Final Rules – Two New HRA Options for 2020

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The Administration has released final rules governing Health Reimbursement Arrangements (HRAs) that give employers of all sizes some intriguing new options. Beginning in 2020, employers can offer select classes of employees a new “Individual Coverage HRA” instead of traditional group health plan coverage that can be used to reimburse premiums for Medicare or individual health insurance chosen by the employee. The rules also create a new “Excepted Benefit HRA” that can be offered in addition to a traditional group health plan to help cover a wide range of medical expenses even if the employee declines to enroll in the traditional group health plan.

Background

Current guidance prohibits employers from paying for an employee’s individual health insurance policy. HRAs that reimburse more than excepted benefits must also be integrated with a group health plan, meaning that HRA coverage can be offered only to employees and dependents who are also covered by the group health plan. The Departments first issued proposed HRA regulations designed to expand the use of HRAs in October 2018; those regulations have now been finalized. The new rules are effective for plan years beginning 01/01/2020.

New HRA Rules Summary

Two new HRAs are being “created” through regulatory action:

1. Individual Coverage HRA (ICHRA)
2. Excepted Benefit HRA (EBHRA)

ICHRA allows employers to reimburse employees for individual health plans and medical expenses. In function, ICHRA works just like a QSEHRA but significantly loosens the restrictions that limited QSEHRA to a niche market. EBHRA works with a traditional group health plan but allows employers more flexibility in what they can reimburse.

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Here's a summary chart to compare the HRAs:

	QSEHRA Qualified Small Employer Health Reimbursement Arrangement	**ICHRA** Individual Coverage Health Reimbursement Arrangement	**EBHRA** Excepted Benefit Health Reimbursement Arrangement
Plan Type	Individual Plans	Individual Plans	Group Health Plans
Group Health Plan Rules	Employer must not offer Group Health Plan	Employer must not offer Group Health Plan	Employer must offer Group Health Plan; employee must decline plan
Size Limits	1-50 FTE	None	None
Contribution Limits	$5,150 for Single; $10,450 for Family	No Limits	$1,800 per year
Reimbursement Options	Premiums + Expenses (including Excepted Benefits)	Premiums + Expenses (including Excepted Benefits)	"Excepted Benefits" only
Premium Tax Credit (PTC) Interaction	Offsets	If 'unaffordable", employees can choose PTC or HRA; if "affordable", no PTC	PTC not available
Employer Design Flexibility	Can vary rates by family size or age; Can set participation threshold for Part-Time and Seasonal	Can offer different plans by class; Can vary rates within classes by Family Size or Age	All the same
Employer Requirement	MEC	Coverage that meets PHS 2711 & 2713	Be offered the group health plan (can reject)
Employee Eligiblity	All employees are eligible to participate but only those with MEC may be reimbursed	All employees are eligible to participate	All employees are eligible to participate

Individual Coverage HRA (ICHRA)

1. An HRA funded by employers and used by employees to pay for individual health coverage.
2. This HRA can also be designed to reimburse other eligible §213(d) expenses.
3. This type of HRA cannot be offered to a class of employees who are eligible for group health plan coverage. Allowable employee classes are defined in the regulations (more below).

Excepted Benefit HRA (EBHRA)

1. A limited stand-alone HRA with an $1,800 annual maximum benefit that can be used to reimburse §213(d) medical expenses for eligible employees and dependents.
2. Unlike an individual coverage HRA, an excepted benefit HRA can be offered only to employees who are also eligible for an employer sponsored group health plan.

New Option #1: Insurance Coverage HRA (ICHRA)

This option allows employers of all sizes, not just small employers, to provide tax-free funding to an employee HRA that could be used to purchase individual health insurance policies (including Medicare). An employer can design the HRA to reimburse only premiums, or the HRA could be set up to also allow employees to have eligible §213(d) medical expenses reimbursed (like a traditional HRA). The rules include provisions designed to limit an employer's ability to steer higher-risk employees to the individual market.

Overview of the Requirements. An individual coverage HRA must meet the following requirements:

HRA participants must be enrolled in individual coverage (or Medicare).

All individuals eligible for reimbursement under the HRA must be enrolled in individual health coverage and provide proof of that coverage.

- Eligible individual health coverage includes coverage purchased through a public Exchange, coverage purchased directly from an insurance carrier outside the Exchange, and individual coverage sold through a private exchange.
    - The HRA can be integrated with Medicare Part A and B or Part C and may be used to reimburse Medicare premiums if certain criteria are met.
    - The HRA can also be integrated with student health insurance, catastrophic coverage, and "grandmothered" and grandfathered individual health insurance.
- ***Excepted benefits only does not qualify***. Eligible coverage does NOT include short-term, limited-duration insurance (STLDI), coverage that consists solely of excepted benefits, TRICARE, or healthcare sharing ministries.
- ***Participant attestation***. Participants must confirm enrollment in individual health coverage annually as well as each time a request is made for HRA reimbursement. Employer responsibilities are limited. Although the employer can require third party verification, simply collecting an attestation similar to the model would be adequate.
    - A model attestation form provided by the agencies can be found here – https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/HRA-Model-Attestations-PDF.pdf.
- ***New special enrollment period.*** Individuals will be permitted a 60-day special enrollment period for public Exchange and non-Exchange individual coverage at the time at which the individual coverage HRA is first offered.

Limits based on specific "classes" of employees. A very important part of the rules limits this HRA coverage to only employees who are not offered an employer sponsored group health plan. Employers cannot offer both a traditional group health plan and an individual coverage HRA to the same class of employees. Employers must choose to offer a group health plan or the individual coverage HRA based on specific "classes" defined in the

regulations. Note that offering different coverage to different classes of employees could still cause the employer sponsored group health plan to violate §125 or §105(h) non-discrimination rules, so class-based offerings must be designed carefully, taking these rules into consideration.

- The following classes are permitted:
    - Full-time employees (as defined under either §105(h) or §4980H);
    - Part-time employees (as defined under either §105(h) or §4980H);
    - Seasonal employees (as defined under either §105(h) or §4980H);
    - Salaried workers;
    - Non-salaried workers (hourly workers);
    - Employees working in the same geographic location (generally, the same insurance rating area, state, or multi-state region);
    - Employees covered by a collective bargaining agreement;
    - Employees who have not satisfied a waiting period;
    - Non-resident aliens with no U.S.-based income;
    - Temporary employees of staffing firms (assuming they are common law employees of the contracting employer and not of the staffing firm); or
    - Any group of employees formed by combining two or more of these classes.
- ***Same terms and conditions.*** The individual coverage HRA must be offered on the same terms and conditions to all employees within each class; however, the dollar amount may differ based on age (3:1) or number of dependents eligible for reimbursement. When designing employer contribution to the HRA, employers must also consider the Age Discrimination in Employment Act (ADEA). A flat employer contribution that requires older employees to pay more for the purchase of age-rated individual health insurance could be a violation of the ADEA. We hope that the IRS and the EEOC provide further guidance on this issue.
- Classes can be defined separately for each entity within a controlled group or an affiliated service group.
- A minimum class size rule applies when the employer offers a traditional group health plan to some employees and an individual coverage HRA to other employees based on full-time vs. part-time status; salaried vs. non-salaried status; or geographic location (if the location is smaller than a state). The minimum class size that must be eligible for the individual coverage HRA is: (i) 10 employees for an employer with < 100 employees; (ii) 10% of the total number of employees for an employer with 100 to 200 employees; and (iii) 20 employees for an employer with > 200 employees.
- A special rule permits employers to offer the individual coverage HRA to new hires within a class after a certain point in time while allowing existing employees to continue on the traditional group health plan.

Participants must be able to opt out of coverage and waive future reimbursement. Enrollment in the HRA would cause an employee to lose eligibility for a premium tax credit (PTC) when purchasing individual health insurance through a public Exchange, and therefore eligible participants must be given the option to opt out of HRA coverage and waive any future reimbursements. If the HRA provides minimum value and is affordable, an eligible participant who is offered coverage would lose eligibility for a PTC even if the individual opts out of coverage (similar to the rules that apply for employer sponsored group health plan coverage).

Affordability. The regulations include a complex formula for determining whether an ICHRA is affordable for purposes of eligibility for marketplace premium assistance. According to these regulations, for purposes of determining affordability, the employer's annual contribution to the ICHRA for monthly single coverage amount, minus the monthly premium for the lowest-cost silver plan for self-only coverage cannot exceed 9.86% (indexed for 2020) of an individual's household earnings. Presumably, the current three safe harbors available for employer shared responsibility purposes (federal poverty level, rate of pay, or W-2) could be used for the ICHRA affordability standard. It is expected that future guidance will clarify this, as well as provide a methodology that could be used by employers subject to the employer's shared responsibility provisions.

Employers must provide a new notice to eligible individuals. The notice must include information such as a description of the terms of the HRA, the maximum dollar amount available, substantiation requirements for participation and reimbursements, the ability to opt out, information about PTC eligibility, and more. The notice must be provided at least 90 days before the beginning of each plan year, or, for those who become eligible later or enroll after the beginning of the plan year, no later than the individual's effective date. The DOL provides a model notice that can be used for this purpose (available in both **word** and **pdf** format). The information contained in the model notice must be customized to the particular HRA..

Pre-Tax Contributions Through a Cafeteria Plan. Employers may permit employees participating in the individual coverage HRA to pay for the remainder of the individual coverage premium (the portion not reimbursed by the HRA) on a pre-tax basis through the employer's cafeteria plan so long as the individual coverage is not purchased through a public Exchange. Employees may not pay pre-tax through a cafeteria plan for coverage purchased through a public Exchange. NOTE: The option for employees to pay for non-Exchange coverage premiums on a pre-tax basis through a cafeteria plan is available only to those who are participating in the individual coverage HRA.

Additional Compliance Considerations.

In addition to the main requirements set forth above, the final rules provide guidance for coordination of the individual coverage HRA with a variety of other compliance requirements. These are discussed in further detail below.

ERISA. The individual coverage of each participant that is integrated with the HRA would not be subject to ERISA, assuming requirements similar to the DOL voluntary safe harbor requirements are met. The employer must not select or endorse any particular insurance carrier or coverage options, cannot receive any financial incentive, and must notify participants annually that the individual health insurance is not subject to the Employee Retirement Income Security Act (ERISA).

The individual coverage HRA itself, however, would generally be subject to ERISA, requiring plan documentation and Form 5500 filings as applicable. In addition, a summary of benefits and coverage (SBC) is required.

§125 and §105(h) Nondiscrimination. §105(h) nondiscrimination rules prohibit a self-funded group health plan, including an individual coverage HRA, from favoring highly compensated individuals in regard to eligibility or benefits. However, so long as the individual coverage HRA is limited solely to reimbursement of individual coverage premiums, §105(h) nondiscrimination rules would not apply directly to the HRA. Individual coverage HRAs available more broadly to reimburse §213(d) qualifying medical expenses would be subject to §105(h). IRS Notice 2018-88 proposed a safe harbor that would permit variations in employer contributions within classes (including permitted 3:1 age variations). We expect the IRS to provide additional guidance confirming details soon.

Employers must also consider the fact that if a class of employees is excluded from eligibility to the employer's group health plan, so that that class can be offered an individual coverage HRA, it could cause §125 or §105(h) discrimination issues for the employer's group health plan.

ACA §4980H Employer Shared Responsibility Rules (The Employer Mandate). The HRA would be considered an offer of minimum essential coverage (MEC) for purposes of satisfying §4980H(a) employer shared responsibility requirements. If the HRA also provides minimum value and is affordable, the offer would also satisfy Section 4980H(b) requirements.

IRS Notice 2018-88 proposed a method for determining minimum value and affordability and requested comment. The proposed methodology ties minimum value and affordability to the lowest cost silver plan offered through the public Exchange, which will vary by where employees work and by their age. The HRA will be considered to provide minimum value

and will be affordable if the monthly cost for single coverage under the lowest cost silver plan minus the single monthly employer HRA contribution does not exceed the affordability percentage (e.g. 9.86% in 2019) compared to the employee's household income.

NOTE: Employers will probably be able to continue using the affordability safe harbors (i.e. FPL, rate of pay and Form W-2). We expect the IRS to provide additional guidance confirming details soon. That being the case, tracking the cost of coverage and setting "affordable" HRA contributions may prove complicated, especially for employers with employees in a variety of locations (adding to the complexity that already exists for differences in cost due to age).

HSA Compatibility. An HRA that only reimburses individual health insurance premiums or excepted benefits will not prevent eligibility to contribute to an HSA. However, if the HRA is also available to reimburse cost-sharing prior to meeting the HDHP minimum deductible, individuals enrolled will not be eligible to contribute to an HSA. Employers are allowed to offer two HRA options and still meet the "same terms" rule for classes described above. The employer could offer the following within a particular class – (i) an HRA limited solely to reimbursement of individual health insurance premiums for those who are otherwise eligible to contribute to an HSA; and (ii) an HRA more broadly available to reimburse any Section 213(d) qualifying medical expenses.

Medicare. Employers are permitted to offer an individual coverage HRA to those eligible for or enrolled in Medicare and may also allow reimbursement of Medicare premiums without violating the Medicare Secondary Payer (MSP) rules so long as the HRA is not designed to limit reimbursement only to expenses not covered by Medicare. The individual coverage HRA would be considered a group health plan and therefore generally the primary payer to Medicare. HHS has promised additional guidance in regard to primary payer responsibilities.

COBRA. As a self-funded group health plan, the individual coverage HRA would be subject to COBRA consistent with rules that apply to current HRAs. However, losing HRA coverage due to failing to maintain individual coverage is not considered a qualifying event.

New Option #2: Excepted Benefit HRA (EBHRA)

Currently, employers are prohibited from offering a stand-alone HRA to active employees unless the HRA reimburses claims only for limited expenses such as dental and vision (or other excepted benefits). The new rules would allow a stand-alone HRA to be offered alongside a traditional group health to reimburse all §213(d) expenses except for insurance premiums. To maintain excepted benefit status, the HRA must meet requirements very similar to those currently imposed on a general-purpose health FSA:

- The maximum benefit cannot exceed $1,800 for the plan year (indexed annually);

- Employees must be eligible (but not necessarily enrolled) for both the employer's group health plan and the HRA;
- The HRA must be available for all similarly situated individuals, regardless of any health factor; and
- The HRA cannot be used to reimburse individual health insurance premiums, group health plan premiums (other than COBRA), or Medicare premiums. It can reimburse premiums for excepted benefits, such as dental and vision coverage, and for short-term, limited duration coverage.

Note that an excepted benefit HRA cannot be offered to the same employees who are offered an individual coverage HRA. An excepted benefit HRA can be offered only to employees who are eligible for the employer's group health plan, whereas an individual coverage HRA can be offered only to employees who are not eligible for the employer's group health plan.

Summary

The new rules make no changes to the employer's ability to integrate an HRA with group health plan coverage. Employers are also still allowed to offer a stand-alone HRA for the reimbursement of excepted benefits, and to offer a full stand-alone HRA to retirees. These rules provide additional options that employers may want to explore, although many may not be ready to adopt such changes by early 2020. The attractiveness of such options will depend on the employer's staffing and benefit-offering goals and on the individual coverage options and vendor solutions available (which may vary from market to market and may change over time).

A copy of the final regulations can be found here – https://www.federalregister.gov/documents/2019/06/20/2019-12571/health-reimbursement-arrangements-and-other-account-based-group-health-plans.

The Departments also released an FAQ, found here – https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/HRA-FAQs.pdf.