Tri-Agency Proposed Rule on Health Reimbursement Arrangements

The Department of the Treasury (Treasury), Department of Labor (DOL), and Department of Health and Human Services (HHS) (collectively, the Departments) released their proposed rule regarding health reimbursement arrangements (HRAs) and other account-based group health plans. The DOL also issued a news release and fact sheet on the proposed rule.

The proposed rule's goal is to expand the flexibility and use of HRAs to provide individuals with additional options to obtain quality, affordable healthcare. According to the Departments, these changes will facilitate a more efficient healthcare system by increasing employees' consumer choice and promoting healthcare market competition by adding employer options.

To do so, the proposed rules would expand the use of HRAs by:

- Removing the current prohibition against integrating an HRA with individual health insurance coverage (individual coverage)
- Expanding the definition of limited excepted benefits to recognize certain HRAs as limited excepted benefits if certain conditions are met (excepted benefit HRA)
- Providing premium tax credit (PTC) eligibility rules for people who are offered an HRA integrated with individual coverage
- Assuring HRA and Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) plan sponsors that reimbursement of individual coverage by the HRA or QSEHRA does not become part of an ERISA plan when certain conditions are met
- Changing individual market special enrollment periods for individuals who gain access to HRAs integrated with individual coverage or who are provided QSEHRAs

Public comments are due by December 28, 2018. If the proposed rule is finalized, it will be effective for plan years beginning on or after January 1, 2020.

Background

An HRA is a type of account-based group health plan funded solely by employer contributions that reimburses an employee for Internal Revenue Code Section 213(d) medical care expenses incurred by

the employee, or the employee's spouse, dependents, and children who are not age 27 as of the end of the taxable year, up to a maximum fixed-dollar amount during a coverage period.

These reimbursements are excludable from the employee's income and wages for federal income tax and employment tax purposes. An HRA can allow amounts that remain at the end of the year to be available to reimburse medical care expenses incurred in later years.

Integration Rules

The proposed rule would allow an HRA to be integrated with individual coverage (other than coverage that consists solely of excepted benefits), including student health insurance coverage.

The HRA's integration with individual coverage will comply with the Patient Protection and Affordable Care Act (ACA) requirement of preventive services coverage without cost-sharing and the ACA's prohibition against annual and lifetime limits if the HRA requires the participant and any dependents to be enrolled in individual coverage for each month the individuals are covered by the HRA.

Nondiscrimination

To prevent a plan sponsor (employer) from intentionally or unintentionally, directly or indirectly, steering any participants or dependents with adverse health factors away from the employer's traditional group health plan and into the individual market, the proposed integration rules prohibit an employer from offering the same class of employees both a traditional group health plan and an HRA integrated with individual coverage.

When an employer offers an HRA that is integrated with individual coverage to a class of employees, the proposed integration rules require that the HRA be offered on the same terms (both in the same amount and on the same terms and conditions) to all employees within the class.

If an employer allows carryover of unused HRA amounts for use in future plan years, these carryover amounts will be disregarded when determining whether the HRA is offered on the same terms, if the method for determining whether participants have access to unused amounts (and for determining the amount of unused funds) in future years is the same for all participants in a class of employees.

However, an employer would violate the integration rules if it offers a more generous HRA to individuals based on an adverse health factor.

Because HRA participants' individual coverage premiums may vary by age and family size, there is an exception to the "same terms" rule described above. An employer can increase the HRA amount for a class of employees if the increase is attributable to differences in age or family size. Because an HRA with a maximum dollar amount that varies based on age may have difficulty passing Section 105(h) nondiscrimination testing's uniformity requirement, the Treasury and IRS intend to issue guidance to describe a safe harbor that, if certain conditions are met, would allow such an HRA to satisfy the uniformity requirement.

Classes of Employees

Under the proposed rule, an employer may only offer:

- the HRA on different terms to different groups of employees, and
- either an HRA integrated with individual health insurance coverage, or a traditional group health plan by groups of employees,

if the groups are the following specific classes of employees, subject to certain exceptions:

1. Full-time employees (using either the definition that applies for purposes of Section 105(h) or 4980H of the Code, as determined by the employer)
2. Part-time employees (using either the definition that applies for purposes of Section 105(h) or 4980H of the Code, as determined by the employer)
3. Seasonal employees (using either the definition that applies for purposes of Section 105(h) or 4980H of the Code, as determined by the employer)
4. Employees who are included in a unit of employees covered by a collective bargaining agreement (CBA) in which the employer participates
5. Employees who have not satisfied a waiting period for coverage
6. Employees who have not reached age 25 before the beginning of the plan year
7. Non-resident aliens with no U.S.-based income (generally, foreign employees who work abroad)
8. Employees whose primary site of employment is in the same rating area

Further, an employer may group the classes above in combinations of two or more to be an additional class of employees. An employer that offers an HRA to former employees would place them in the same class as the employees were in before their service separation. Further, the HRA must be offered to those former employees on the same terms as all other employees within the class.

An employer must draft its HRA document to define its classes of employees prior to the beginning of the plan year when the definitions will apply.

Opt-Out and Waiver of Future Reimbursements

The HRA must require that medical care expenses for any individual covered by the HRA will not be reimbursed if the individual ceases to be covered by individual coverage. Further, if an individual covered by the HRA ceases to be covered by individual coverage, the participant must forfeit the HRA, according to applicable laws (including COBRA and other continuation of coverage requirements).

The HRA must allow participants to opt out of and waive future reimbursements from the HRA at least annually. Further, upon employment termination, either the remaining amounts in the HRA must be forfeited or the participant must be allowed to permanently opt out of and waive future reimbursements from the HRA. This ensures that the participant may choose to either claim the PTC, if eligible, or continue HRA participation after service separation.

Premium Contributions Through a Cafeteria Plan

If premium contributions are run through a Section 125 cafeteria plan, the employer may permit employees who purchase individual coverage outside the Exchange to pay premiums through the cafeteria plan. However, employers are prohibited from allowing employees who purchase individual coverage on the Exchange to pay premiums through a cafeteria plan.

If an employer makes a salary reduction arrangement under a cafeteria plan, the arrangement must be made available to any participant in a class of employees on the same terms to all participants (other than former employees) in a class of employees.

Individual Coverage Substantiation

To be integrated with individual coverage, the HRA must require participants and any dependents covered by the HRA to be enrolled in individual coverage and to substantiate compliance with this requirement.

An HRA must implement reasonable procedures to verify that individuals whose medical care expenses are reimbursable by the HRA are, or will be, enrolled in individual coverage during the plan year.

Reasonable enrollment substantiation procedures may include requiring a participant to provide:

- a third-party document (for example, from the issuer) showing that the participant and any dependents covered by the HRA are, or will be, enrolled in individual coverage during the plan year (for example, an insurance card or an explanation of benefits for the relevant time period); or
- a participant attestation that the participant and any dependents are or will be enrolled in individual coverage, the date coverage began or will begin, and the coverage provider's name.

An HRA may rely on the participant's attestation or documentation unless the HRA has actual knowledge that an individual is not, or will not be, enrolled in individual coverage for the plan year.

Following the initial coverage substantiation, with each new reimbursement request of an incurred medical care expense for the same plan year, the participant must provide substantiation that the participant and any dependents whose medical care expenses are requested to be reimbursed continue to be enrolled in individual coverage for the month when the medical care expenses were incurred. The attestation may be part of the reimbursement request form.

As with enrollment substantiation for the plan year, an HRA may rely on the participant's attestation or documentation unless the HRA has actual knowledge that the participant or any individual seeking reimbursement for the month was not enrolled in individual coverage for the month.

Notice Requirement

The HRA would be required to provide a written notice to each participant at least 90 days before the beginning of each plan year. For participants who are not yet eligible to participate at the beginning of the plan year (or who are not eligible when the notice is provided at least 90 days prior to the beginning of the plan year), the HRA would be required to provide the notice no later than the date on which the participant is first eligible to participate in the HRA.

The proposed written notice would be required to include:

- a description of the HRA's terms, including the maximum dollar amount made available;
- a statement of the participant's right to opt-out of and waive future reimbursement under the HRA;
- a description of the potential availability of the PTC if the participant opts out of and waives the HRA and the HRA is not affordable under the proposed PTC regulations;
- a description of the PTC eligibility consequences for a participant who accepts the HRA;
- a statement that the participant must inform any Exchange to which he or she applies for advance PTC payments of the availability of the HRA, the HRA amount, the number of months the HRA is available to the participant during the plan year, whether the HRA is available to the participant's dependents, and whether the participant is a current or former employee;
- a statement that the participant should retain the written notice because it may be needed to determine whether the participant is allowed the PTC;
- a statement that the HRA may not reimburse any medical care expense unless the substantiation requirements are met; and
- a statement that the participant must inform the HRA if the participant or any dependent whose medical care expenses are reimbursable by the HRA is no longer enrolled in individual coverage.

The notice would provide some of the information that participants need in order to understand how the HRA may impact PTC eligibility. The notice would also inform participants of their responsibilities under the HRA. If certain requirements are met, the notice would be required to also include a statement to advise participants that individual coverage integrated with the HRA is not subject to ERISA.

The written notice would be permitted to include other information if it does not conflict with the proposed rule's required notice information.

Excepted Benefit HRAs

If an employer wants to offer an HRA that is not integrated with non-HRA group coverage, Medicare, TRICARE, or individual coverage, the HRA must meet the following requirements to qualify as an excepted benefit HRA:

1. The HRA must not be an integral part of the plan.
2. The HRA must provide benefits that are limited in amount (not to exceed $1,800, indexed for inflation for plan years beginning after December 31, 2020).
3. The HRA cannot provide reimbursement for premiums for certain health insurance coverage (such as individual coverage, coverage under a group health plan (other than COBRA or other group continuation coverage), or Medicare Parts B or D).
4. The HRA must be made available under the same terms to all similarly situated individuals (as defined by HIPAA's nondiscrimination regulations) regardless of any health factor.

An excepted benefit HRA would be allowed to reimburse premiums for individual coverage that consists solely of excepted benefits (such as limited scope dental or vision benefits), coverage under a group health plan that consists solely of excepted benefits, short-term limited duration insurance (STLDI) premiums, and COBRA premiums.

An employer can only offer an excepted benefit HRA if traditional group health plan coverage is also made available to the employees who are eligible to participate in the excepted benefit HRA. An employer would not be permitted to offer both an HRA integrated with individual coverage and an excepted benefit HRA to any employee.

Premium Tax Credit

An employee who is offered an HRA integrated with individual coverage but opts out of it, and an individual who is offered such an HRA because of a relationship to the employee (a related HRA individual), are eligible for minimum essential coverage (MEC) under an eligible employer-sponsored plan for any month the HRA is affordable and provides minimum value (MV). These individuals are ineligible for the PTC for their Exchange coverage for the months the HRA is affordable and provides MV.

An employee's required HRA contribution would be the excess of:

1. the monthly premium for the lowest cost silver plan for self-only coverage available to the employee through the Exchange for the rating area where the employee lives; over
2. the monthly self-only HRA amount provided by the employee's employer, or, if the employer offers an HRA that provides for a single dollar amount regardless of whether an employee has self-only or other-than-self-only coverage, the monthly maximum amount available to the employee.

Under the proposed rules, the monthly self-only HRA amount would be the self-only HRA amount newly made available to the employee under the HRA for the plan year, divided by the number of months in the plan year the HRA is available to the employee.

The monthly maximum amount available to the employee under the HRA, which is relevant if the HRA provides one amount regardless of the number of individuals covered, would be the maximum amount newly made available to the employee under the HRA, divided by the number of months in the plan year the HRA is available to the employee.

Under the proposed PTC regulations, an employee who is offered an HRA integrated with individual coverage would not be eligible to claim the PTC for Exchange coverage unless the premium of the lowest cost silver plan for self-only coverage offered by the Exchange for the rating area in which the employee resides less the HRA amount exceeds 9.5 percent (indexed) of the employee's household income.

Please see this Advisor's Appendix for examples from the proposed rule for determining affordability.

Employer Shared Responsibility Provisions

Generally, an applicable large employer (ALE) will owe "Penalty A" under Section 4980H(a) if it fails to offer an eligible employer-sponsored plan to at least 95 percent of its full-time employees and their dependents and at least one full-time employee is allowed the PTC for the month. If an ALE offers an eligible employer-sponsored plan (including an HRA) to at least 95 percent of its full-time employees and their dependents, the employer would not be liable for Penalty A for that month.

According to the proposed rule, an ALE may owe "Penalty B" under Section 4980H(b) if at least one full-time employee is allowed the PTC, which may occur if the eligible employer-sponsored plan offered was not affordable or did not provide MV, or if the employee was not offered coverage.

The extent to which a full-time employee who was offered an HRA will be eligible for the PTC depends on the rules proposed under Section 36B.

The Treasury and the IRS intend to issue guidance that describes an anticipated safe harbor for purposes of determining whether an employer that has offered an HRA integrated with individual coverage would be treated as having made an offer of affordable coverage that provides MV for purposes of Section 4980H, regardless of whether the employee who received that offer declines the HRA and claims the PTC.

Individual Coverage and ERISA Plan Status

The DOL clarifies that the ERISA terms "employee welfare benefit plan," "welfare plan," and "group health plan" do not include individual coverage if, among other items, the employer, employee organization, or other plan sponsor is not involved in selecting the individual coverage that is integrated with the HRA.

Under the proposed rule, the ERISA status of an HRA, QSEHRA, or supplemental salary reduction arrangement would remain unaffected.

However, individual coverage selected by the employee in the individual market and reimbursed by such a plan would not be treated as part of a group health plan, or as health insurance coverage offered in connection with a group health plan, or as a part of any employee welfare benefit plan for purposes of ERISA's Title I, if all the following conditions are satisfied:

- The purchase of any individual coverage is completely voluntary for employees.
- The employer, employee organization, or other plan sponsor does not select or endorse any particular issuer or insurance coverage. Providing general contact information regarding availability of health insurance in a state (such as providing information regarding www.healthcare.gov or contact information for a state insurance commissioner's office) or providing general health insurance educational information (such as the uniform glossary of health coverage and medical terms) is permitted.
- Reimbursement for nongroup health insurance premiums is limited solely to individual coverage.
- The employer, employee organization, or other plan sponsor receives no cash or other consideration in connection with the employee's selection or renewal of any individual coverage.
- Each plan participant is notified annually that the individual coverage is not subject to ERISA. For an HRA integrated with individual coverage, the notice must meet the requirements set forth in the proposed integration rules at 29 CFR 2590.702-2(c)(6). For a QSEHRA or an HRA that is not subject to 29 CFR 2590.702-2(c)(6), an employer may use the following model language to satisfy this condition:

  > "The individual health insurance coverage that is paid for by this plan, if any, is not subject to the rules and consumer protections of the Employee Retirement Income Security Act. You should contact your state insurance department for more information regarding your rights and responsibilities if you purchase individual health insurance coverage."

  An employer does not need to provide the notice with a supplemental salary reduction arrangement because the notice will be provided by the HRA or QSEHRA that the salary reduction arrangement supplements.

Individual Market Special Enrollment Periods

To allow employees to take advantage of QSEHRAs and HRAs that are integrated with individual coverage, HHS proposes to allow employees and their dependents to enroll in individual coverage or to change from one individual coverage plan to another plan outside of the individual market annual open enrollment period, if they gain access to an HRA integrated with individual coverage or a QSEHRA.

Also, an employee or an employee's dependent who gains access to an HRA integrated with individual coverage or who is provided a QSEHRA may elect to enroll in or change to different Exchange or off-Exchange individual coverage.

HHS proposes that the special enrollment period's coverage effective date would be the first day of the first month following an individual's plan selection.

Further, HHS proposes a special enrollment period advance availability option to allow qualified individuals, enrollees, and dependents to qualify up to 60 days in advance of the qualifying event.

Proposed Applicability Date

The HRA integration, HRA excepted benefit provisions, and DOL clarification are proposed to apply to group health plans and health insurance issuers for plan years beginning on or after January 1, 2020.

The PTC provisions are proposed to be effective for taxable years beginning on and after January 1, 2020. The HHS special enrollment period provisions are proposed to be effective January 1, 2020.

10/24/2018

Appendix

Below are the Departments' affordability examples from the proposed rule.

(ix) Examples. The following examples illustrate the provisions of this paragraph (c)(5). The required contribution percentage is defined in paragraph (c)(3)(v)(C) of this section and is updated annually. Because the required contribution percentage for 2020 has not yet been determined, the examples assume a required contribution percentage for 2020 of 9.86%.

(A) Example 1. Determination of affordability. (1) In 2020 Taxpayer A is single, has no dependents, and has household income of $28,000. A is an employee of Employer X for all of 2020. X offers its employees an HRA described in paragraph (c)(3)(i)(B) of this section that reimburses $2,400 of medical care expenses for single employees with no children (the self-only HRA amount) and $4,000 for employees with a spouse or children for the medical expenses of the employees and their family members. A enrolls in a qualified health plan through the Exchange in the rating area in which A resides and remains enrolled for all of 2020. The monthly premium for the lowest cost silver plan for self-only coverage of A that is offered in the Exchange for the rating area in which A resides is $500.

(2) A's required HRA contribution, as defined in paragraph (c)(5)(ii) of this section, is $300, the excess of $500 (the monthly premium for the lowest cost silver plan for self-only coverage of A) over $200 (1/12 of the self-only HRA amount provided by Employer X to its employees). In addition, 1/12 of the product of 9.86 percent and A's household income is $230 ($28,000 x .0986 = $2,761; $2,761/12 = $230). Because A's required HRA contribution of $300 exceeds $230 (1/12 of the product of 9.86 percent and A's household income), the HRA is unaffordable for A for each month of 2020 under paragraph (c)(5) of this section. If A opts out of and waives future reimbursements from the HRA, A is not eligible for minimum essential coverage under the HRA for each month of 2020 under paragraph (c)(3)(i)(B) of this section.

(B) Example 2. Determination of affordability for a related HRA individual. (1) In 2020 Taxpayer B is married and has one child who is a dependent of B for 2020. B has household income of $28,000. B is an employee of Employer X for all of 2020. X offers its employees an HRA described in paragraph (c)(3)(i)(B) of this section that reimburses $3,600 of medical care expenses for single employees with no children (the self-only HRA amount) and $5,000 for employees with a spouse or children for the medical expenses of the employees and their family members. B, B's spouse, and B's child enroll in a qualified health plan through the Exchange in the rating area in which B resides and they remain enrolled for all of 2020. No advance credit payments are made for their coverage. The monthly premium for the lowest cost silver plan for self-only coverage of B that is offered in the Exchange for the rating area in which B resides is $500.

(2) B's required HRA contribution, as defined in paragraph (c)(5)(ii) of this section, is $200, the excess of $500 (the monthly premium for the lowest cost silver plan for self-only coverage for B) over $300 (1/12 of the self-only HRA amount provided by Employer X to its employees). In addition, 1/12 of the product of 9.86 percent and B's household income for 2020 is $230 ($28,000 x .0986 = $2,761; $2,761/12 = $230). Because B's required HRA contribution of $200 does not exceed $230 (1/12 of the product of 9.86 percent and B's household income for 2020), the HRA is affordable for B under paragraph (c)(5) of this section, and B is eligible for minimum essential coverage under an eligible employer-sponsored plan for each month of 2020 under paragraph (c)(3)(i)(B) of this section. In addition, B's spouse and child are also eligible for minimum essential coverage under an eligible employer-sponsored plan for each month of 2020 under paragraph (c)(3)(i)(B) of this section.

(C) Example 3. Exchange determines that HRA is unaffordable. (1) The facts are the same as in Example 2, except that B, when enrolling in Exchange coverage for B's family, received a determination by the Exchange that the HRA was unaffordable, because B believed B's household income would be lower than it turned out to be. Consequently, advance credit payments were made for their 2020 coverage.

(2) Under paragraph (c)(5)(iv) of this section, the HRA is considered unaffordable for B, B's spouse, and B's child for each month of 2020 provided that B did not, with intentional or reckless disregard for the facts, provide incorrect information to the Exchange concerning the HRA or B's household income.

(D) Example 4. Affordability determined for part of a taxable year (part-year period). (1) Taxpayer C is an employee of Employer X. C's household income for 2020 is $28,000. X offers its employees an HRA described in paragraph (c)(3)(i)(B) of this section that reimburses medical care expenses of $3,600 for single employees without children (the self-only HRA amount) and $5,000 to employees with a spouse or children for the medical expenses of the employees and their family members. X's HRA plan year is September 1 to August 31 and C is first eligible to participate in the HRA for the period beginning September 1, 2020. C enrolls in a qualified health plan through the Exchange in the rating area in which C resides for all of 2020. The monthly premium for the lowest cost silver plan for self-only coverage of C that is offered in the Exchange for the rating area in which C resides for 2020 is $500.

(2) Under paragraph (c)(3)(vi) of this section, the affordability of the HRA is determined separately for the period September 1 through December 31, 2020, and for the period January 1 through August 31, 2021. C's required HRA contribution, as defined in paragraph (c)(5)(ii) of this section, for the period September 1 through December 31, 2020, is $200, the excess of $500 (the monthly premium for the lowest cost silver plan for self-only coverage for C) over $300 (1/12 of the self-only HRA amount provided by X to its employees). In addition, 1/12 of the product of 9.86 percent and C's household income is $230 ($28,000 x .0986 = $2,761; $2,677/12 = $230). Because C's required HRA contribution of $200 does not exceed $230, the HRA is affordable for C for each month in the period September 1 through December 31, 2020, under paragraph (c)(5) of this section. Affordability for the period January 1 through August 31, 2021, is determined using C's 2021 household income and required HRA contribution.

(E) Example 5. Carryover amounts ignored in determining affordability. (1) Taxpayer D is an employee of Employer X for all of 2020 and 2021. D is single. For each of 2020 and 2021, X offers its employees an HRA described in paragraph (c)(3)(i)(B) of this section that provides reimbursement for medical care expenses of $2,400 to single employees with no children (the self-only HRA amount) and $4,000 to employees with a spouse or children for the medical expenses of the employees and their family members. Under the terms of the HRA, amounts that an employee does not use in a calendar year may be carried over and used in the next calendar year. In 2020, D used only $1,500 of her $2,400 maximum reimbursement and the unused $900 is carried over and may be used by D in 2021.

(2) Under paragraph (c)(5)(v) of this section, only the $2,400 self-only HRA amount offered to D for 2021 is considered in determining whether D's HRA is affordable. The $900 carryover amount is not considered in determining the affordability of the HRA.