The Departments of Labor, Treasury, and Health and Human Services have released final rules removing the prohibition on pairing HRAs with individual health policies. The final rules also allow certain HRAs and other account-based group health plans to qualify as limited excepted benefits. These rules are generally effective for plan years beginning on or after January 1, 2020.

IN DEPTH

In response to President Trump’s October 12, 2017, Executive Order 13813, the Secretaries of Labor, Treasury, and Health and Human Services (HHS) (collectively, the Departments) have issued final rules (the Final Rules), model notices, model attestations and frequently asked questions (the FAQs) that will give employers greater flexibility to offer new types of health reimbursement arrangements (HRAs) for plan years beginning on and after January 1, 2020. The Final Rules provide for two new types of HRAs: the individual coverage HRA and the excepted benefit HRA.

Background

Late last year, the Departments proposed rules (the Proposed Rules) to liberalize the use of HRAs by removing and clarifying several Affordable Care Act (ACA)
During the two-month comment period, the Departments received more than 500 comments from employers, health insurance issuers, state regulators, state exchanges, unions and individuals. In light of these comments, the Final Rules largely adopt the Proposed Rules with a few key clarifications detailed below:

**Individual Coverage HRAs (ICHRA)**

The Final Rules permit employers to offer an ICHRA to employees and former employees as an alternative to traditional group health plan coverage, subject to certain conditions. To satisfy the Final Rules, the individual coverage HRA must meet the following requirements:

- **All individuals covered by the ICHRA must be enrolled in individual market health coverage or Medicare.** Just as under the Proposed Rules, the Final Rules require that an individual (and any dependents) maintain qualifying individual health coverage for each month each individual is covered by the ICHRA. Plan sponsors may continue to apply the existing statutory structure with respect to what expenses may be reimbursed from the ICHRA or they may choose to narrow the scope of permitted reimbursements.

- **No choice between ICHRA and traditional group health plan coverage.** The Final Rules clarify that employers are prohibited from offering a class of employees a choice between an ICHRA and traditional coverage under a group health plan.
  - The Final Rules provide for 10 enumerated employee classes and give employers the flexibility to determine additional classes based on a combination of two or more classes. To address potential adverse selection into the individual market, the Final Rules also prescribe minimum employee class sizes that scale depending on employer size (e.g., 10 employees for an employer with 100 employees, 20 employees for an employer with 200 employees). The minimum class size applies at the common law employer level (versus as a controlled group), and is applied on an annual basis.
  - In response to industry comments to the Proposed Rules regarding typical benefit offerings, the Final Rules permit a class distinction between hourly and salaried employees, include a “new hire” subclass, and eliminate “employees under age 25” as a permitted employee class. The Final Rules also clarify that an employer may distinguish between collectively bargained agreements when defining a class.

- **Same-terms.** Just like the Proposed Rules, the Final Rules require that an ICHRA be offered on the “same terms” (including both the amount and the same terms and conditions) to all employees within a certain class.
  - The Final Rules include the Proposed Rules’ provision allowing increases in ICHRA contribution amounts based on participant age or family size without violating the same-terms requirement. Unlike the Proposed Rules,
the Final Rules cap age-based contributions for older employees at three-times the contribution level of the youngest ICHRA participant (similar to the ACA’s 3:1 age rating rules).

- The Final Rules allow employers to offer an ICHRA to some, but not all, former employees within an employee class. However, the Final Rules also clarify that employers who offer ICHRAs to former employees in a class must comply with the “same-terms” requirement. For example, the Final Rules note that a plan sponsor would not comply with the “same-terms” requirement if it provided an employee class with larger or smaller ICHRA amounts based on years of service or status as a former employee.

- The preamble to the Final Rules specifically notes that “benign discrimination” is also prohibited. Employers may not offer more generous benefits only to certain employees in a class of employees (e.g., a higher contribution for employees battling heart disease).

**Opt-out provisions.** The Final Rules clarify that employers may establish time frames for enrollment of an ICHRA, and that ICHRAs must generally allow participants to opt out of and waive future reimbursements from an ICHRA upon enrollment, at least once annually, and upon termination of employment. This provision is important for individuals who may want to retain premium tax credit (PTC) eligibility.

**Substantiation and verification.** The Final Rules include the Proposed Rules’ requirement that ICHRAs implement and comply with “reasonable procedures” to verify that individuals are enrolled in individual health insurance both on an annual basis and as part of each reimbursement request. To assist with this rule, the Final Rules include model attestation language employers may rely on to meet this substantiation requirement.

**Notice requirement.** In order to ensure that individuals eligible for ICHRAs understand how such coverage could potentially impact their PTC eligibility, the Final Rules expand the detailed notice requirement outlined in the Proposed Rules and include a model notice that must be provided at least 90 days in advance of each plan year. In addition, plan sponsors of an ICHRA must provide a summary of benefits and coverage (SBC) that describes the coverage, including cost sharing, exceptions, reductions and limitations on coverage, and other information.

**Excepst Benefit HRAs (EBHRA)**

As an alternative to the ICHRA option, the Final Rules recognize certain HRAs as limited excepted benefits. An EBHRA allows participants to obtain reimbursement for certain qualified expenses even if they choose not to enroll in their employer’s group health plan coverage. In a departure from the Proposed Rules, the Final Rules also provide that an EBHRA cannot reimburse short-term plan premiums if (a) the HRA is offered by a fully insured or partially insured small employer, and (b) the Departments find that reimbursement for short-term plan premiums has significantly harmed the small group market in the employer’s state. If such a finding is made, the Departments must formally publish this finding in the Federal Register.
The Final Rules largely adopt the Proposed Rules’ standards and require the following for an EBHRA:

- **Otherwise not an integral part of the plan.** In order to satisfy existing statutory requirements for excepted benefits, the HRA must not be an “integral part” of the employer’s group health plan. This means that a plan sponsor must offer other group health plan coverage to the employees who are also offered the EBHRA for a particular plan year. The “other” coverage must not be another account-based group health plan or coverage consisting solely of excepted benefits.

- **Limited in amount.** An EBHRA would be limited to annual contributions of $1,800 per year (indexed for inflation after 2020, with the indexed amount announced by June 1 of each year at the same time the HSA and HDHP announcements are made).

- **Prohibition on reimbursement of premiums for certain types of coverage.** An EBHRA may not reimburse premiums for individual health insurance coverage, coverage under a group health plan (other than COBRA or other group continuation coverage), or Medicare parts A, B, C or D. The Final Rules permit reimbursement of premiums for individual coverage that consists solely of excepted benefits or coverage under a group health plan that consists solely of excepted benefits, as well reimbursement of short-term limited duration insurance premiums and COBRA premiums.

- **Uniform availability.** Benefits provided under an EBHRA must be made available under the same terms and conditions to all similarly situated individuals, regardless of any health factor.

**ERISA Application**

The Final Rules clarify that the Proposed Rules’ definition of “employee welfare benefit plan” and “welfare plan” under the Employee Retirement Income Security Act (ERISA) will not include individual health insurance coverage, the premiums of which are reimbursed by an HRA, including an HRA integrated with individual health insurance coverage, a retiree-only HRA that reimburses premiums for individual health insurance coverage, or a qualified small employer health reimbursement arrangement (QSEHRA), provided certain safe harbor requirements are met. Without this clarification, individual market policies could become part of an HRA (or QSEHRA) for purposes of ERISA.

**Employer Shared Responsibility (“Pay or Play”)**

The Final Rules stated that guidance regarding compliance with the ACA employer shared responsibility regulations will be forthcoming.

**Next Steps**

These Final Rules present plan design opportunities for employers of all sizes effective January 1, 2020. The differences between the various types of account-
based group health plans are often subtle and the type of plan best suited to meet each employer’s goals may be difficult to determine. Employers should work with their benefits counsel to understand how these new rules could potentially save costs and structure more efficient health coverage for their employee populations.

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