Published: November 7, 2018

Guidance Proposes to Broaden HRA Rules

Ed MacConnell | Total Benefit Solutions Inc. | (215) 355-2121 | edmac@totalbenefits.net

The Departments of Treasury, Labor, and Health and Human Services (collectively, the "Departments") issued proposed guidance that, if finalized, creates a mechanism for employers to offer Health Reimbursement Arrangements (HRAs) in connection with individual health insurance coverage.

The proposed regulations add two new HRA options for employers to consider:

- **HRA integrated with individual health insurance coverage.** Beginning with the first plan year on or after January 1, 2020, permit integration of an HRA with individual health insurance coverage provided certain conditions are met.

- **Excepted Benefit HRA.** Beginning with the first plan year on or after January 1, 2020, employers that offer traditional group health plan coverage may consider offering an Excepted Benefit HRA with a maximum annual benefit amount of $1,800.

The above options are in addition to the already existing options of (i) HRA integrated with group health plan coverage, (b) retiree-only HRA, (c) limited purpose dental and vision HRA, and (d) qualified small employer HRA (QSEHRA).

Additionally, the proposed rules provide helpful clarifications including:

- Individual health insurance policies purchased through an HRA (as allowed by this rule) or through a QSEHRAs do not become part of an ERISA plan, provided certain conditions are met.

- While premiums for individual health insurance coverage purchased through the Marketplace, referred to as a qualified health plan, may not be paid for by the employer pursuant to pre-tax salary reductions under a Section 125 Cafeteria plan, the rule permits employees to purchase non-qualified health plans (e.g., individual health insurance coverage not sold in the Marketplace) on a pre-tax basis, if the employer's cafeteria plan includes that option.

- The availability of premium tax credits (PTC) when the individual has access to an HRA that can be integrated with individual health insurance coverage.

- Special enrollment opportunity provided to purchase individual health insurance coverage (both inside and outside of the Marketplace) for individuals who gain access to an employer-based HRA that is integrated with individual health insurance coverage.

Currently, employers do not need to do anything with respect to their existing HRAs or coverage options. The guidance seeks comments on a variety of issues and is proposed to take effect for plan years beginning on or after January 1, 2020.

Nothing in these proposed rules overrides state insurance laws that prohibit employer contributions toward individual health insurance coverage.

The following summary highlights some of the important aspects of these rules and how they may affect employers looking to implement this type of arrangement.

Background

There is a lot of regulatory history that sets the stage for the changes included in the proposed rule. In a nutshell, the law has generally barred employers from offering (and paying for) individual health insurance policies.

Notably, the Affordable Care Act (ACA) and subsequent regulatory guidance:

- require that HRAs be integrated with group health plan coverage;

- prohibit integration of an HRA with individual health insurance coverage; and

- bar employers from paying for (or reimbursing) the purchase individual health insurance policies on behalf of an employee.

Noncompliance with this general prohibition could result in penalties of $100/per affected individual/per day ($36,500 for one individual per year).

At the time, the regulators required integration with group health plan coverage because, standing alone, an HRA could not meet the ACA requirements that (1) prohibit lifetime and annual dollar limits on essential health benefits (EHBs) (as HRAs have an annual dollar limit and reimburse EHBs) and (2) mandate preventive care services be covered without cost sharing. By integrating the HRA with otherwise ACA-compliant group health plan coverage, the HRA could be deemed to meet the ACA market rules.

The 21st Century Cures Act (the "Cures Act") was enacted in 2016 and, among other things, created QSEHRAs, HRAs that are not integrated with group health plan coverage available to certain small employers.

Integration Of An HRA With Individual Health Insurance Coverage

The rules expand HRA integration to allow integration with individual health insurance subject to the following conditions:

- Participants and any dependents covered by the HRA must be enrolled in individual health insurance coverage;
- A traditional group health plan may not be offered to the same participants;
- The HRA must be offered on the same terms to all participants within the same classification of employee;
- The participant who is otherwise eligible for the HRA must have the opportunity to "opt-out" and waive future reimbursements from the HRA at least annually;
- The participant must provide substantiation of individual health insurance coverage for the plan year; and
- Written notification describing the arrangement is provided at least annually.

Permitted classifications and "same terms" requirements

For this purpose, permitted classifications of employees are defined by the regulations and include;

- Full-time employees;
- Part-time employees;
- Seasonal employees;
- Collectively bargained employees;
- Employees who have not satisfied a waiting period;
- Employees who are under age 25 when the plan year begins;
- Non-resident aliens with no U.S. based income (generally foreign employees who work abroad); and
- Employees who work in the same geographic rating area for purposes of insurance underwriting.

Notably, a classification of salaried vs. hourly is not a permissible classification under these rules.

For purposes of defining "full-time employee," "part-time employee," and "seasonal employee", the proposed rule requires the use of either:

- The definitions under the employer mandate (Code Section 4980H); or
- The definitions as used in the nondiscrimination rules for self-insured health plans (Code Section 105(h)).

The elected definition must be included in the HRA plan document and consistent across all classifications (i.e., if the 4980H definition is used for full-time employees, it must be used for part-time and seasonal employees).

Additionally, under the proposed rule, the maximum dollar amount available for reimbursement to participants in a class of employees may be increased based on the following:

- As the age of the participant increases, so long as the same dollar amount is available to all participants in the classification who are the same age;

- The number of dependents who are covered under the HRA increases, so long as the same dollar amount is available to all participants in the classification who have the same number of dependents.

As varying HRA benefit amounts by age or number of dependents may give rise to discrimination issues under Code Section 105(h), the IRS is expected to provide a safe harbor to alleviate the discrimination issue if certain conditions are met.

Substantiation Requirements

The HRA must implement, and comply with, reasonable procedures to verify that participants and dependents are (or will be) enrolled in individual health insurance coverage for the plan year. To properly substantiate the participant may provide:

- A document from the carrier (or other third party) showing the participant and dependents covered by the HRA are (or will be) enrolled in individual health insurance (e.g., an insurance card, explanation of benefits (EOB)); or

- Attestation by the participant stating the participant and dependents covered by the HRA are or will be enrolled in individual health insurance coverage, the date coverage began (or will begin) and the name of the provider of the coverage.

Additionally, for each reimbursement request, the participant (and, if applicable, the dependent who received the medical care) must substantiate that he or she continues to be enrolled in individual health insurance coverage for the month during which the medical care expense was incurred. The substantiation may be in the form of an attestation.

The employer offering the HRA may rely on the participant's documentation or attestation unless there is actual knowledge that any individual covered by the HRA is not (or will not be) enrolled in individual health insurance coverage for the plan year or the month, as applicable.

Notice requirements

The HRA must provide written notice at least 90 days prior to the start of the plan year that meets content requirements outlined by the regulation. The notice includes a description of the HRA, the maximum dollar amounts available, opt-out and waiver rights, effect of the coverage on availability of any premium tax credit, and the substantiation rules.

ERISA Implications

The proposed rule clarifies that ERISA generally will not apply to the underlying individual health insurance coverage that is purchased through the HRA so long as:

- The purchase of individual health insurance coverage is voluntary for participants and beneficiaries. The fact that the employer requires such coverage to be purchased as a condition for participation in the HRA does not make the purchase involuntary.
- The employer does not select or endorse any issuer or coverage. Providing general information regarding the availability of health insurance in a state or general health insurance educational information is not considered endorsement for this purpose.
- Reimbursement is limited solely to individual health insurance coverage.
- The plan sponsor receives no consideration in the form of cash or otherwise in connection with the employee's selection or renewal of any individual health insurance coverage.
- Each plan participant is notified annually that the individual health insurance coverage is not subject to Title I of ERISA.

While the individual health insurance policies are not subject to ERISA if they meet these requirements, the HRA remains subject to all ERISA requirements (including COBRA).

Premium Tax Credit Implications

Under the proposed rule, an employee who is offered an HRA that is integrated with individual health insurance coverage is considered to have minimum essential coverage (MEC) under an eligible employer sponsored plan so long as the coverage is (1) affordable and (2) the employee does not opt-out and waive future reimbursements from the HRA. If the employee has MEC, he or she may not be eligible for a PTC. The proposed rules go into great detail regarding how affordability is determined for this purpose. As the guidance and comments develop, we will provide further clarification.

Employer Mandate Implications

To the extent Applicable Large Employers (ALEs) consider offering an HRA integrated with individual health insurance coverage, the IRS indicates subsequent guidance will include a safe harbor for purposes of determining whether an offer of such coverage is considered an affordable offer of minimum value coverage for purposes of 4980H (the employer mandate), regardless of whether the employee who was offered such coverage, declined the HRA, and claims a PTC.

Additionally, future guidance is expected to extend the existing affordability safe harbors (W-2, Rate of Pay, and Federal Poverty Level) to employers offering an HRA integrated with individual coverage.

State Law

Some state insurance laws bar employers from purchasing (directly or indirectly) health insurance coverage from the individual market on behalf of employees. Both Oregon and Texas prohibit this practice. Nothing in these federal rules overwrites the state's authority to regulate individual insurance markets. Therefore, it appears prohibitions at the state level remain valid and may limit this HRA option in certain areas.

Excepted Benefit HRA

The regulations create a new, limited Excepted Benefit HRA (EB HRA). This type of HRA is different from an integrated group health plan HRA and subject to more restrictive conditions.

To be considered an EB HRA (or other account-based plan), the arrangement must meet the following conditions:

- There must be other group health plan coverage available for the plan year to participants that is not limited to excepted benefits and is not an HRA or other account-based plans.
- The benefit amount available each year cannot exceed $1,800. The $1,800 will have a cost-of-living adjustment annually beginning with the 2021 plan year.
- The arrangement cannot reimburse premiums for individual health insurance coverage, group health plan coverage (other than COBRA premiums), or Medicare Part B or Part D premiums. There is an exception that would allow this arrangement to reimburse premiums for coverage that is an excepted benefit and otherwise eligible for reimbursement (e.g. short-term limited duration plans).
- The EB HRA (or other account-based group health plan) is made available under the same terms to similarly situated individuals regardless of any health factor.

Notably:

- While the EB HRA must be offered with other group health plan coverage, participants are not required to enroll in the group health plan coverage. Thus, a participant can decline the group health plan coverage but accept the EB HRA. This is a significant difference from integrated HRAs (which require group health plan coverage).
- If an employer offers an EB HRA, the employer may not offer a QSEHRA or HRA that is integrated with individual health insurance coverage.

Employer Action

- No action is required by employers as this rule is in proposed format and cannot be relied on at this point.
- If interested, employers and other stakeholders may provide comments to the Departments by December 28, 2018.
- Stay tuned for further guidance on this topic.