Two New HRAs Coming in 2020

In a June 2019 Notice ("Final Regulations"), the IRS has reversed course on a couple of ACA-related items and now allows two new forms of Health Reimbursement Arrangements (HRAs) for plan years beginning on or after January 1, 2020. The new rules make it easier for employers to provide health coverage to their employees through HRAs. In some cases, employers now have the option to offer some or all of their employees either a traditional group health plan or a defined-contribution to an HRA to reimburse employees for the purchase of individual or Medicare health coverage.

The first new form is called an Individual Coverage HRA (ICHRA), which allows an employer to reimburse an employee pre-tax for the purchase of individual health coverage or Medicare. The second new HRA is the dollar-limited Excepted Benefit HRA (EBHRA), which allows an employer to reimburse employees on a pre-tax basis for most out-of-pocket medical expenses.

Individual Coverage HRA

The ICHRA is a clear reversal of the previous IRS position dating back to 2013. In the Pre-ACA days, employers (and in particular smaller employers) would often feel they could not afford a traditional group health plan for its employees, and instead would provide a fixed dollar reimbursement to any employee purchasing individual or family coverage on the open market. For example, an employer might reimburse an employee on a pre-tax basis for up to $400 per month if that employee purchased health coverage for herself. In some cases, the employer would even offer reimbursement for Parts B, C, or D of Medicare coverage or Tricare coverage for veterans.

In the infamous Notice 2013-54, the IRS set forth new rules requiring that any account-based plan such as an HRA must be integrated with a qualifying group health plan. That is, in order to participate in an employer's contribution to an HRA (and yes, only employer contributions are allowed for all types of HRAs), the employee was now required to be enrolled in her or her spouse's employer's group health plan. According to the 2013 Notice, the type of Pre-ACA arrangement described above was now a violation of the ACA's market reform rules, and would result in a penalty of up to $36,500 per employee per year. Of course, that dissuaded a number of employers from offering the Pre-ACA type of reimbursement program. The rationale for this requirement was that the Pre-ACA design violated the ACA prohibition against annual dollar limits on essential health benefits as

well as the requirement to provide certain preventive health benefits without cost-sharing.

The new Final Regulation reinstates the Pre-ACA design by allowing for the integration of the ICHRA with certain qualifying individual health plan coverage or Medicare in order to satisfy the ACA's market reforms. In order to be considered "integrated" with individual health coverages or Medicare, the Final Regulations provide that the ICHRA must meet several conditions.

1. Requirement that All Individuals Covered by the HRA Are Enrolled in Individual Health Insurance or Medicare Coverage

   In order to be integrated with individual health insurance coverage, any participant (regardless of whether a current or former employee) and dependent who can receive reimbursements from the ICHRA must be enrolled in individual health insurance or Medicare coverage for each month that they are covered by the ICHRA. Substantiation of enrollment in such coverage is required (the substantiation requirements are discussed below).

2. Prohibition Against Offering Both an ICHRA and a Traditional Group Health Plan to the Same Class of Employees

Generally, an employer may not offer an ICHRA to a class of employees if the employer offers a "traditional group health plan" to the same class of employees. A "traditional group health plan" is defined as any group health plan except (i) an account-based health plan, and (ii) a plan that consists solely of excepted benefits. However, employers are permitted to create "classes" within their workforce, based on nine specified categories enumerated in the Final Regulations (e.g., full-time, part-time, salaried, non-salaried, etc.). If the employer offers an ICHRA to an employee in a given class, it must offer the ICHRA on the same terms to all employees in that class, but could offer a traditional group health plan to employees in a different class. One note that is also particularly helpful: to employers is that the Final Regulations allow for defining employee classes on a common-law rather than controlled group basis. This allows an employer that is part of a controlled group to look at each individual employer within the group as a separate entity when determining the classes of employees to which it will offer either the traditional health plan or an ICHRA.

There are minimum class sizes if an employer offers an ICHRA to one or more groups of employees in addition to a traditional group health plan to another group of employees. For an employer with fewer than 100 employees, the class must contain at least 10 members. For employers with 100 to 200 employees, no class can be smaller than 10 percent of the total number of employees. Lastly, for an employer with more than 200 employees, a class must contain at least 20 members. The minimum class size requirement does not apply if the employer does not offer a group health plan to any of its employees.

There's also a new rule that would allow new hires to be offered an ICHRA while awaiting group health plan eligibility, and for grandfathering existing employees in a traditional group health plan.

3. Same-Terms Requirement

With only three exceptions, employers that offer an ICHRA to a class of employees must offer it on the same terms and conditions to all employees in the same class. Interestingly, the Final Regulations prohibit the use of even "benign" discrimination by not allowing the employer to provide greater ICHRA benefits to those having an adverse health status such as cancer or diabetes. The three exceptions to this rule are:

a) Age. The Final Regulations permit an employer to increase the contribution to the ICHRA upon an increase in the participant's age. However, such an increase must also apply to all similarly aged participants in the same class of employees. Within this exception, the maximum contribution to the oldest participant in the entire plan cannot exceed three times the amount that is made to the youngest participant in the plan. We do expect further guidance from the IRS on how this new rule would interact with the current nondiscrimination rules that normally apply to all self-funded plans (including HRAs) under IRC Section 105(h). Note: the preamble to the Final Regulations specifically do not allow for any consideration of years of service in determining the contribution amount to an ICHRA.

b) Number of Dependents. The maximum dollar amount available under an ICHRA may also increase as the number of the participant's dependents covered under the ICHRA in-

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creases, on a uniform basis within the class.

c) Former Employees. An ICHRA is treated as offered on the same terms even if the employer offers the ICHRA to some but not all former employees within a class. If it is offered to former employees, it must be offered on the same terms as it is to all other active employees in that class. Do remember that a retiree-only HRA outside of the new ICHRA has always been allowed post-ACA without any integration requirements.

4. Opt-Out Provisions

For any month for which an individual is covered by an ICHRA, they are ineligible for a premium tax credit at the Exchange for the same month. For that reason, participants must be offered the ability to opt-out of an ICHRA and waive future reimbursements at least annually and upon termination of employment.

5. Substantiation and Verification of Individual Health Insurance Coverage and Medicare

In order to be considered integrated, an ICHRA must implement and follow reasonable procedures to verify that all participants and dependents covered by an ICHRA are enrolled in qualifying individual health coverage (other than excepted benefits or short-term limited duration insurance) or Medicare. This can take the form of documentation by a third party or attestation by the participant. No expense can be reimbursed from the ICHRA prior to substantiation and verification of individual health coverage for that month. The Final Regulations and the accompanying FAQs do provide model attestations for participants.

6. Notice Requirements

Since coverage under an ICHRA will render someone ineligible for a premium tax credit from the Exchange, the employer must provide a written notice to eligible employees at least 90 days prior to the beginning of each plan year that their participation in the ICHRA will make them ineligible for a premium tax credit. For new hires or those newly eligible not at the beginning of the plan year, the notice must be given no later than the date on which the participant is first eligible to participate in the ICHRA. The FAQs again provide a model notice that will satisfy this requirement.

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ICHRAs and ERISA

While all HRAs, including the new ICHRAs and EBHRAs are subject to ERISA (unless the plan sponsor is a governmental entity or a church plan), the Final Regulations exempt from ERISA the underlying individual health coverage with which the ICHRA is integrated, where certain safe harbors are met.

a. The purchase of any individual health coverage must be completely voluntary for employees.
b. The sponsor of the ICHRA cannot select or endorse any particular insurance issuer or insurance coverage.
c. Premium reimbursements under the ICHRA must be limited to qualifying individual health coverage.
d. The plan sponsor cannot receive any consideration in the form of cash or otherwise in connection with the employee's selection or renewal of individual health coverage.
e. Each plan participant must be notified annually that the individual health coverage is not subject to ERISA.

Individual Health Coverage Can Now be Purchased Pre-Tax

Another exciting change from the previous rules is that an employer can adopt a cafeteria plan under IRC Section 125 to enable participants to pay the portion of the premium for individual health coverage that is not covered by the ICHRA on a pre-tax basis (if the employer so allows). Of course, all of the regular requirements of Section 125 would apply to the plan, including having a plan document and SPD as well as prospective enrollment procedures with allowable changes only for qualified changes in status.

Excepted Benefit HRA (EBHRA)

The second new form of HRA is the Excepted Benefit HRA, also available starting with plan years beginning on or after January 1, 2020. This is a standalone HRA that an employer can offer to active employees without regard to whether they are enrolled in any group or individual health coverage. The name derives from benefits excepted under HIPAA. An EBHRA participant is not considered enrolled in the ACA's Minimum Essential Coverage (MEC) and thus would not be precluded from receiving a premium tax credit at the Exchange.

In order to offer an EBHRA, the following requirements must be met.

1. Otherwise Not an Integral Part of the Plan. The employer is required to offer other non-account based group health coverage to employees that is not an ex-

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cepted benefit such as dental and/or vision-only plans.

2. Dollar Limitation. The amount of new employer contributions each year cannot exceed $1,800 (indexed for inflation after December 31, 2020). Amounts not utilized in one plan year may be carried over to the next, and will not count toward the $1,800 indexed amount. Carryover is a plan design option and not a requirement.
3. Prohibition on Reimbursement of Premiums for Certain Types of Coverage. An EBHRA may be designed to be used for any unreimbursed eligible medical expense under IRC Section 213(d) or any subset thereof (*e.g.* deductibles-only, or vision-only), with the exception of premiums for individual and non-COBRA group coverage which cannot be reimbursed from an EBHRA. Thus, an EBHRA could be designed to allow for reimbursement of COBRA, dental, vision, or short-term limited duration insurance premiums as well as most other unreimbursed Section 213(d) expenses.
4. Uniform Availability. An EBHRA must be made available on a uniform basis to all similarly situated employees (*e.g.* full-time, part-time, collectively bargained, etc.).
5. Employee Notice. EBHRAs that are subject to ERISA are not required to satisfy any additional notice requirements. However, the Final Regulations state that HHS will propose a notice requirement for all non-federal governmental EBHRAs.

Summary

These two new HRAs provide many planning opportunities for employers large and small. While small employers with under 50 full-time and FTEs have had yet another form of HRA—the Qualified Small Employer HRA (QSEHRA)—since 2016, there are new considerations for adopting an ICHRA with higher dollar limits than allowed under a QSEHRA. For all employers, a complete review of how they approach the provision of either group health coverage or encouraging participation in the individual marketplace through an ICHRA and a true defined contribution approach may be in order. We have prepared a quick two-page chart comparing all of the different account-based plan types on our website. This chart outlines many of the requirements for each type of plan.

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