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Departments Propose Expanding Employers' HRA Options

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In response to last year's White House directive to expand employers' ability to offer HRAs to their employees and allow them to be used with non-group health coverage, the departments have issued proposed regulations that set out conditions under which an HRA can satisfy the ACA's market reforms through integration with individual coverage. The proposed rules also provide for an excepted benefit HRA option that would not be integrated with individual coverage. Treasury and IRS subsequently issued a notice that provides guidance on how HRAs integrated with individual coverage can comply with the ACA's employer mandate and Code Section 105(h) nondiscrimination requirements. Comments on both the proposed regulations and the notice are due by December 28, 2018, and the departments expect final rules to apply to plan years beginning on or after January 1, 2020.

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Background

A health reimbursement account (HRA) is a type of account-based group health plan funded solely through employer contributions that was first recognized by the IRS in 2002. Under IRS guidance, HRA funds may be used to reimburse an employee for medical care expenses (including copays, deductibles, medical expenses not covered by an employer's major medical plan, and premiums for healthcare coverage) incurred by the employee or the employee's dependents up to a maximum dollar amount for a coverage period. These reimbursements are excludable from an employee's taxable income and wages.

The Affordable Care Act (ACA) severely curtailed employers' use of HRAs for active employees. This is because most HRAs are group health plans subject to the ACA's market mandates, including the prohibition on annual and lifetime dollar limits, which they cannot satisfy unless they are integrated with other coverage; retiree-only HRAs are not subject to the ACA's market reforms but may be affected by other provisions of the proposed guidance. In 2013, the departments announced that HRAs subject to the

ACA mandates cannot be integrated with individual coverage or used on a "standalone" basis to purchasing health coverage in the individual marketplace. This meant that the only way an HRA could comply with ACA market mandates was if it was offered to employees enrolled in the employer's comprehensive group health plan coverage. (See our February 21, 2013 *For Your Information.*) In 2016, Congress enacted legislation that permitted certain small employers — generally those with 50 or fewer employees — to offer an HRA that pays or reimburses qualified medical expenses (including health insurance premiums) incurred by certain employees and their family members. This type of arrangement is known as a qualified small employer HRA, or QSEHRA. (See our December 16, 2016 *Legislate.*) However, Congress did not provide this relief to large employers.

Departments propose new HRA rules

In October 2017, the White House issued an executive order directing the departments of Treasury, Labor, and Health & Human Services (together, the departments) to consider new rules that would expand employers' ability to offer health reimbursement arrangements (HRAs) to their employees and to allow HRAs to be used in conjunction with non-group health coverage. (See our October 20, 2017 *Legislate.*) On October 23, 2018, the departments issued a new proposed rule, designed to expand the use of HRAs, that sets out conditions under which an HRA can satisfy the ACA's market reforms through integration with individual coverage and provides for an excepted benefit HRA option not integrated with individual coverage.

Individual coverage HRAs

The proposed rule would allow an HRA to satisfy the ACA's market reforms via integration with individual coverage. To qualify as an individual coverage HRA, an HRA must satisfy certain conditions. In the departments' view, these conditions "are necessary and appropriate to avoid the risk of market segmentation and to ensure that there are protections against discrimination based on health status" and thus avoid destabilizing the individual market.

Why offer individual coverage HRAs?

An employer may use individual coverage HRAs to:

- Provide tax-favored financial assistance to employees who are ineligible for the employer's health plan, such as part-time employees
- Satisfy the ACA employer shared responsibility requirement that it offer minimum essential coverage to at least 95 percent of its full-time employees (and thus avoid assessments)
- Replace the employer's health plan

Conditions for integration

- Enrollment in individual health insurance coverage. An individual must be enrolled in individual health insurance coverage for any given calendar month in order to be reimbursed by the HRA for medical expenses incurred during that month. Any individual coverage except coverage consisting exclusively of excepted benefits meets this requirement.
- No offer of traditional group health plan. A plan sponsor cannot offer the same class of employees a choice between an individual coverage HRA and traditional health insurance coverage.

The proposed employee classes are: (1) full-time; (2) part-time; (3) seasonal; (4) those in a collective-bargaining unit; (5) those who have not satisfied a waiting period for coverage; (6) those under age 25 at the beginning of the plan year; (7) non-resident aliens with no U.S.-based income; and (8) those whose primary site of employment is in the same rating area. The departments believe that these are classes that employers "use for benefits and other purposes" and that employers would be "unlikely to shift employees between the classes simply for purposes of offering an HRA."

> **Buck comment.** The departments did not propose employee classes based on form of compensation, such as hourly or salaried employees, expressing concern that employers could too easily change this status in an attempt to discriminate based on health status — but they asked for comments on whether a classification like this should be permitted.

> A plan sponsor must use either the definition of "full-time employee," "part-time employee," or "seasonal employee" under Code Section 4980H (ACA employer mandate provisions) or the definition of those terms under Code Section 105(h) (nondiscrimination testing of self-insured health plans). Once it chooses the Code section definition for a plan year, the plan sponsor must apply the definitions in that section for all three classes for that plan year. The HRA plan document must specify which Code section definition is being used and must be amended for any subsequent plan year if the plan sponsor changes these definitions.

Under the proposal, a class can consist of groups of employees described as a combination of two or more of the above classes — for example, part-time employees who are included in the same unit of employees that is covered by the collective bargaining agreement.

- HRA offered on same terms. A plan sponsor that offers an individual coverage HRA to a class of employees generally must offer the HRA on the same terms (including in the same amount) to all employees in the class. This rule would prevent a plan sponsor from offering an HRA in a larger amount to an individual who is known to have a medical condition that requires expensive treatments. Amounts carried over in an HRA from a prior year would be disregarded.

  However, the departments would permit variances in terms under specific circumstances. Recognizing that premiums typically increase based on the age and the number of covered dependents, the proposal allows for an increased HRA contribution based on these factors — so long as all similarly situated participants in the same class receive the same increase. The departments plan to create a safe harbor under which plans can increase the maximum amount available due to age without violating the Code Section 105(h) nondiscrimination rules.

  Additionally, recognizing that eligibility for retiree health coverage "varies widely," the proposed rules also allow for an HRA to be offered to some but not all former employees within a given class, so long as it is offered on the same terms to other employees within that class.

- Ability to Opt Out. An individual must have the opportunity at least annually to opt out of, and waive future reimbursements from, the HRA. This requirement would allow otherwise eligible individuals and covered dependents to receive a premium tax credit (PTC), a refundable credit available under certain conditions to cover premiums for marketplace health insurance. Individuals and covered dependents are not eligible for a PTC for a month in which the individual is enrolled in an HRA that is "affordable"

and provides "minimum value." (See our July 16, 2018 *For Your Information* for more on the PTC.) For determining affordability, the proposal uses the lowest cost silver plan for self-only coverage available to the employee through the marketplace for the rating area where the employee resides.

When an individual terminates employment, the amount in the HRA must be forfeited, or the individual must be allowed to permanently opt out of and waive future reimbursements from the HRA. This way, the former employee can choose whether to continue to participate in the HRA or to claim the PTC, if otherwise eligible to do so.

- Substantiation. An HRA must implement and comply with "reasonable procedures" to verify that individuals whose medical expenses the HRA reimburses are, or will be, enrolled in individual health insurance coverage during the plan year. The proposal allows for substantiation either via a document from a third party, like the insurer, or through self-attestation — and the HRA can rely on this documentation absent actual knowledge to the contrary. The substantiation requirement is ongoing, with verification required prior to each expense reimbursement.
- Notice. To ensure that individuals eligible to participate in an individual coverage HRA understand how the offer of enrollment can affect their ability to claim the PTC, the proposal requires the HRA to provide written notice to eligible participants at least 90 days before the beginning of each plan year, or no later than the date on which the participant first becomes eligible to participate in the HRA.

  The notice would have to include general information such as the maximum dollar amount made available under the HRA and the PTC eligibility consequences for a participant who accepts the HRA. However, it would not need to include participant specific information such as whether the HRA is considered affordable in a particular participant's circumstance.

New Marketplace Enrollment Opportunity

To facilitate access to individual coverage HRAs, employees and their dependents would have new marketplace special enrollment opportunities when they become eligible for and enroll in an HRA. These rules, which would also apply to QSEHRAs, create a special enrollment opportunity where an employer begins offering an individual coverage HRA mid-year, as well as where an employee becomes eligible for an individual coverage HRA mid-year. An individual would have 60 days before and after becoming enrolled in an individual coverage HRA or QSEHRA in which to enroll in marketplace coverage. Coverage would generally become effective on first day of the month following enrollment in the HRA (if the individual selects the marketplace coverage before becoming enrolled in the HRA) and the first day of the month following the individual's selection of the coverage (if the individual selects a marketplace plan on or after the date of HRA enrollment).

Individual Coverage and ERISA

ERISA applies to group health plans; however, individual coverage may be treated as group health plan coverage when paid for through employer contributions. The proposed rules state that the definition of "group health plan" for purposes of ERISA will not include individual health insurance coverage purchased by HRA funds if the following conditions are met:

- The purchase of the individual coverage by the employee is completely voluntary

- The HRA plan sponsor does not select or endorse any particular insurer or insurance coverage
- Reimbursement of nongroup health insurance premiums is limited solely to individual health insurance coverage
- The HRA plan sponsor receives no consideration in connection with the employee's selection or renewal of any individual health insurance coverage
- Each plan participant must be notified annually that the individual health coverage is not subject to ERISA

An employer may permit an employee to pay any remaining premium due for individual coverage integrated with an HRA through salary reduction without the coverage becoming subject to ERISA — if the above conditions are satisfied. Note, however, that Code Section 125(f)(3) prohibits the use of salary reductions to pay for individual coverage on the public marketplace, so this would only be applicable to individual coverage purchased outside of the marketplace.

> **Buck comment.** As the departments note, treatment of individual coverage as a group health plan "could result in conflicting requirements, uncertainty and confusion." For example, individual coverage would likely violate some of group health plan market rules — such as the single risk pool requirement.

Retiree-Only HRAs

Because retiree-only HRAs are exempt from the ACA's market mandates, the integration with group coverage requirement that currently applies to HRAs for active employees does not apply in the retiree-only HRA context. (See our August 24, 2015 *FYI*.) While the proposed provision on the application of ERISA to individual coverage purchased with HRA funds does not explicitly address retiree-only HRAs, there is some concern that the revised "group health plan" definition must be broader to ensure that the individual coverage purchased with retiree-only HRAs funds is not subject to ERISA. For example, many employers offering retiree-only HRAs require them to be used to purchase individual coverage through a private health exchange. Would this coverage be "voluntary" under the revised definition of "group health plan," as proposed? The final regulations may answer this question.

Excepted benefit HRAs

Health benefits that qualify as "excepted benefits" are not subject to ACA market reforms. Some types of benefits, such as accident-only coverage or on-site clinics, are excepted under all circumstances. Other benefits, such as limited-scope dental and vision benefits, employee assistance programs, wraparound coverage, and health flexible spending arrangements, are excepted only if they satisfy certain conditions. (See our October 8, 2014 *For Your Information*.)

What about HRAs covering existing excepted benefits?

Some employers currently offer HRAs that cover excepted benefits like vision and dental. The new proposed rules would not affect such HRAs — meaning that employers could continue to offer them without a dollar limit.

The proposed regulations recognize that there may be instances where an employer wants to offer an HRA that is not integrated with either other non-HRA group or individual coverage and would create an additional category of excepted benefit — an excepted benefit HRA — for this purpose. An excepted benefit HRA could be used to reimburse participants for the same types of medical expenses as permitted under an HRA generally — without

being subject to the ACA's market reforms. However, to qualify as an excepted benefit, the HRA (or other account-based group health plan other than a health FSA) would have to satisfy the following four conditions:

- Group health plan coverage must be available. The plan sponsor offering the HRA must make group health plan coverage (other than an account-based group health plan or coverage consisting solely of excepted benefits) available for the plan year to participants eligible for the HRA. However, HRA participants and their dependents would not be required to enroll in the other group health plan to be eligible for the excepted benefit HRA.
- Limitation on newly available benefits. Amounts newly made available in the HRA for a plan year cannot exceed $1,800, indexed for inflation for plan years beginning after December 31, 2020. If a plan sponsor provides more than one HRA or other account-based group health plan to the participant for the same period, the amounts newly made available under all such plans are aggregated to determine whether the limit has been exceeded. Amounts carried over from prior years are disregarded.
- No reimbursement of certain health insurance premiums. The excepted benefit HRA or other account-based group health plan generally may not be used to reimburse premiums for individual health insurance coverage, group health plan coverage, or for Medicare Parts B or D. However, it may be used to reimburse premiums for individual or group health plan coverage consisting solely of excepted benefits, such as limited-scope dental or vision coverage, premiums for COBRA and other continuation coverage, and for short-term, limited-duration insurance.
- Uniform availability. The excepted benefit HRA or other account-based group health plan must be available under the same terms to all similarly situated individuals, regardless of any health factor. The plan sponsor cannot condition eligibility based on a health factor (such as having or not having cancer) nor can it vary amounts available in an HRA on that basis. As with the proposed rules for HRAs integrated with individual coverage, this condition aims to prevent a plan sponsor from trying to steer participants or dependents with adverse health factors away from the sponsor's traditional group health plan.

Permissible to offer both individual coverage HRA and excepted benefit HRA?

No. As discussed above, an employer may offer an individual coverage HRA to a class of employees only if it does not also offer a traditional group health plan to the same employee class. In contrast, an employer may offer an excepted benefit HRA only if it also offers a traditional group health plan coverage to employees eligible for the excepted benefit HRA. For this reason, under the proposal, an employer could not offer both an individual coverage HRA and an excepted benefit HRA to any employee.

Satisfying employer mandate and section 105(h) nondiscrimination rules

Following the release of the proposed regulations, Treasury and IRS issued Notice 2018-88 on November 19, 2018 to address additional questions about HRAs integrated with individual coverage. Specifically, the notice addresses whether an employer that offers an individual coverage HRA made an offer of coverage that can satisfy the requirements of the "employer mandate." Employers have been unable to use HRAs to satisfy the employer mandate given the prohibition in the 2013 regulations against HRAs being integrated with individual coverage or used on a standalone basis as a means of purchasing marketplace coverage.

Notice 2018-88 provides that an HRA is an eligible employer-sponsored plan, and that an ALE that offers an individual coverage HRA to at least 95 percent of its full-time employees and dependents would not be subject to the (a) assessment. It proposes — and requests comments on — the following voluntary safe harbors that employers could use in assessing "affordability" for purposes of the (b) assessment:

Employer Mandate Refresher

This ACA requirement under Section 4980(h) provides that applicable large employers (ALEs) – generally those with at least 50 full-time employees – must either offer eligible employer-sponsored health coverage to 95 percent of full-time employees and their dependents or pay a nondeductible assessment if at least one full-time employee enrolls in marketplace coverage and receives a PTC (the "(a)" assessment). Even if they offer employees coverage, ALEs may still be subject to an assessment if the coverage they offer to full-time employees is "unaffordable" or fails to provide minimum value (the "(b)" assessment). (See our July 16, 2018 *FYI* for background on the employer mandate.)

- Lowest cost silver plan for self-only coverage offered by the exchange in the rating area of an employee's worksite location (rather than place of residence)
- Prior year's cost for calendar year individual coverage HRAs
- Cost of first month of coverage for the plan year, in the case of non-calendar year individual coverage HRAs

Alternatively, it is expected that ALEs will be able to use one of the safe harbors provided in the current Section 4980(h) regulations for determining affordability (W-2 wages, rate of pay, or federal poverty line). (See our May 24, 2018 *For Your Information* for background on these safe harbors.) Individual coverage HRAs that meet the affordability test under a proposed or existing safe harbor would be treated as providing minimum value.

Additionally, Treasury and IRS anticipate future guidance on how HRA arrangements that permit employees in different classes to receive different HRA amounts can satisfy Code Section 105(h) nondiscrimination rules, which generally require that employer contributions be uniform for all HRA participants. (See our November 8, 2017 *FYI In-Depth* for background Section 105(h) nondiscrimination rules.) Specifically, the notice indicates that an individual coverage HRA could comply with Section 105(h) if it provides the same maximum dollar amount to all employees in a class specified in the proposed

regulations, save any variations due to age that correlate with increases in the price of an individual policy in the relevant insurance market.

In closing

Comments on the proposed rule and notice are due by December 28, 2018, and a final rule is expected to go into effect for plan years beginning on or after January 1, 2020. It is not clear how much interest the individual coverage HRA model will generate among large employers. In a competitive job market, this approach may be attractive to employers not currently offering coverage to a segment of their employees — for example, part-timers — and seeking to recruit and retain employees. The existence (or lack thereof) of a robust individual coverage market in a given geographic area might affect an employer's interest in adopting this approach.

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