Health Reimbursement Arrangement Rules and Issues

Overview

Health Reimbursement Arrangements (HRAs) are self-funded group health plans that reimburse employees for certain medical expenses incurred by employees and their dependents on a tax favored basis. Typically an employer will establish a "notional" or unfunded account for each participating employee, and then reimburse qualifying expenses until the account balance is exhausted. HRAs must be funded with employer dollars and there are no limits on employer funding (note new rule for EBHRAs). Employee contributions, including salary reductions through a cafeteria plan, are not permissible. In addition, employees can never be paid cash or provided other benefits from the HRA upon termination of employment or under any other circumstances. While employed, balances generally carry forward from year to year.

This Insight discusses a number of common questions that arise with respect to HRA coverage.

ERISA

HRAs are generally subject to ERISA when sponsored by an employer that is subject to ERISA. Where an HRA is sponsored by an entity not subject to ERISA (e.g., governmental entity or church), ERISA does not apply.

HRAs sponsored by public sector plans (school districts, county, and city plans) are not subject to ERISA.

Where an HRA is subject to ERISA, all of ERISA's requirements for welfare benefit plans apply, including reporting and disclosures (5500 reporting), fiduciary responsibilities, and other ERISA administration and enforcement. HRAs are also subject to ERISA's claims and appeals procedures and just like other group health plans they require a plan document and summary plan description (SPD) or inclusion in a wrap SPD.

HIPAA

HRAs are also generally subject to HIPAA's portability provisions (special enrollment rights) and nondiscrimination based on health status (note EBHRAs are not subject to HIPAA portability rules).

Moreover, HRAs are self-funded medical plans so employers sponsoring an HRA should consider their compliance with HIPAA's privacy and security rules, including the requirement to distribute a Privacy Notice, have written policies and procedures, employee training, secure IT systems, and designation of HIPAA Privacy and Security Officers. While this is not overly burdensome, it does require administration and work on the part of the employer. Employers implementing an HRA as their first self-funded medical plan should be aware of the HIPAA requirements.

COBRA

HRAs are group health plans that are subject to COBRA. Applying COBRA rules to HRAs raises special challenges, most notably the amount of coverage that should be made available and how to determine the appropriate cost of that coverage (the COBRA applicable premium).

- **Independent election rights:** One of the basic principles of COBRA is that each qualified beneficiary has an independent right to elect COBRA. This can be complicated in the context of HRA coverage. Informal IRS comments suggest that each qualified beneficiary may have the right to elect COBRA coverage in the full amount available under the HRA. In other words, a termination of employment that affects a family of 4 could result in each family member electing HRA coverage separately. This effectively creates 4 separate HRA accounts and 4 available account balances when there used to be one. From a practical standpoint, when a family unit remains intact, most employers only extend the existing coverage (which could be elected by any qualified beneficiary). By contrast, in a situation where a single individual loses coverage (e.g., a spouse following a divorce, or a dependent child who ages out of the plan), the plan may need to allow the qualified beneficiary to make his or her own independent HRA COBRA election.
- **Amount of Coverage:** The amount of coverage available when qualified beneficiaries elect COBRA coverage is also complex. When the qualified beneficiary is a single individual with no prior claims submitted for reimbursement from the HRA, determining the amount of coverage is straightforward: It's the amount originally available under the HRA. If a married individual with employee plus spouse coverage gets divorced and the HRA balance was $2,000 prior to the qualifying event, the former spouse should likely get access to the full $2,000. Although some COBRA administrators elect instead to divide the balance ($1,000), informal IRS comments suggest that the former spouse should likely be eligible for the full $2,000. Determining the amount of coverage is even more complicated when the parties have submitted claims prior to the qualifying event. In this case, the plan needs to understand how it will offset specific claims against each qualified beneficiary's coverage. Where the amount of coverage is in question, the employer will likely want to engage its carrier/TPA and/or COBRA administrator for additional support. Employers should also engage with these parties and understand whether they follow the "mushrooming" or non-mushrooming approach to HRA COBRA elections by dependents.
- **New Employer Funding:** Employers that offer HRAs often struggle with when to make contributions. Common options are to fund at the start of the plan year, quarterly, semi-annually, monthly, or per pay period. The best option may depend on the employer's tolerance for administrative tasks and the amount of employer funding at issue. Employers

should understand that a qualified beneficiary who elects COBRA for the HRA gains both access to the existing funds at the time of the qualifying event and any new employer contributions to the account. This is why qualified beneficiaries often elect the HRA only where they have large balances due to carryovers, or if their qualifying event occurred on the eve of the next employer deposit.

- **Calculating the Applicable Premium:** HRAs are always self-funded, meaning the COBRA applicable premium can be determined using two methods: past-cost and actuarially. Many HRAs cannot use the past cost method. New HRAs cannot use the past-cost method (they have no past cost for a prior year) and must use the actuarial method. HRAs with several years of history also may not be able to use the past-cost method because the carryover feature may produce a significant difference in coverage from one year to the next (i.e., higher or lower coverage limits in a subsequent year). The past-cost method can only be used if the coverage and the number of employees participating in the plan have not changed significantly from the prior determination period. To use this method, the employer must determine the plan's cost in the prior determination period and then multiply it by the implicit price deflator of the gross national product for the 12-month period ending at the midpoint of the determination period. The U.S. Department of Commerce Bureau of Economic Analysis publishes implicit price deflator on a monthly basis. The actuarial method is the recommended approach and involves an approximation of the plan's future costs, which requires an analysis of claims data over the determination period, along with other factors such as the number of employees and beneficiaries covered under the plan. Under IRS safe harbor guidance, a plan satisfies the regulatory requirements for establishing applicable premium when it uses a "blended" approach so that the premium is the same for all qualified beneficiaries regardless of their HRA account balances.
- **Integration Rules and COBRA:** Affordable Care Act (ACA) rules that require most HRA's to be integrated with employer sponsored major medical coverage (note exception for ICHRAs and EBHRAs) further complicate how employers offer COBRA. Under these rules an HRA cannot be offered as a single separate COBRA election. It must be offered bundled with major medical and an option can also be presented that is only major medical without the HRA coverage (that excludes the added cost of the HRA). If the cost of the HRA is included in the COBRA rate for major medical employers could/should offer 1 COBRA election including both major medical and the HRA. Employees that elect this bundled option would automatically get the HRA and come into employer HRA funding on the same schedule as active employees. In cases where the HRA is inextricably tied to major medical (sometimes through a carrier's design), that may be the only way the carrier or TPA will administer the plan. Providing two election options (medical bundled with the HRA and medical offered on a standalone basis), may be preferable because many employees will not elect the option that includes the HRA. This eliminates any administrative costs connected to the HRA and the cost of additional employer HRA funding for COBRA qualified beneficiaries.

Eligibility for Tax-Free Reimbursements

HRAs can generally only provide tax-free reimbursements for medical care to employees, former employees, retirees, spouses, children under age 27, and other tax dependents. Where eligibility for other employer sponsored benefits includes broader categories of covered dependents, their expenses may not be reimbursed from the HRA. Common categories of covered dependents and whether their expenses are reimbursable are discussed below.

- **Domestic Partners:** The medical expenses of an employee's domestic partner cannot be reimbursed on a tax favored basis unless the domestic partner is also a tax dependent. The term "tax dependent" refers to the criteria set forth in IRC 152 as modified by section 105(b). For purposes of tax-free health coverage, a domestic partner must be a family or household member (household members must share a principal place of abode with the employee during the tax year) and the employee must provide over half of that individual's support during the tax year. Additionally, the individual cannot be claimed as a qualifying child by another taxpayer and must be a citizen or national of the U.S., a resident of the U.S., or a country contiguous to the U.S. (Note that references to tax treatment refer to federal tax treatment.)
- **Same-sex Spouses:** Same-sex spouses are treated the same as opposite spouses, meaning same-sex spouses can have their medical expenses reimbursed on a tax favored basis.
- **Self-Employed Individuals:** Self-employed individuals are generally not eligible for tax-free HRA coverage. This includes sole proprietors, partners, and more-than-2% shareholders in a Subchapter S corporation. There is an argument that self-employed individuals could be able to participate in an HRA on an after-tax basis (e.g., the self-employed individual being taxed on the value of the HRA coverage, possibly using the COBRA rate to determine value). This is a complex area of the law, and clients who wish to extend HRA coverage to self-employed individuals should consult with tax counsel in advance.

Non-Discrimination Requirements

HRAs are self-funded group health plans and are subject to non-discrimination rules under IRC section 105(h). These rules prohibit discrimination in favor of Highly Compensated Individuals as to eligibility to participate or benefits received under the plan. Any of the following designs are potentially problematic:

- Making HRA coverage available to a class of employees that is likely to be Highly Compensated;
- Varying HRA coverage amounts for different groups of employees;
- Basing HRA coverage amounts on factors like the employee's income or years of service.

Whether intentional or not, any of these designs can have the effect of providing more favorable benefits to Highly Compensated Individuals. The safest approach from a 105(h) standpoint is to provide uniform coverage for all eligible participants. Contributions to an HRA that are provided as a wellness program reward are generally not an issue if the same wellness incentive funding is available to all wellness plan participants.

HSA-Incompatible Coverage

A general purpose HRA—one that does not limit expense reimbursement to dental, vision, or post-deductible expenses—is first dollar coverage that will make an individual ineligible to contribute to an health savings account (HSA). Often, an employer will sponsor a high deductible health plan and provide both an HSA and an HRA option for employees. This allows for employees who are ineligible to make or receive HSA contributions because they are enrolled in other non-HDHP coverage (e.g. Tricare, Medicare, or a spouse's plan) to receive the benefit of an account based plan. In this situation, the employer should be clear that enrollment in the HRA precludes participation in an HSA. Where an employer uses online enrollment, the system would ideally be programmed to preclude participation in both options.

HRAs and Healthcare Reform

HRAs, because they are group health plans, are subject to many of the health care reform rules and requirements. Although some of those changes have little practical effect on HRAs others are significant and have changed how HRAs are offered. The most notable healthcare reform issues are addressed below.

- **Dollar Limits:** The ACA prohibits annual and lifetime dollar limits on essential health benefits. By design, virtually all HRAs have dollar limits, which means that most HRA coverage cannot be offered on a stand-alone basis and must be integrated with other employer sponsored major medical coverage that complies with the rules on dollar limits (note exception foe ICHRAs and EBHRAs). To ensure compliance, the HRA should limit reimbursements to employees and dependents that are also covered under the employer's major medical coverage. There are exceptions to this general rule.
    - **Retiree-only HRAs:** A retiree-only plan is one that covers fewer than 2 active employees. Retiree-only plans are excepted from the ACA rules prohibiting dollar limits, and therefore can be offered on a stand-alone basis. Plan sponsors considering this design should be aware that retiree-only HRAs will generally be considered minimum essential coverage (MEC) under the ACA and could preclude subsidy eligibility. Retiree HRAs may also need to be reported as minimum essential coverage by the former employer on Form 1094/1095 (see above) if not exempt from reporting under the supplemental coverage rule discussed below.
    - **Certain Limited Scope HRAs:** Limited scope HRAs that only reimburse expenses for dental or vision coverage are another exception. As with retiree-only HRAs, these limited scope HRAs are excepted from ACA rules on dollar limits. This type of coverage will also not be considered MEC under the ACA. Limited scope HRAs also do not affect HSA eligibility, meaning an individual could have high deductible health plan coverage and limited scope HRA coverage, and still be eligible to contribute to an HSA. As noted above, general purpose HRA coverage (e.g., HRA coverage that is not limited to dental/vision) is incompatible coverage for purposes of HSA eligibility.

- **1094/1095 Reporting:** As noted above, most HRAs must be integrated with a major medical plan that complies with ACA rules on dollar limits, and eligibility for HRA reimbursements must match enrollment in the employer's major medical coverage. As a result, these integrated HRAs usually do not need to be reported because they qualify as "supplemental coverage." Note that the rules technically allow an HRA to be integrated with a major medical plan sponsored by a different employer, however, this creates significant reporting obligations for the employer sponsoring the HRA. Integrating an HRA with another employer's medical plan also creates a real time claims substantiation issue for dependent expense reimbursements because to meet integration requirements the plan must ensure that other employer coverage was in force at the time the expense was incurred. As a result, this plan design is never used. Retiree-only HRA coverage is also subject to special reporting rules. Retiree-only HRAs that allow reimbursement of Medicare premiums, Medicare supplement premiums, dependent expenses, and other out-of-pocket medical costs must be reported by the ALE. By contrast, retiree-only HRAs that limit reimbursements to Medicare premiums and Medicare supplement plan premiums do not need to be reported (the coverage is considered supplemental to Medicare).
- **Summaries of Benefits and Coverage (SBC):** Integrated HRAs can be described together with major medical coverage in a single SBC. Regulatory agencies' FAQs suggest that plans could also choose to provide a separate SBC for the HRA. Although the agencies recognize the challenge in doing so (e.g., many of the fields in the SBC template will be blank or have "not applicable" as an entry).
- **W-2 Reporting:** HRAs are exempt from the W-2 reporting requirement under transition relief guidance; however, employers have the option of reporting the value of major medical coverage and HRA coverage together (e.g., an integrated arrangement), if that is administratively simpler than separating them.
- **Fees:** HRAs that are integrated with an insured major medical plan are subject to the PCORI fee. A non-duplication rule exempts HRAs if they are integrated with the employer's self-funded major medical plan and that plan operates on the same plan year as the HRA. Stand-alone general purpose HRAs (e.g. retiree-only plans) are subject to the PCORI fee. Limited scope HRAs (e.g., dental/vision) are not subject to the PCORI fee if they qualify as excepted benefits.

Two New Types of HRAs (EBHRAs and ICHRAs)

In mid-2019, the Departments of the Treasury, Labor, and Health and Human Services (Departments) finalized regulations that created two new types of HRAs: (1) Excepted Benefit HRAs (EBHRAs), and (2) Individual Coverage HRAs (ICHRAs). The rules for both new HRA options are discussed below.

Excepted Benefit HRAs (EBHRAs)

An EBHRA is a new type of HRA that qualifies as a HIPAA excepted benefit. The significance of that designation is that an excepted benefit is not subject to ACA market reform rules, including rules on lifetime or annual limits and first dollar coverage of preventive care. Moreover, an excepted benefit will not be considered employer sponsored minimum essential coverage that disqualifies someone from Exchange subsidies. These types of arrangements cannot pay insurance premiums for group,

individual, or Medicare coverage, and the benefit cannot exceed $1,800 (indexed for inflation beginning in 2021). Excepted benefit HRAs can reimburse 213(d) medical expenses as well as premiums for individual or group coverage *that consists solely of excepted benefits, COBRA premiums, and STLDI premiums* (subject to possible limitations in certain markets).

In addition, in order for an HRA to be an excepted benefit, other "traditional" group health plan coverage must be made available by the same plan sponsor to the participants offered the HRA. HRA participants (and their dependents) would not be required to enroll in that other group health plan in order to be eligible for the EBHRA, but the offer of traditional coverage is required. Importantly, the same class of employee cannot be offered both an EBHRA and ICHRA (discussed below). This results from the requirement that a traditional group health plan be offered along with the EBHRA and the requirement that someone offered an ICHRA cannot also be offered a traditional group health plan.

Finally, an EBHRA must be made available under the same terms to all similarly situated individuals regardless of any health factor. This precludes steering any participants or dependents with adverse health factors away from the plan sponsor's traditional group health plan. The regulations give the example that an excepted HRA could not be offered only to employees who are cancer-free or who pass a physical examination. Conversely, an employer could not make greater amounts available for employees who have cancer or who fail a physical examination.

Note that an EBHRA remains subject to ERISA, HIPAA and COBRA (with the exception of HIPAA's portability rules). Underlying plan documents and inclusion with Form 5500 filings is required. Completion of an SBC is not required due to excepted benefit status.

Individual Coverage HRAs (ICHRAs)

ICHRAs are a new class of HRAs that are not subject to the general prohibition against integrating an HRA with individual health coverage. ICHRAs can specifically reimburse individual market premiums (and other 213(d) medical expenses if the employer chooses such a design) or Medicare premiums. ICHRA participants and any dependents must actually be enrolled in individual health coverage (other than coverage that consists solely of excepted benefits).

Note that an ICHRA remains subject to ERISA, HIPAA and COBRA. Underlying plan documents and inclusion with Form 5500 filings is required. In addition to ACA reporting, the ACA's summary of benefit coverage (SBC) requirement will also apply. Specific substation, non-discrimination, and notice and opt-out procedures are discussed below.

Substantiating Enrollment in Individual Coverage

An employer sponsoring an ICHRA must implement reasonable procedures to verify that individuals covered by the ICHRA are enrolled in individual health coverage during the plan year. Procedures can include a requirement that a participant substantiate enrollment in individual coverage by providing either: (1) a document from a third party (for example, the issuer) showing that the participant and any dependent(s) covered by the ICHRA are enrolled in coverage (e.g., an insurance card or an explanation of benefits pertaining to the relevant time period); or (2) an attestation by the participant stating that the participant and any dependent(s) are enrolled in individual coverage, the date coverage began or will begin, and the name of the provider of the coverage. Substantiation is required annually and with each request for reimbursement of any medical expense. Notably, the ongoing proof or attestation can be part of the form used for requesting reimbursement.

Non-Discrimination

ICHRAs are subject to various non-discrimination provisions designed to prevent adverse selection or health status discrimination. In addition to the prohibition against offering the same class of employees a choice between a traditional group health plan and an ICHRA, the ICHRA offering must be the same for each class of employee and offered on the same terms to all employees within a class.

Classes of Employees

An employer that offers a traditional group health plan and an ICHRA must make one option or the other available based on specific classes of employees. Permissible classes of employees include: (1) full-time employees; (2) part-time employees; (3) seasonal employees; (4) salaried employees; (5) non-salaried employees; (6) employees who are included in a unit of employees covered by a collective bargaining agreement (CBA) in which the plan sponsor participates; (7) employees who have not satisfied an ACA-compliant waiting period for coverage; (8) non-resident aliens with no U.S.-based income (generally, foreign employees who work abroad); (9) employees whose primary site of employment is in the same insurance market rating area; and (10) employees employed by a staffing firm for temporary placement at entities unrelated to the staffing firm (temporary workers).

An ICHRA plan sponsor may define "full-time employee," "part-time employee," and "seasonal employee" using definitions from sections 105(h) non-discrimination rules that apply to self-funded plans or 4980H rules on the ACA's pay or play mandate, but it must be consistent across these three classes of employees. Definitions must apply on an annual basis but can be changed in subsequent years.

ICHRAs also are subject to very specific rules regarding the required size of certain employee classes. Under the final rules, the minimum class size requirement generally applies to: (1) salaried employees, (2) non-salaried employees, (3) full-time employees, (4) part-time employees, and (5) employees whose primary site of employment is in the same rating area (requirement does not apply if the geographic area defining the class is a state or a combination of two or more entire states). The applicable class size minimum is: (a) 10, for an employer with fewer than 100 employees; (b) a number, rounded down to a whole number, equal to 10 percent of the total number of employees, for an employer with 100 to 200 employees; and (c) 20, for an employer that has more than 200 employees. The determination of whether a class of employees satisfies the applicable class size minimum is based on the number of employees in the class who are offered the ICHRA as of the first day of each plan year.

Same Terms/Reimbursement Amounts

In addition to the above requirement that ICHRAs be available based on class of employee, plan sponsors must offer ICHRAs on the same terms to all employees within the class. There are, however, exceptions with respect to the maximum reimbursement amount for age and number of covered dependents. The maximum dollar amount available under the ICHRA for participants within a class may increase as the age of the participant increases. The same amount attributable to that increase in age must be available to all participants of the same age within the same class. Also, the maximum dollar amount made available under the terms of the ICHRA to the oldest participant(s) cannot be more than three times the maximum dollar amount made available under the terms of the ICHRA to

the youngest participant(s). The maximum dollar amount available under an ICHRA within a class of employees may increase as the number of the participant's dependents who are covered under the ICHRA increases. However, the same amount attributable to that increase in family size must be available to all participants in that class of employees with the same number of dependents covered by the ICHRA.

Lastly, for a participant who becomes covered by an ICHRA after the first day of the plan year, the employer may make the full annual amount available or adopt a reasonable proration methodology.

Notice and Opt-Out Requirements

An individual covered by an ICHRA is not eligible for a PTC for any month the ICHRA is in force, regardless of the amount of reimbursement available. Because employees eligible for these ICHRAs may not realize that it will have consequences with respect to PTC eligibility, ICHRA rules included a notice and opt out-requirement. A notice to each participant is required 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), the ICHRA would be required to provide the notice no later than the date on which the participant is first eligible to participate in the HRA. Model language is available. Plans also must also allow participants to opt out of and waive future reimbursements from the ICHRA at least annually and on termination of employment.

Pay or Play

Although we anticipate subsequent guidance with additional details on the impact of ICHRAs on Applicable Large Employer (ALE) Pay or Play requirements[1] existing ICHRA rules confirm that where an ALE offers an ICHRA to at least 95 percent of its full-time employees (and their dependents), the ALE would not be liable for Pay or Play part (a) penalties. Part (b) penalty risk is more difficult to assess. An individual covered by an ICHRA will be ineligible for PTC subsidies and not trigger part (b) penalties. However, the rules are considerably more complicated when an individual is offered an ICHRA but declines that coverage. In that case, whether the employee is eligible for a PTC depends on whether the ICHRA is deemed "affordable" to the employee. Based on the standard discussed below, an affordable plan will also always be considered a minimum value plan.

The affordability analysis for ICHRA provides that an ICHRA is "affordable" for an employee for the month if the employee's "required HRA contribution" does not exceed 1/12 of the product of the employee's household income and the required contribution percentage (the indexed unaffordability threshold set at 9.86% for 2019 and 9.78% for 2020). For this purpose, 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 in which the employee resides; 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

[1] Under ACA Pay or Play rules an ALE can face significant "part (a)" penalties if they do not offer Minimum Essential Coverage (MEC) to substantially all of their full-time employees ($2,000 for every full-time employee minus 30 – penalty shown annualized and not indexed). If an ALE offers coverage to full-time employees they can still face penalties for full-time ineligible employees and/or if the coverage they offer is "unaffordable" or is not at least a 60% minimum value plan ($3,000 per full-time employee who receives subsidized Exchange coverage – penalty shown annualized and not indexed)—the "part (b)" penalty.

the employee (amount newly available for the plan year divided by the number of months in the plan year).

Example:

In 2020, Adam is single, has no dependents, and has an annual household income of $28,000. Adam works for ABC Co., which offers its employees an individual coverage HRA that reimburses $2,400 of medical care expenses for single employees with no children. Adam enrolls in a qualified health plan through the Exchange. The monthly premium for the lowest cost silver plan is $500. Is Adam's ICHRA plan affordable?

Adam's "required HRA contribution" is $300, which is the excess of $500 (the monthly premium) coverage of Adam) over $200 (1/12 the annual HRA amount Adam receives from his employer). Affordability is determined based on Adam's income ($28,000 multiplied by 9.78 percent and divided by 12). An affordability premium for Adam is $238 and below. Because Adam's required HRA contribution of $300 exceeds $238, the HRA plan is unaffordable for Adam for each month of 2020. If Adam opts out of and waives future reimbursements from the ICHRA, he would be subsidy eligible if all other factors permit.

This new affordability calculation is likely to be challenging for employers, employees, and Exchanges.