Hip, Hip, HRA? New Rules Regarding Account-Based Group Health Plans Could Have Some Employers Cheering

PUBLISHED: June 25, 2019

AUTHORS: Kathryn Amin, Christine Keller, Rachel Leiser Levy, Stephen Pennartz, Seth Perretta, Malcolm Slee, Brigen Winters

On June 13, the Departments of Treasury, Labor, and Health and Human Services (the "Departments") issued final regulations (the "Final Regulations") regarding health reimbursement arrangements ("HRAs") and other account-based group health plans, along with model attestations, notices, and frequently asked questions. The new rules potentially make it easier for employers to provide health coverage to their employees through HRAs. In the wake of the new rules, however, employers that currently use a traditional group plan model will likely have many questions about whether their workforce will be willing to adapt to a solely account-based model and the logistics involved in making such a move. Below, we summarize the Final Regulations and discuss some of the issues involved.

Background

The Final Regulations are the last outstanding item issued in response to President Trump's Executive Order No. 13813 ("Promoting Healthcare Choice and Competition Across the United States") (the "Executive Order"). The Executive Order directed the Departments to consider issuing sweeping new healthcare guidance in a stated effort to lower premium costs and increase choice in the individual health insurance market. One of the Executive Order's initiatives was expanding the use and availability of HRAs.

The Final Regulations create two new methods by which employees may use HRA dollars in conjunction with health insurance purchased on the individual market. The first method permits the use of HRA funds to purchase individual health insurance coverage or Medicare (thereby creating

opportunities for "Individual Coverage HRAs" or "ICHRAs"). The second method creates a limited-dollar HRA that employees may use to pay for most out-of-pocket medical expenses ("Excepted Benefit HRAs" or "EBHRAs").

Individual Coverage HRAs

A. Integration Rules

Guidance previously issued by the Departments in 2013 provided that an HRA (or other employer-sponsored arrangement designed to pay for health coverage purchased in the individual market) for active employees had to be "integrated" with another group health plan to satisfy the Affordable Care Act's ("ACA's") market reform requirements. The stated legal rationale for this earlier guidance was that a stand-alone HRA or other similar arrangement for active employees would fail to satisfy two of the ACA's "market reform" provisions: the prohibition against annual dollar limits on essential health benefits; and the requirement to provide certain preventive services without cost-sharing. The Final Regulations permit an ICHRA to be integrated with certain qualifying *individual* health plan coverage or Medicare in order to satisfy the market reforms. In order to be "integrated" with individual market coverage/Medicare, the Final Regulations provide that the ICHRA must meet several conditions, described below.

1. *Requirement that All Individuals Covered by the HRA Are Enrolled in Individual Health Insurance or Medicare Coverage*

In order to be integrated with individual market health insurance coverage, any participant (regardless of whether a current or former employee) and dependent who can receive reimbursements from the ICHRA *must* be enrolled in individual market health insurance or Medicare coverage for each month that they are covered by the ICHRA. Substantiation of enrollment in such coverage is required (the substantiation requirements are discussed below).

2. *Prohibition Against Offering Both an HRA Integrated with Individual Health Insurance Coverage and a Traditional Group Health Plan to the Same Class of Employees*

Generally, an employer may not offer an ICHRA to a class of employees if the employer offers a "traditional group health plan" to the same class of employees. A "traditional group health plan" is defined as any group health plan *except* (i) an account-based health plan, and (ii) a plan that consists solely of excepted benefits. However, employers are permitted to create "classes" within their workforce, based on nine specified "classes" enumerated in the Final Regulations (e.g., full-time, part-time, salaried, non-salaried, etc.). If the employer offers an ICHRA to an employee in a given class, it must offer the ICHRA on the same terms to all employees in that class, but could offer a traditional group health plan to employees in a different class.

GROOM INSIGHT: Helpfully, the Final Regulations clarify that the employee classes are to be applied using a common law employer standard and not on a controlled group basis. This should provide additional helpful flexibility for controlled group employers considering the possible use of an ICHRA.

If an employer is considering developing "classes" of employees for purposes of offering an ICHRA, it should be aware that the Final Regulations add minimum class size requirements for certain classes, in an attempt to prevent adverse selection in the individual market. The minimum class size depends on the size of the employer.

GROOM INSIGHT: The Final Regulations allow an employer to offer an ICHRA to newly hired employees in a class, while not offering an ICHRA and/or offering a traditional group health plan to ongoing employees in the same class. This is helpful for employers that want to slowly transition to a ICHRA model for certain classes of employees, e.g., part-time employees.

3. *Same-Terms Requirement*

Subject to three notable exceptions discussed below, employers that offer an ICHRA to a class of employees must offer the ICHRA on the same terms and conditions to all employees within the same class. Interestingly, the Departments prohibit the use of "benign discrimination" – that is, the offering of a more generous ICHRA to individuals based on an adverse health factor (*e.g.*, diabetes, cancers, or chronic illnesses).

GROOM INSIGHT: The Departments' decision in this regard is notable because certain federal rules allow for such benign discrimination in other circumstances (for example, HIPAA's wellness rules). Thus, employers will need to analyze whether practices that are acceptable in some spheres (such as providing for enhanced HRA contributions as a wellness incentive for individuals with a health factor under HIPAA) are permissible when offered in connection with an ICHRA.

Age

The Final Regulations permit an employer to increase the maximum amount available to a participant under an ICHRA based on an increase in a participant's age. The Final Regulations make clear, however, that the same increase must apply to *all similarly aged* participants in the same class of employees. While employers may offer additional ICHRA money to older participants, the maximum dollar amount made available to the oldest participant in a plan may not exceed three times the amount made available to the youngest participant in the plan.

GROOM INSIGHT: There is no minimum employer contribution that an employer must provide to participants with respect to an ICHRA. Thus, it appears that an ICHRA contribution could be as little as $1. However, employers interested in using an ICHRA to avoid all employer mandate penalties will likely need to contribute larger amounts to ensure that the individual coverage is otherwise "affordable" for the participants (although a minimal contribution would shield against the big penalty associated with not offering coverage). As also noted below, the IRS has indicated it will be issuing further guidance on this issue in the near future.

Treasury and IRS plan to issue proposed regulations describing how an employer could increase the maximum dollar amount under an ICHRA based on a participant's age without violating the nondiscrimination rules of Code section 105(h).

Some employers had hoped the Final Regulations would allow employers to provide employees with different ICHRA amounts based on years of service. However, the preamble to the Final Regulations clearly states that an employer would not comply with the same terms requirement if it provided some employees in a class with larger or smaller HRA amounts based on years of service.

Number of Dependents

The maximum dollar amount available under an ICHRA may also increase as the number of the participant's dependents covered under the ICHRA increases. Again, the increase must be made on a uniform basis within the class.

Former Employees

An ICHRA is treated as offered on the same terms even if the employer offers the ICHRA to some, but not all, former employees within a class. To the extent an ICHRA is offered to former employees, however, it must be offered to the former employees on the same terms as it is offered to all other active employees in that class. The preamble reiterates that employers may continue to offer retiree-only HRAs that are not subject to these integration rules.

GROOM INSIGHT: Unused amounts in an ICHRA may be carried over from year to year without violating the uniform availability rules, provided that access, methodology, and formulas for determining carryover amounts are applied uniformly within the class.

GROOM INSIGHT: The Final Regulations permit an employee to salary reduce on a pre-tax basis through a cafeteria plan to pay for any portion of the premium for individual health coverage that is not covered by the ICHRA, but only for coverage that is purchased off-Exchange. This is because Code section 125(f)(3) prohibits the use of cafeteria plans to purchase a qualified health plan that is offered on-Exchange. The ability to pay a portion of the premium through salary reductions under a

cafeteria plan is considered to be a term of the ICHRA, and, therefore, must be made available on the same terms to all employees in the same class.

---

4. *Opt-out Provisions*

For any month for which an individual is covered by an ICHRA, the individual is not eligible for a premium tax credit ("PTC") for that same month. For that reason, the Final Regulations provide that employers that offer ICHRAs must allow participants to opt-out of and waive future reimbursements from the ICHRA at least annually and on termination of employment.

5. *Substantiation and Verification of Individual Health Insurance Coverage and Medicare*

In order to be integrated, an ICHRA must implement and follow "reasonable" procedures to verify that all participants and dependents covered by the ICHRA are enrolled in individual health insurance coverage (other than excepted benefits or STLDI) or Medicare during the plan year. For these purposes, reasonable procedures may consist of (1) documentation by a third party, or (2) an attestation by the participant. Notably, the Final Regulations provide that new verification is required prior to any expense being reimbursed.

GROOM INSIGHT: The requirement to verify coverage prior to reimbursing any expense may not be that onerous for ICHRAs that process reimbursement requests either through paper or electronically , but would appear to be very difficult for ICHRAs that use debit cards. It is unclear how someone could verify that they have individual coverage prior to each use of the debit card, unless perhaps a statement on the debit card itself would suffice. Additionally, for ICHRAs that reimburse monthly premiums (which should be the norm), it would appear that the sponsoring entity will need to substantiate enrollment in qualifying individual insurance coverage on at least a monthly basis.

The Departments provide model attestations for participants to provide to the sponsor of the ICHRA.

6. *Notice Requirements*

Because coverage under an ICHRA will render someone ineligible for a PTC, an employer must provide written notice to eligible employees at least 90 days before the beginning of each plan year that their participation in an ICHRA will render them ineligible for a PTC. For participants who are not eligible for the ICHRA at the beginning of the plan year, such as new hires, the Final Regulations provide that the notice must be given no later than the date on which the participant is first eligible to participate in the ICHRA. There are specific content requirements for the notice relating to the terms of the ICHRA and the participant's rights. Along with the Final Regulations, the Departments provided a model notice that ICHRAs may provide to employees to satisfy the notice requirements.

GROOM INSIGHT: To comply with the notice requirement, the ICHRA must determine the amounts that will be newly made available for the plan year prior to the start of the plan year.

B. Individual Health Insurance Coverage and ERISA Plan Status

In the Final Regulations, the Department of Labor ("DOL") reiterates that an HRA itself is a group health plan that is subject to ERISA, including its fiduciary duties as well as its reporting and disclosure rules. (This is true whether the HRA is an ICHRA or an EBHRA.) However, the Final Regulations except from the scope of ERISA the individual insurance coverage integrated with the ICHRA where certain safe harbor criteria are met.

Significantly, the Final Regulations allow an employee to utilize a cafeteria plan to use pre-tax wages to pay the portion of the premium for individual market insurance coverage that is not covered by the ICHRA or a Qualified Small Employer Health Reimbursement Arrangement ("QSEHRA") (a QSERHA is a statutorily-created HRA for small employers) without rendering the individual insurance part of the group health plan. Thus, employers that offer an ICHRA or QSEHRA can also offer a related cafeteria plan that their employees can use to pay for their share of the premiums on a pre-tax basis.

GROOM INSIGHT: The Departments' guidance regarding the treatment of salary reduction arrangements offered alongside an ICHRA or QSEHRA is welcome news. It will help reduce the costs of a defined contribution health strategy by allowing employees to pay for their share of off-Exchange individual health insurance coverage with tax-free dollars. This guidance is significant because earlier guidance took the position that such an arrangement creates a group health plan that would violate the ACA's market reforms. Such an arrangement has not been permissible since 2013. Now, an employer again can allow employees to salary reduce on a pre-tax basis to pay for off-Exchange individual market insurance coverage – allowing the entire premium for the coverage to be paid on a tax-advantaged basis – so long as it is offered alongside an ICHRA or QSEHRA.

Specific Safe Harbor Criteria: Under the DOL's safe harbor, the individual insurance will be considered separate and apart from the HRA (or other account-based plan) if the following criteria are satisfied: (1) the purchase of any individual health insurance coverage must be completely voluntary for employees; (2) the sponsor of the ICHRA cannot select or endorse any particular issuer or insurance coverage; (3) premium reimbursements must be limited to qualifying individual health insurance coverage; (4) the sponsor cannot receive consideration in the form of cash or otherwise in connection with the employee's selection or renewal of health insurance coverage; (5) each plan participant must be notified annually that the individual health insurance coverage is not subject to ERISA.

GROOM INSIGHT: In the preamble to the Final Regulations, DOL states that "a private exchange could be designed in a way that limits employees' choice of issuer, or promotes certain issuers or

coverage options over others. In that case, coverage offered through the private exchange would not satisfy the prohibition on endorsement in the safe harbor." DOL's position on endorsement and the current private exchange model (which often focuses on a subset of carriers, or products in a given market) is likely to stand as an obstacle to the use of the ICHRA and QSEHRA. It will be interesting to see if, and how, the private exchange model evolves to reflect the Final Regulation's safe harbor. Until then, sponsors considering use of the ICHRA may be wise to carefully consider the private exchange services (including what insurance is available via the exchange) to avoid unintended endorsement for purposes of the safe harbor. Additionally, the safe harbors apply to current non-ICRHA/QSEHRA HRAs, and so employers with retiree HRAs paired with private retiree health exchanges may want to review their current arrangement to consider whether modifications may be warranted.

GROOM INSIGHT: DOL states in a footnote that the HRA may reimburse Medicare premiums for Medicare beneficiaries without causing the reimbursement of individual health insurance coverage premiums for other individuals to fall outside the safe harbor. This is a welcome clarification for employers with participants who are age 65 or over.

GROOM INSIGHT: The prohibition on the receipt of consideration by the sponsoring entity is not surprising given ERISA's existing fiduciary duties and the prohibitions on self-dealing. Nonetheless, employers and other stakeholders will need to be careful to ensure that they are not receiving economic value in connection with employee's purchase of the individual insurance policies (including not only the return or sharing of broker commissions on the policies, but also indirect compensation) Of special note, DOL explains in the preamble its view that even receipt of compensation from third parties to cover the cost of operating the HRA would be payments not permissible under the safe harbor.

C. Employer Mandate Compliance and ICHRAs

The Final Regulations do not provide specific rules regarding how an employer can satisfy the employer mandate requirements by providing an ICHRA. The preamble states that Treasury and IRS intend to propose rules under Code section 4980H, such as safe harbors for determining ICHRA affordability for employer mandate purposes.

GROOM INSIGHT: The preamble states that HHS will make lowest cost silver plan data available to employers in all states that use the Federal HealthCare.gov platform, for purposes of helping to determine whether the ICHRA is affordable under these rules.

The preamble notes that although individuals offered ICHRAs integrated with Medicare are not eligible for a PTC, and thus do not need to know whether the ICHRA is affordable, employers would still need to know whether the ICHRA is affordable for such individuals for employer mandate purposes. Thus, Treasury and IRS are considering whether they need to provide clarification regarding how an employer determines whether an ICHRA is affordable and provides minimum value for employees enrolled in Medicare.

D. Individual Market Special Enrollment Periods

The Final Regulations create a new individual market special enrollment period for employees and their dependents if they newly gain access to an ICHRA a QSEHRA. This rule also applies to employees/dependents who were previously offered, or enrolled in, the ICHRA/QSEHRA, as long as they were not covered by the ICHRA/QSHERA on the day immediately prior to the "triggering event."

GROOM INSIGHT: The special enrollment period rules can get confusing for individuals. Seemingly recognizing this, the preamble states that by November 1, 2019, HHS will provide resources to assist individuals offered an ICHRA on information about whether they may qualify for a special enrollment period.

E. Premium Tax Credit Eligibility and ICHRAs

An individual who is eligible for an ICHRA is not eligible for a PTC for a month if (1) the individual is enrolled in the ICHRA for the month, or (2) the individual opts out of the ICHRA for the month, but the ICHRA is considered "affordable." Under the Final Regulations, any ICHRA that is considered affordable automatically satisfies the "minimum value" requirement.

The Departments state that by November 1, 2019, HHS will provide resources to assist individuals offered an ICHRA with determining their PTC eligibility. The Departments will work closely with the state Exchanges to ensure that the Exchanges' applications and other materials are updated to assist individuals with an ICHRA to determine whether they are eligible for a PTC.

The New "Excepted Benefit" HRA

The Final Regulations allow for the use of a stand-alone HRA that an employer can offer to active employees without regard to whether they are enrolled in other health coverage. This HRA is considered an "excepted benefit" under HIPAA. An individual who is covered under the EBHRA is

not considered enrolled in "minimum essential coverage" and would therefore not be precluded from receiving a PTC for coverage purchased on an Exchange based on enrollment in the EBHRA.

GROOM INSIGHT: Employers should consider an EBHRA if their desire is to provide a relatively modest annual amount that employees can used on a tax-free basis to reimburse medical expenses, and the employer has no interest in monitoring what, if any, other coverage employees may have.

The following requirements must be satisfied in order for an HRA to qualify as an EBHRA:

1. **Otherwise Not an Integral Part of the Plan.** In order to satisfy this requirement, which is set forth in the statutory definition of a limited excepted benefit, the employer must offer other, non-account based, medical coverage to employees that is not an excepted benefit (*e.g.*, not dental or vision-only).
2. **Limited in Amount.** The amount of new employer contributions (i.e., not including carry over amounts) each year cannot exceed $1,800 (indexed for inflation after December 31, 2020, with the indexed amount announced by June 1st each year).
3. **Prohibition on Reimbursement of Premiums for Certain Types of Coverage.** The EBHRA may be used to reimburse any medical expense defined in Code section 213(d) with the exception of premiums for individual and non-COBRA group health insurance, which may not be reimbursed. COBRA, dental, vision, and short-term limited duration insurance premiums may be reimbursed.
4. **Uniform Availability.** The EBHRA must be made available on a uniform basis to all similarly situated employees (i.e., groups based on a bona fide employment-based classification such as full-time, part-time, occupation, collectively bargained employees, geographic distinction, length of service or date of hire).
5. **Notice.** EBHRAs that are subject to ERISA are not required to satisfy any additional Notice requirements under the Final Regulations. Future rulemaking by HHS will propose a notice requirement with respect to non-federal governmental plan EBHRAs.

GROOM INSIGHT: The Final Regulations clarify that an HRA that reimburses only dental or vision expenses or premiums, which are themselves HIPAA excepted benefits, need not comply with the EBHRA requirements described above in order to be considered an excepted benefit. An EBHRA can also be designed to be compatible with an HSA (e.g., a post-deductible arrangement, or an arrangement that reimburses only premiums for high deductible health plan STDI or COBRA coverage).

Applicability Date

The ICHRA and EBHRA provisions, as well as the ERISA plan clarification provisions, apply to group health plans and health insurance issuers for plan years beginning on or after January 1, 2020. The PTC provisions take effect for taxable years beginning on and after January 1, 2020, and the special enrollment period provisions take effect on January 1, 2020.