.
S—Subsidiary.
S.P.R.—Statement of Procedural Rules.
Stat.—Statutes at Large.
T—Target Corporation.
T.C.—Tax Court.
T.D.—Treasury Decision.
TFE—Transferee.
TFR—Transferor.
T.I.R.—Technical Information Release.
TP—Taxpayer.
TR—Trust.
TT—Trustee.
U.S.C.—United States Code.
X—Corporation.
Y—Corporation.
Z—Corporation.

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