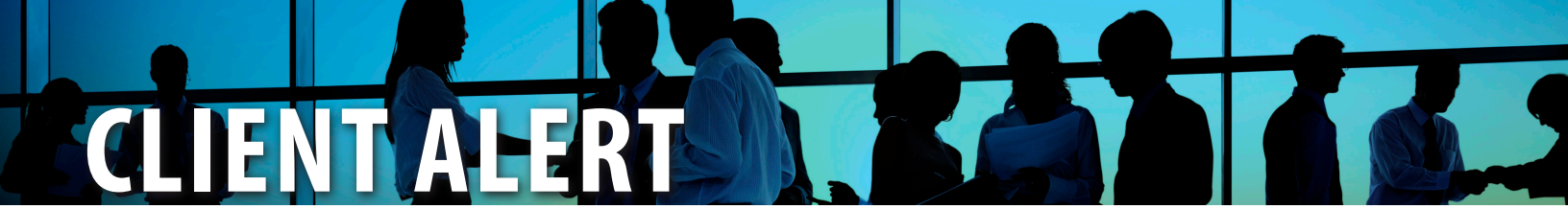


EMPLOYEE BENEFITS

NEW HRA ALTERNATIVES FOR EMPLOYERS

by Cynthia A. Moore

The IRS issued final regulations on June 20, 2019 (the "Final Regulations"), which will allow employers to offer two new categories of health reimbursement accounts ("HRAs") for plan years beginning on or after January 1, 2020: an individual coverage HRA and an excepted benefit HRA.

1. Background

The Final Regulations were issued in response to Executive Order 13813, in which the President directed the Departments of Treasury, Labor, and Health & Human Services (the "Departments") to expand the use of HRAs and to allow HRAs to be used in conjunction with non-group health coverage.

HRAs have raised a number of issues since the enactment of the Affordable Care Act ("ACA"). An HRA is funded solely by the employer and typically has an annual limit on the amount of medical expenses it will reimburse. Due to this annual limit on reimbursements, HRAs generally violate the ACA's prohibition against a group health plan imposing an annual dollar limit on essential health benefit, set forth in Section 2711 of the Public Health Service Act ("PHS Act"), which is incorporated by reference into ERISA. A non-grandfathered HRA with an annual limit can also violate the ACA's requirement that a group health plan pay for all preventive care services mandated under Section 2713 of the PHS Act.

The IRS had previously issued guidance in the form of FAQs, notices and regulations, which provided that an HRA would be deemed to comply with these ACA provisions as long as it was integrated with other group health plan coverage. However, prior to issuance of the Final Regulations, the IRS had consistently stated that an HRA could not be integrated with individual health insurance coverage. This IRS position frustrated small employers in particular, many of whom had previously paid for or reimbursed premiums for employees who purchased individual health insurance coverage relying on longstanding IRS guidance, including Rev. Rul. 61-146.

2. Individual Coverage HRAs

The Final Regulations allow an HRA to be integrated with individual health insurance coverage (an "Individual Coverage HRA" or "ICHRA") as long as certain following conditions are met:

A. Conditions that Must be Met

1. Enrollment in individual health insurance coverage. The participant and any of his or her dependents whose medical care expenses are reimbursable under the ICHRA must be enrolled in individual health insurance that complies with PHS Act Sections 2711 and 2713, for each month that the individual(s) are covered by the ICHRA. Individual health insurance coverage that consists solely of excepted benefits (*i.e.,* limited scope dental or vision insurance) does not qualify for this purpose, nor does short-term limited duration insurance. However, any other individual health insurance policy, whether purchased on or off the Exchange, is deemed to comply with PHS Sections 2711 and 2713, and a plan sponsor is not required to independently verify compliance. The ICHRA must provide that it will not reimburse any medical expenses after the individual is no longer covered by an individual health insurance policy or Medicare.

   An ICHRA can also be integrated with Medicare. Therefore, an employee who is enrolled in Medicare Parts A and B or Part C can be offered an ICHRA. The integration rules are satisfied if the employee is enrolled in Medicare and his/her spouse is enrolled in individual health insurance coverage, or vice versa. This rule applies regardless of whether the employer is subject to the Medicare secondary payer ("MSP") rules. However, to comply with the MSP rules, an employer with 20 or more employees could not offer Medicare-eligible beneficiaries only an ICHRA while offering all other employees a traditional group health plan. This would also violate the "same terms" requirement discussed below. Benefits under the ICHRA would be primary to Medicare for employers who are subject to the MSP rules.

2. No traditional group health plan coverage. If a plan sponsor offers a class of employees an ICHRA, it may not offer that same class of employees a traditional group health plan. Therefore, an employee may not be offered a choice between an ICHRA and a traditional group health plan.

Comments:

- A group health plan that consists solely of excepted benefits is not considered to be a traditional group health plan. Therefore, a plan sponsor could offer employees an ICHRA and a group health plan that is an excepted benefit (*i.e.*, limited scope dental or vision insurance.)

- An employer may allow premiums paid for an individual health insurance policy purchased outside of the Exchange to be paid for on a pre-tax basis through a cafeteria plan. This arrangement is not considered to be a traditional group health plan.

3. Same Terms Requirement. A plan sponsor that offers an ICHRA to a class of employees must offer the ICHRA on the same terms (that is, in the same amount and otherwise on the same terms and conditions) to all employees in the class. Permitted variations include the following:

(a) The maximum dollar amount may increase based on the number of the participant's dependents covered under the ICHRA.

(b) The maximum dollar amount may increase based on age, as long as the maximum dollar amount made available to the oldest participant is not more than three times the maximum dollar amount made available to the youngest participant.

(c) The maximum dollar amount for an employee who is newly eligible during the plan year may be pro-rated.

(d) A plan sponsor may offer participants in a class of employees a choice between an HSA-compatible ICHRA and an ICHRA that is not HSA-compatible. An HSA-compatible ICHRA could be a "limited purpose" HRA (limited to reimbursing such expenses as dental or vision expenses) or a "post-deductible" HRA (reimburses expenses after the high deductible is met), or a combination of these arrangements.

(e) Amounts carried over from prior years are disregarded in determining whether an ICHRA meets the same terms requirement, as long as the rules for carrying over amounts are the same for all participants in a class of employees.

Permitted classes of employees. If coverage will vary based on a class of employees, the plan sponsor must make that distinction before the beginning of the plan year and that classification may not change during the plan year. Classes of employees are determined on a common law employer (entity) level and not on a controlled group basis. Permitted classes are:

- Full-time employees (as defined under ACA rules or the rules under Section 105(h) of the Internal Revenue Code ("Code"))
- Part-time employees (as defined under the ACA rules or the Code Section 105(h) rules)
- Salaried employees
- Non-salaried employees
- Employees whose primary site of employment is in the same rating area
- Seasonal employees (as defined under the ACA rules or the Code Section 105(h) rules)
- Employees covered by a collective bargaining agreement
- Employees who have not satisfied a waiting period for coverage (not to exceed the ACA's 90-day waiting period)
- Non-resident aliens with no U.S.-based income
- Employees of a temporary staffing company
- A group of participants that is a combination of two or more of the foregoing classes

Minimum class size. In some circumstances, a class of employees cannot be offered an ICHRA unless the class satisfies a minimum class size. As a threshold matter, the minimum class size requirement applies only if the plan sponsor offers a traditional group health plan to one or more classes of employees and offers an ICHRA to one or more other classes of employees. The minimum class size requirement does not apply to the class of employees offered a traditional group health plan; it only applies to the classes of employees offered the ICHRA. Further, the minimum class size requirement only applies to a class offered an ICHRA if the class is full-time employees, part-time employees, salaried employees, non-salaried employees or employees whose primary site of employment is in the same rating area. Other operating rules and exceptions:

- The minimum class size requirement does not apply to employees whose primary site of employment is the same rating area if the geographic area defining the class is a State or a combination of States.

- The minimum class size requirement only applies to full-time/part-time employees if one class is offered a traditional group health plan and the other class is offered an ICHRA, and then only to the class offered the ICHRA.

  The minimum number of employees that must be in a class is:

  (a) 10, for an employer with fewer than 100 employees;

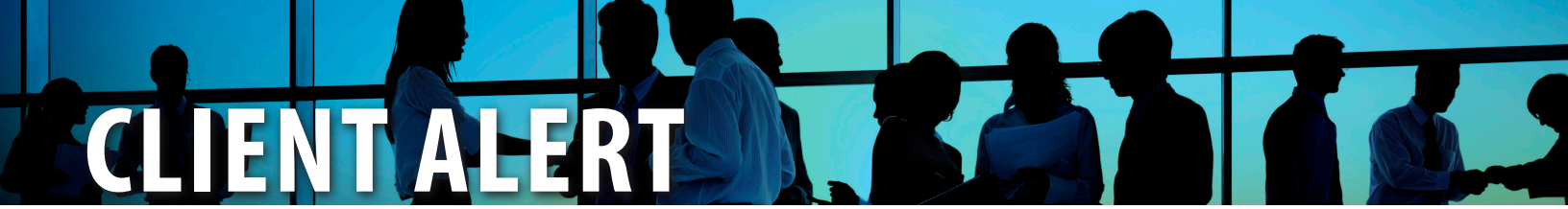
  (b) 10% of the total number of employees for an employer with 100 to 200 employees; and

  (c) 20, for an employer with more than 200 employees.

The total number of employees is determined in advance of the plan year based on the number of employees that the employer reasonably expects to employ on the first day of the plan year. Thus, unlike the ACA test, employer size is determined on a prospective basis and not a lookback basis. However, like the ACA, compliance with the minimum class size requirement is based on the number of employees who are offered the ICHRA as of the first day of the plan year, and not the number who actually enroll. The determination is not affected by changes in the number of employees of the class during the plan year.

Example: Employer D, who has 150 employees, offers a traditional group health plan to its 120 full-time employees and an ICHRA in the amount of $2,400 to its 30 part-time employees. Employer D determines full-time and part-time status on the basis of the ACA lookback measurement method. Full-time and part-time employees are permitted classes of employees. The minimum class size requirement applies because the full-time class of employees is offered a traditional group health plan and the part-time class of employees is offered an ICHRA. The minimum class size is met because the number of part-time employees who are offered the ICHRA (30) is greater than 10% of the employer's total number of employees (10% x 150 = 15)

Special rule for new hires. An employer who offers a traditional group health plan to a class of employees may, on a prospective basis, provide



that employees hired on or after a specified date will be offered an ICHRA (the "new hire subclass") while employees hired before that date will continue to be offered the traditional group health plan. The minimum class size requirement does not apply to the new hire subclass. For example, an employer could offer full-time employees hired on or after January 1, 2021 an ICHRA while full-time employees hired before that date would be offered a traditional group health plan.

4. Opt out. Like the existing rules that apply to integrated HRAs, an ICHRA must give employees the opportunity to opt out of the ICHRA one time per plan year, and upon termination of employment. Alternatively, the remaining amounts in the ICHRA can be forfeited upon termination of employment. Opt-out is required because coverage under an HRA could make the employee ineligible to claim a premium tax credit ("PTC") on the Exchange.

5. Substantiation of Coverage Under Individual Health Insurance or Medicare. Two types of coverage substantiation are required:

   (a) First, an employee must provide evidence that he/she and his/her eligible dependents are enrolled in individual health insurance coverage or Medicare on or before the first day of the ICHRA's plan year (or before the first day coverage is effective for a newly hired employee) (the "annual coverage substantiation requirement"). The evidence can be in the form of documentation from a third party (such as an insurance card) or an attestation by the employee.

   (b) Second, the employee must substantiate coverage for the month in which the reimbursement from the ICHRA is requested (the "ongoing substantiation requirement"). An attestation is also sufficient for this purpose.

The Departments have issued model attestations forms that can be used for this purpose, which can be viewed as part of the FAQs issued by the Departments: https://www.hhs.gov/sites/default/files/health-reimbursement-arrangements.pdf

An employer can rely on the employee's annual or ongoing substantiation as long as the employer does not have actual knowledge that the individual is not enrolled in individual health insurance coverage or Medicare for the plan year or month, as applicable.

6. Notice requirement. The employer must provide a notice to participants at least 90 days before the beginning of the plan year (or no later than the effective date of coverage for new hires). The notice must include, among other information:

   (a) A description of the terms of the ICHRA;

   (b) The participant's right to opt out of the ICHRA;

   (c) The effect on the PTC if the participant enrolls in, or waives coverage under, the ICHRA; and

   (d) A description of the substantiation requirements.

The Departments have published a model notice that can be viewed as part of the Departments' FAQs (see link above).

B. Other Considerations

1. Which types of Medical Expenses Can an ICHRA Reimburse?

   An ICHRA can reimburse any type of medical expense that qualifies under Code Section 213(a), or an employer can limit it to:

   - Reimbursements only for premiums (including premiums under Medicare Parts B and D, or for Medigap policies); and/or
   - Reimbursements for cost-sharing expenses (deductibles, coinsurance or copayments).

   The Departments generally anticipate that an ICHRA will reimburse employees for premiums, as the employee must be enrolled in individual health insurance or Medicare to qualify for coverage under the ICHRA.

2. Is an ICHRA governed by ERISA?

   Yes, an ICHRA is a group health plan subject to ERISA. Therefore, the ICHRA should have a plan document and is subject to all applicable reporting and disclosure requirements, including the summary plan description (SPD) and summary of benefits and coverage (SBC) requirements.

   The Final Regulations also amended ERISA regulations to provide that individual health insurance coverage selected by an employee, the premiums for which are reimbursed by the ICHRA, is not part of a group health plan and is not a welfare benefit plan under ERISA if all of the following conditions are met:

   (a) The purchase of any individual health insurance coverage is completely voluntary for participants and beneficiaries. This is the case even though the purchase of such coverage is required as a condition for participation in the ICHRA.

   (b) The employer does not select or endorse any particular health insurance issuer or insurance coverage.

(c) Reimbursement for non-group health insurance premiums is limited to individual health insurance coverage that does not consist solely of excepted benefits.

(d) The employer receives no consideration (in the form of cash or otherwise) in connection with the employee's selection or renewal of individual health insurance coverage.

(e) Each plan participant is notified annually that the individual health insurance coverage is not subject to Title I of ERISA.

3. Is an ICHRA Subject to COBRA?

Yes. Therefore, if an employee terminates employment or has a reduction in hours that causes him/her to lose eligibility for the ICHRA, COBRA continuation coverage must be offered. However, failing to maintain individual health insurance coverage is not a qualifying event. Thus, losing eligibility for the ICHRA due to a failure to maintain individual health insurance coverage does not create a right to COBRA continuation coverage.

C. Impact of ICHRA Coverage on Eligibility for the Premium Tax Credit

An ICHRA is eligible employer-sponsored coverage for purposes of an employee's eligibility for the ACA premium tax credit ("PTC"). Under the general rules, if an employee is offered coverage under an eligible employer-sponsored plan that is affordable and provides minimum value ("MV"), the employee is not eligible for a PTC. An employee also loses eligibility for the PTC if he/she enrolls in coverage even if the coverage is not affordable. The Final Regulations provide that if an ICHRA is affordable, it is deemed to provide MV. Therefore, the key to PTC eligibility is whether the ICHRA is affordable.

- If the ICHRA is affordable, the employee is not eligible for a PTC, even if the employee opts out of the ICHRA.
- If the ICHRA is not affordable, the employee is eligible for a PTC if the employee opts out of the ICHRA.

The Final Regulations set out a formula for determining whether an ICHRA is affordable.

Step 1: Calculate the employee's "required HRA contribution", which is the monthly premium for the lowest cost silver plan for self-only coverage offered in the Exchange for the rating area in which the employee resides, less the "monthly HRA amount". The monthly HRA amount is the self-only amount newly made available under the HRA for the plan year, divided by the number of months in the plan year the HRA is available to the employee.

Step 2: Multiply the employee's household income by the required contribution percentage (9.78% for 2020), and divide the result thereof by 12.
Step 3: If the required HRA contribution is less than the product determined in Step 2, the HRA is affordable.

Example: Employee A is single and has household income of $28,000. A is eligible for an HRA with an annual reimbursement amount of $2,400 for self-only coverage ($200 per month.) The monthly premium for the lowest cost silver plan offered in the rating area where A resides is $500.

Step 1: The required HRA contribution is $300, calculated as $500 (monthly silver plan premium) less $200 (monthly HRA amount.)

Step 2: Household income of $28,000 x 9.78% (the 2020 required contribution percentage) = $2,738/12 = $228.

Step 3: Because the required HRA contribution of $300 is greater than the product determined in Step 2, the HRA is not affordable and A can qualify for a PTC if he opts out of coverage under the HRA.

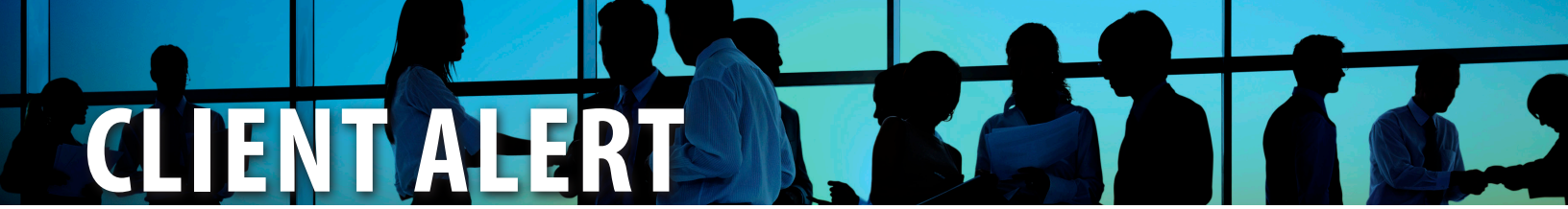
Comment: In determining its contribution to an ICHRA, an employer may wish to estimate the potential impact of offering the ICHRA on an employee's eligibility for the PTC, i.e., by determining the self-only premium for the lowest cost silver plan and modeling whether the required HRA contribution for employees at different pay levels will be affordable or not. As the employer does not typically know the employee's household income, the employer cannot make a precise calculation of affordability. Employees are directed to the State's Exchange website to find out whether the HRA is affordable, at:

https://www.healthcare.gov/marketplace-in-your-state

D. *Affordability Under Code Section 4980H*

Although the ICHRA is aimed primarily at small employers, who have objected to their inability to reimburse premiums for individual health insurance under prior guidance, ICHRAs are not limited to small employers and may be offered by large employers. To avoid penalties under Code Section 4980H, an applicable large employer or "ALE" (one with 50 or more full-time employees) must (a) offer coverage to 95% of its full-time employees to satisfy Section 4980H(a); and (b) offer coverage that is affordable and provides minimum value (MV) to satisfy Section 4980H(b).

The Final Regulations do not address how an employer is to determine whether an ICHRA is affordable for purposes of the shared responsibility rules under Code Section 4980H. However, IRS Notice 2018-88, issued on November 19, 2018, outlined a proposed approach to determining affordability and requested comments. In the preamble to the Final Regulations, the IRS stated that it intends to issue proposed regulations on the issues addressed in Notice 2018-88.



In Notice 2018-88, the IRS would generally follow the process described above in the PTC context for determining whether the offer of an ICHRA is "affordable" for purposes of avoiding a penalty under Code Section 4980H(b). The IRS is considering the issuance of additional safe harbors that would ease an employer's administrative burden in determining the affordability of an ICHRA. For example, rather than using the lowest cost silver plan in the rating area where the employee lives, an ALE could use the lowest cost silver plan based on the employee's primary site of employment. For Section 4980H purposes, an ALE would be permitted to use any of the affordability safe harbors (Form W-2 wages safe harbor, rate of pay safe harbor or federal poverty line safe harbor) rather than the employee's household income in the Step 2 calculation. Finally, an ICHRA that is affordable would be deemed to provide MV.

Employers may not rely on the guidance provided in Notice 2018-88 and therefore, in the absence of more formal guidance, it will be almost impossible for ALEs to determine whether an ICHRA is affordable for the plan year beginning January 1, 2020.

E. *Satisfying Non-Discrimination Rules Under Code Section 105(h)*

HRAs, including an ICHRA, are self-insured medical reimbursement plans and must generally satisfy the non-discrimination rules under Code Section 105(h).[1] Among other requirements, the Section 105(h) non-discrimination rules provide that any maximum limit in the plan attributable to employer contributions must be uniform for all participants. This "uniform benefit" rule conflicts with the ICHRA rules permitting employer contributions to vary by class of employees and by age.

In Notice 2018-88, the IRS outlined a possible solution to this issue. The IRS anticipates the future guidance will provide that the Section 105(h) rules will not be violated if the same maximum dollar amount is provided to all employees within a permitted class of employees. Further, employer contributions may vary by age, if the same maximum dollar amount attributable to the increase in age is made available to all employees who are members of that same class of employees who are the same age. Presumably, any future guidance will also provide that contributions for older employees may not be more than three times the employer contribution for younger employees, as set forth in the Final Regulations on ICHRAs.

As in the case of the Section 4980H rules summarized above, employers may not rely on the guidance provided in Notice 2018-88 for purposes of complying with the Section 105(h) non-discrimination rules.

3. Excepted Benefit HRAs

The Final Regulations also allow an employer to offer a new type of HRA referred to as an "Excepted Benefit HRA" for plan years beginning on or after January 1, 2020. As in initial matter, an Excepted Benefit HRA should not be confused with an HRA that only reimburses expenses for excepted benefits. As described in IRS Notice 2015-87, Q&A 5, an HRA that only reimburses expenses for excepted benefits – such as an HRA that reimburses premiums for limited scope dental or vision insurance – is exempt from the ACA's market requirements because those requirements do not apply to a group health plan that provides only excepted benefits. Therefore, an HRA that provides only excepted benefits is not subject to the requirements described below.

In general, an excepted benefit is exempt from the ACA's market requirements that apply to group health plans, including the prohibition on an annual or lifetime limit on essential health benefits. Common types of excepted benefits include:

- Dental insurance;
- Vision insurance;
- Long-term care insurance;
- Health FSAs; and
- EAPs

An Excepted Benefit HRA will qualify as a new category of excepted benefit if the following conditions are met.

1. Otherwise not an integral part of the plan. The employer must offer a traditional group health plan to each participant in the Excepted Benefit HRA. The participant is not required to enroll in the traditional group health plan.

2. Limited Benefit. The amount made available under the Excepted Benefit HRA in the plan year is $1,800 or less (indexed for future years.) Amounts carried over from prior years are disregarded for this purpose.

3. HRA cannot reimburse certain types of health insurance premiums. An Excepted Benefit HRA cannot reimburse premiums for individual health insurance, group health plan coverage or Medicare premiums. An Excepted Benefit HRA may reimburse premiums for COBRA coverage or for excepted benefits, or any other medical care expenses. As with any HRA, the plan sponsor has the discretion to decide which medical care expenses the Excepted Benefit HRA will reimburse.

4. Uniform availability. The Excepted Benefit HRA is made available under the same terms to all similarly situated individuals (as defined under the HIPAA non-discrimination rules) regardless of any health factor. Under the HIPAA non-discrimination rules, an employer is permitted to make distinctions among groups of participants based on a bona fide employment-based classification consistent with the employer's usual business practice. Examples of bona fide classifications are full-time v. part-time, different geographic location, union v. non-union, date of hire, length of service, current employee v. former employee and different occupations. Even though these permitted distinctions are much more flexible than the classes of employees and minimum class size rules that apply to an ICHRA, keep in mind that an Excepted Benefit HRA is a

self-insured medical reimbursement plan subject to the non-discrimination rules under Code Section 105(h). Therefore, it would likely not be permissible to make the HRA available to a class of employees that is largely comprised of highly compensated individuals.

5. Notice requirement. An Excepted Benefit HRA is not subject to any special notice rules, but must provide an SPD and comply with all other reporting and disclosure requirements if the HRA is an ERISA-governed plan.

An Excepted Benefit HRA may be a good add-on benefit for an employer who offers a traditional group health plan to its employees. It is not required to be "integrated" with other group health plan coverage so the employer does not need to verify the existence of other coverage. It can provide assistance with cost sharing or other medical care expenses.

An employer cannot offer an Excepted Benefit HRA and an ICHRA to the same group of employees. Why? Because an ICHRA can only be offered to an employee who is not eligible for a traditional group health plan, and an Excepted Benefit HRA can only be offered to an employee who is eligible for the employer's traditional group health plan.

4. Conclusion

ICHRAs and Excepted Benefit HRAs will give employers another tool to assist employees in obtaining health insurance coverage or paying for ever-increasing out of pocket costs. However, employers must also take care to ensure that all of the conditions are met for each new type of HRA and that the various compliance obligations are satisfied.

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[1] Under existing regulations, an HRA that reimburses employees only for premiums to purchase health insurance policies is not subject to the Section 105(h) non-discrimination rules. Treas. Reg. Section 1.105-11(b)(2).

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