THE
NATIONAL LAW REVIEW

Agencies Propose Regulations Expanding Access to Health Reimbursement Arrangements

Article By
Alden J. Bianchi
Mintz
Employment, Labor & Benefits Advisory

- Health Law & Managed Care
- Labor & Employment

- All Federal

Wednesday, December 12, 2018

Health Reimbursement Arrangements (or "HRAs") are employer-funded, account-based group health plans, which are used to reimburse certain medical expenses incurred by eligible employees, their spouses, and their dependents. While participants can use HRA proceeds to pay for certain medical insurance premiums, current law prohibits employers from offering HRAs to their employees for the purpose of reimbursing the cost of individual health insurance policies. This is about to change. This post explains why.

Background

Guidance implementing the Affordable Care Act ("ACA") issued by the Department of Health and Human Services ("HHS"), the Department of the Treasury ("Treasury Department") and the Internal Revenue Service ("IRS"), and the Department of Labor ("DOL") (collectively, the "Departments") generally bars employers from making

HRAs available to enable employees to purchase health insurance of their choice in the individual health insurance market. The Departments referred to these arrangements as “stand-alone” HRAs. The Departments previously determined that that stand-alone HRAs would fail to satisfy the following ACA requirements:

- Public Health Service Act (“PHS Act”) section 2711, which generally bars group health plans from imposing annual or lifetime limits on the dollar amount of benefits; and
- PHS Act section 2713, which requires non-grandfathered group health plans to provide preventive services without imposing any cost-sharing requirements.

Consequently, an employer that sought to provide an annual amount of money to an employee for the purpose of purchasing individual market coverage would run afoul of the ACA. In the Department’s view, only HRAs that could be “integrated”— or paired only with employer-sponsored group health coverage— could pass muster under the ACA. In 2016, Congress provided a narrow exception to these rules, subsequently allowing certain small employers to offer stand-alone HRAs under a “Qualified Small Employer Health Reimbursement Arrangement (or “QSEHRA”) to their eligible employees.

For a comprehensive discussion of prior law on the subject of stand-alone HRAs, please see Intricacies of Health Premium Reimbursements by the author.

The Proposed Individual Coverage HRA “Integration” Regulations

In response to an October 2016 executive order, the Departments issued proposed regulations reversing their previous position on stand-alone HRAs. The purpose of the proposed regulations is, in their words, to “expand the usability of HRAs by eliminating the current prohibition on integrating HRAs with individual health insurance coverage.” If adopted in final form, the proposed regulations would permit employers to offer HRAs to employees enrolled in individual health insurance coverage, provided certain conditions are met. Covered employees would be permitted to use amounts in an HRA integrated with individual health insurance coverage to pay expenses for medical care, including premiums for individual health insurance coverage. The proposal also includes separate rules setting forth conditions under which certain HRAs would be recognized as limited excepted benefits (these rules are discussed below). While each Department adopts substantially similar rules, there are some differences:

- The Treasury Department and the IRS proposal includes separate rules regarding premium tax credit eligibility;
- The DOL proposal includes separate rules intended to assure plan sponsors that premiums reimbursed by an HRA or under a QSEHRA do not become part of an ERISA plan, provided certain conditions are met; and
- The HHS proposal includes separate rules that would provide a special enrollment period in the individual market for individuals who gain access to an HRA integrated with individual health insurance coverage or who are provided with QSEHRA.

The proposed regulation establishes the following conditions that an HRA must satisfy in order to qualify as an individual coverage HRA:

- *Covered individuals must be enrolled in individual health insurance coverage*

Consistent with prior law guidance, in order to be considered compliant with PHS Act sections 2711 and 2713, the proposed regulations would require an individual coverage HRA to be integrated with individual health insurance coverage. Thus, the individual coverage HRA participant and any dependents must be enrolled in individual health insurance coverage (other than coverage that consists solely of excepted benefits) for each month the individuals are covered by the HRA. If the individual covered by the HRA can merely obtain individual health insurance coverage, but does not do so, the HRA would fail to comply with PHS Act sections 2711 and 2713.

- *An employer that offers an individual coverage HRA to a class of employees must offer the individual coverage HRA on the same terms (that is, both in the same amount and otherwise on the same terms and conditions) to all employees in the class.*

The Departments were concerned that permitting HRAs to purchase individual marker coverage could invite discrimination based on health status. Without some limitations, the employers might seek to discriminate against individual participants and beneficiaries in eligibility, benefits, or premiums based on a health factor. To discourage discrimination based on health status with respect to offering HRAs to “high-cost” employees, the Departments have proposed to limit HRA offers by employee class.

An employer may offer an HRA integrated with individual health insurance coverage to a class of employees only if the employer does not also offer a traditional group health plan to the same class of employees. (A “traditional group health plan” for this purpose means group health plan other than either an account-based group health plan or a group health plan that consists solely of benefits designated as “excepted benefits” by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)). In addition, an employer that offers an HRA integrated with individual health insurance coverage to a class of employees must offer the HRA on the same terms to each participant within the class of employees, subject to certain exceptions.

The classes established under the proposed regulations include the following:

(1) Full-time employees;

(2) Part-time employees;

(3) Seasonal employees;

(4) Employees who are included in a unit of employees covered by a collective bargaining agreement in which the employer participates;

(5) Employees who have not satisfied an ACA-compliant waiting period for coverage;

(6) Employees who have not attained age 25 prior to the beginning of the plan year;

(7) Non-resident aliens with no U.S.-based income; and

(8) Employees whose primary site of employment is in the same rating area.

Additional classes can consist of combinations of two or more of the enumerated classes. Thus, for example, part-time employees included in a unit of employees covered by a collective bargaining agreement might be one class of employees, and full-time employees included in the same unit of employees covered by a collective bargaining agreement might be another class of employees. Where an HRA is offered to former employees (e.g., retirees), former employees are assigned to the class they were in immediately before separation from service.

Variations in benefits within classes are allowed in certain, limited instances. The maximum dollar amount made available under the HRA for participants within a class of employees may increase as the age of the participant increases, so long as the same maximum dollar amount attributable to that increase in age is made available to all participants of the same age within the same class of employees. The maximum dollar amount made available under an HRA within a class of employees may increase as the number of the participant's dependents who are covered under the HRA increases, so long as the same maximum dollar amount attributable to that increase in family size is made available to all participants in that class of employees with the same number of dependents covered by the HRA.

- The participant, and any of his or her dependent(s) whose medical care expenses are reimbursable under the individual coverage HRA, must be enrolled in individual health insurance coverage that is subject to and complies with the ACA for each month that the individual(s) are covered by the individual coverage HRA.

For an HRA to be integrated with individual health insurance coverage, the participant and any dependents must be enrolled in ACA-compliant individual health insurance coverage (other than coverage that consists solely of HIPAA excepted benefits) for each month the individuals are covered by the HRA. If the individual covered by the HRA can merely obtain individual health insurance coverage, but does not actually have coverage, the HRA does not qualify as integrated. Such an arrangement would fail to comply with the above-cited ACA market rules.

- *A participant must be permitted to opt out of and waive future reimbursements from the individual coverage HRA at least annually, and, upon the participant's termination of employment, either the remaining amounts in the individual coverage HRA are forfeited or the participant is permitted to permanently opt out of and waive future reimbursements from the individual coverage HRA.*

If an individual is covered by an HRA that is integrated with individual health insurance coverage for a month, regardless of the amount of reimbursement available under the HRA, the individual is not eligible for the premium tax credit from an ACA exchange/marketplace for that month. Recognizing that there may be circumstances in which an individual may be better off claiming the premium tax

credit, the proposed regulations require employers that offer HRAs to allow participants to opt out of and waive future reimbursements from the HRA at least annually. In addition, upon termination of employment, amounts remaining in the HRA must be forfeited or the participant must be allowed to permanently opt out of and waive future reimbursements from the HRA.

- *The individual coverage HRA must implement reasonable procedures to ensure that individuals whose medical care expenses are reimbursable by the individual coverage HRA are, or will be, enrolled in individual health insurance coverage for the plan year.*

To facilitate the administration, an HRA must implement, and comply with, reasonable procedures to verify that individuals whose medical care expenses are reimbursable by the HRA are, or will be, enrolled in individual health insurance coverage (other than coverage that consists solely of HIPAA excepted benefits) during the plan year. Reasonable procedures may include a requirement that a participant substantiate enrollment in individual health insurance coverage by providing either a document from a third party (for example, the issuer) or an attestation by the participant stating that the participant and any dependents are enrolled in individual health insurance coverage, the date coverage began or will begin, and the name of the provider of the coverage. An HRA may rely on the documentation or attestation provided by the participant unless the HRA has actual knowledge that any individual covered by the HRA is not, or will not be, enrolled in individual health insurance coverage.

Each new request for reimbursement of an incurred medical care expense must be similarly substantiated.

- *The individual coverage HRA must provide a written notice to each participant, in general, at least 90 days before the beginning of each plan year, that explains the consequence of accepting the individual coverage HRA for premium tax credit eligibility and provides information that the plan sponsor has and that the participant will need to determine the effect of being offered the individual coverage HRA on premium tax credit eligibility.*

The proposed regulations include a requirement that an HRA provide written notice to eligible participants 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, 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 written notice must include:

1. A description of the terms of the HRA, including the maximum dollar amount made available, as used in the ACA “affordability” determination;
2. A statement of the right of the participant to opt-out of and waive future reimbursement under the HRA;
3. A description of the potential availability of the premium tax credit if the participant opts out of and waives the HRA and the HRA is not affordable under the rules governing premium tax credits;
4. A description of the premium-tax-credit eligibility consequences for a

participant who accepts the HRA;
5. A statement that the participant must inform any ACA exchange to which they apply for advance payments of the premium tax credit availability of the HRA, the amount of the HRA, the number of months the HRA is available to participants during the plan year, whether the HRA is available to their dependents and whether they are a current or former employee;
6. A statement that the participant should retain the written notice because it may be needed to determine whether the participant is allowed the premium tax credits;
7. A statement that the HRA may not reimburse any medical care expense unless the substantiation requirements are met; and
8. A statement that it is the responsibility of the participant to inform the HRA if the participant or any dependent whose medical care expenses are reimbursable by the HRA is no longer enrolled in individual health insurance coverage.

This notice would also be required to advise participants that individual health insurance coverage integrated with the HRA is not subject to ERISA. Notably, the written notice "would not need to include information specific to a participant."

Excepted Benefit HRAs

HIPAA established health insurance portability rules that applied to group health plans and health insurance issuers. However, these rules did not (and do not) apply to excepted benefits. HIPAA prescribed four statutory categories of excepted benefits, one of which is "limited excepted benefits." Limited excepted benefits include limited scope vision or dental benefits, benefits for long-term care, nursing home care, home health care, or community-based care, or any combination thereof, and "such other similar, limited benefits as are specified in regulations". To be excepted benefits under this category, the benefits must either be insured and provided under a separate policy, certificate, or contract of insurance, or otherwise not be an integral part of the plan.

The ACA insurance market reforms left intact, but expanded the HIPAA portability provisions. While the ACA insurance market reforms also broadly apply to group health plans and health insurance issuers offering group health insurance coverage, excepted benefits are also exempt from the ACA's market reforms, including the ACA's prohibition on annual limits and preventive care coverage requirement discussed above.

Importantly, coverage that consists of excepted benefits is not minimum essential coverage ("MEC") for ACA purposes. Consequently, an individual who otherwise qualifies for a premium tax credit from an ACA exchange/marketplace is not rendered ineligible for a premium tax credits if he or she purchases or is provided with coverage under a plan or arrangement that consists of entirely of excepted benefits. Nor is an offer of an excepted by an employer deemed to constitute an offer of MEC under an eligible employer sponsored plan for purposes of the ACA's employer shared responsibility rules. Consequently, an applicable large employer cannot avoid exposure for assessable payments under Code section 4980H by virtue of an offer of an excepted benefit and nothing more.

The proposed regulations expand the definition of limited excepted benefits to create an "excepted benefit" HRA that is limited in the annual amounts made available and the types of coverage for which premiums may be reimbursed. In order to qualify as an excepted benefit HRA, an arrangement must satisfy the following four requirements:

- *Contemporaneous offer of group health plan coverage*

While an excepted benefit HRA must meet the statutory requirement that it not be "an integral part of the plan," it must also be offered alongside an employer group health plan (other than an account-based group health plan or coverage consisting solely of excepted benefits). Only individuals who are eligible for participation in employer's group health plan are eligible for participation in the excepted benefit HRA. While the employer is required to make an offer of other group health plan coverage, however, excepted benefit HRA participants (and their dependents) would not be required to enroll in the group health plan in order to be eligible for the excepted benefit HRA.

- *Limited amount*

The proposal caps the annual amount of an excepted benefit HRA at $1,800, indexed for inflation (i.e., the Chained Consumer Price Index for All Urban Consumers, unadjusted (C-CPI-U) for plan years beginning after December 31, 2020.)

- *Prohibition on reimbursement of premiums for certain types of coverage*

To qualify as a limited excepted benefit, the HRA would not be permitted to reimburse premiums for individual health insurance coverage, coverage under a group health plan (other than COBRA or other group continuation coverage), or Medicare parts B or D. However, the proposed rules would allow an excepted benefit HRA to reimburse premiums for individual health insurance coverage that consists solely of excepted benefits or coverage under a group health plan that consists solely of excepted benefits, and for COBRA premiums.

- *Uniform Availability*

Under the proposal, an excepted benefit HRA is required to be made available under the same terms to all similarly situated individuals (as defined in the HIPAA nondiscrimination regulations) regardless of any health factor. In the Departments' view, this condition is necessary "to prevent discrimination based on health status and to preclude opportunities for an employer to offer a more generous excepted benefit HRA to individuals with an adverse health factor, such as an illness or a disability, as an incentive not to enroll in the plan sponsor's traditional group health plan."

Notably, under the proposed regulations, an employer would be permitted to offer an individual coverage HRA integrated with individual health insurance coverage to a class of employees so long as it does not also offer a traditional group health plan to the same class of employees. An employer could only offer an excepted benefit HRA, however, if traditional group health plan coverage is also made available to the employees who are eligible to participate in the excepted benefit HRA. Thus, an

employer would not be permitted to offer both an HRA integrated with individual health insurance coverage and an excepted benefit HRA to any employee.

Conclusion

Employer's appetite for offering individual coverage HRAs benefits is not yet clear. Large employers, as well as employers of any size that deploy group health coverage for recruiting and retention purposes will not likely have much interest. But because individual coverage HRAs are themselves group health plans that provide MEC, they might find purchase in industries with large cohorts of contingent and variable workers— e.g., restaurants, retail, staffing, and hospitality— that currently offer so-called preventive-services-only plans. The market for excepted benefit HRAs is equally hard to discern. Other than stand-alone vision and dental benefits, most excepted (e.g., hospital and fixed indemnity plans) are employee-paid. Whether there is a compelling reason for an employer to pay for this benefit remains to be seen.

There are also issues that the proposed regulations did not address. For example, the Treasury Department and the IRS flagged, but deferred on, the issues of compliance with the non-discrimination provisions of Code section 105(h) (after all, HRAs are themselves self-funded group health plans) and how individual coverage HRAs might comply with the Code section 4980H employer shared responsibility rules. The Treasury Department and the IRS subsequently outlined their proposed approach to these items in Notice 2018-88, which we will examine in an another post.

The proposed integration regulations are proposed to apply for plan years beginning on or after January 1, 2020.