Health Reimbursement Account Design and Compliance

A Lexis Practice Advisor® Practice Note by
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This practice note discusses how to design and operate compliant employer-sponsored health reimbursement accounts (HRAs), including compliance considerations under the Internal Revenue Code (Code), the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), and with a particular focus on the Patient Protection and Affordable Care Act (ACA). Also covered are new rules allowing employers to offer so-called individual coverage HRAs (ICHRAs) and excepted benefit HRAs (EBHRAs) beginning on and after January 1, 2020.

This practice note is organized in the following sections:

- Introduction to HRAs
- Basic Requirements for Tax-Favored Treatment
- HRA Design Alternatives
- Effect of ACA Group Market Reform Provisions on HRAs
- HRAs Integrated with Group Coverage or Individual Coverage
- HRAs Exempt from ACA Group Market Reform Provisions
- Other ACA Requirements
- Other Legal Requirements
- Common HRA Pitfalls and Periodic HRA Compliance Reviews

For related annotated forms, see Health Reimbursement Account Clauses (Employee Benefit Wrap Plan) and Health Reimbursement Account Implementation Checklist.

Introduction to HRAs

With continued increases in health care costs and the evolution of the post-ACA health care marketplace, HRAs are an increasingly common feature of employers' benefits packages for both employees and retirees. The increased prevalence of HRAs suggests that for many employers, the cost savings and flexibility that can be achieved through the use of HRAs outweigh the risks arising from the complex legal framework within which HRAs must be designed and administered. Although there are, in fact, many benefits to using HRAs, this is not an area in which employers should tread lightly. There are numerous compliance risks, pitfalls, and traps for the unwary associated with the design and administration of HRAs, particularly under the ACA and related guidance.

An HRA is a notional account that an employer credits with dollar amounts that may be used to pay or reimburse eligible health care expenses incurred by participants and their eligible dependents. No specific section of the Code created the concept of HRAs. Rather, IRS guidance issued beginning in 2002 describes a particular type of health care expense

reimbursement arrangement, referred to as an HRA, that can include a carryover feature, qualifies for tax-favored treatment under I.R.C. §§ 105 and 106, and is subject to the non-discrimination requirements under I.R.C. § 105(h). See I.R.S. Notice 2015-87, I.R.S. Notice 2015-17, I.R.S. Notice 2013-54, I.R.S. Notice 2012-9, Rev. Rul. 2006-36, I.R.S. Notice 2006-69, Rev. Rul. 2005-24, I.R.S. Notice 2002-45, and Rev. Rul. 2002-41.

As described in more detail later in this practice note, HRAs are self-funded group health plans that are subject to the same group health plan mandates that apply to traditional major medical plans. However, due to the unique nature of HRAs, the impact of the group health plan mandates on HRAs can be different than the impact of the group health plan mandates on traditional major medical plans. Significant guidance concerning application of the ACA group market reform provisions to HRAs includes I.R.S. Notice 2013-54; FAQs about Affordable Care Act Implementation Part XI and Part XXII, DOL (Employee Benefits Security Administration (EBSA)) Technical Release 2013-03, I.R.S., FAQ on New Health Coverage Options for Employers and Employees; I.R.S. Notice 2015-17; 75 Fed. Reg. 37,188 (June 28, 2010) and 80 Fed. Reg. 72, 192 (Nov. 18, 2015) (interim final and final regulations concerning ACA implementation); and 84 Fed. Reg. 28,888 (June 20, 2019) (ICHRA and EBHRA final regulations, referred to herein as the 2019 Rules).

Basic Requirements for Tax-Favored Treatment

All HRAs must meet certain basic requirements in order to qualify for tax-favored treatment under the Code.

No employee contributions. HRAs cannot be funded either directly or indirectly by employee contributions. They can only be funded by employer contributions. See Rev. Rul. 2002-41, pt. II; Rev. Rul. 2005-24.

Not offered under a cafeteria plan. HRAs cannot be funded with pre-tax salary reduction contributions or otherwise under an I.R.C. § 125 cafeteria plan. I.R.S. Notice 2002-45, pt. IV. However, a cafeteria plan can allow participants to elect to make pre-tax payments toward the cost of individual health coverage integrated with an ICHRA for the excess of the premium for the individual coverage over the ICHRA premium contributions, provided that the individual coverage is not obtained through an ACA exchange (which is prohibited under the cafeteria plan rules). See 84 Fed. Reg. 28,904.

Restrictions on eligible individuals. HRAs can only pay or reimburse on a tax-free basis eligible health care expenses incurred by:

- An employee or former employee such as a retiree (referred to in this practice note as a participant) –and–
- A participant's spouse, federal tax dependents, or children who are under age 27 as of the end of the taxable year (referred to in this practice note as tax dependents)

I.R.S. Notice 2002-45, pt. III; Rev. Rul. 2006-36.

In order to be payable or reimbursable from an HRA on a tax-free basis, an eligible health care expense must be incurred by the participant or eligible dependent (1) after the establishment of the HRA, and (2) while the participant or eligible dependent, as applicable, is covered by the HRA.

If an HRA pays or reimburses expenses incurred by the dependent of a participant who is not a tax dependent, such as a domestic partner or a domestic partner's child, the employer may take one of two approaches:

1. **HRA coverage imputed as income.** The fair market value of the non-tax dependent's coverage under the HRA must be imputed as additional taxable income to the participant, in which case the non-tax dependent's expenses can be paid or reimbursed from the HRA on a tax-free basis.
2. **HRA-paid expenses included in income.** The dollar amount of the non-tax dependent's expenses that are paid or reimbursed from the HRA must be included in the participant's taxable income, in which case the participant will have to pay taxes on that additional income.

Rev. Rul. 2006-36.

Many employers take approach (1) for ease of administration. Under this approach, a single uniform amount can be imputed as income when the HRA coverage is effective or when additional amounts are credited to the HRA. The various individual claim amounts can then be processed without having to keep track of those differing amounts and impute income equal to the claim amount every time a claim is processed for a non-tax dependent.

However, approach (1) may result in a higher imputed income amount than approach (2). Theoretically, a participant's non-tax dependent could end up incurring expenses that use up the entire HRA balance. Therefore, the total fair market value of the HRA as a whole is typically the amount that must be imputed as income to the participant under approach (1). Usually, however, eligible expenses incurred by the participant's non-tax dependent do not use up the entire HRA balance, since the participant and other covered individuals who are eligible dependents usually incur expenses that are paid or reimbursed from the HRA as well. Taking the more targeted approach (2) allows just those expenses actually incurred by the non-tax dependent and paid or reimbursed

from the HRA to be imputed as income to the participant, rather than the entire fair market value of the HRA as a whole being imputed as income to the participant.

Restrictions on eligible expenses. Although employers have flexibility in designing the types of health care expenses that may be reimbursed under an HRA (e.g., only medical expenses and not dental or vision expenses, or vice versa) as described in HRA Design Alternatives below, HRAs can only pay or reimburse qualified medical expenses as defined in I.R.C. § 213(d) that have not otherwise been (1) reimbursed, (2) covered by insurance, or (3) claimed as an itemized deduction on the participant's federal income tax return. I.R.S. Notice 2002-45, pt. II; Rev. Rul. 2002-41.

For a list of expenses that are qualified medical expenses, refer to the most recent IRS Publication 502, available at www.irs.gov. It is important to note that although an HRA can be designed to pay or reimburse health insurance premiums, there are significant compliance risks related to ACA group market reform provisions associated with this type of design unless the HRA is structured as an ICHRA (see Effect of ACA Group Market Reform Provisions on HRAs and the section "Medicare and TRICARE Premium Reimbursement HRAs" under "HRA Rules relating to Medicare and TRICARE Coverage" found in HRAs Integrated with Group Coverage or Individual Coverage below).

HIPAA compliance. HIPAA non-discrimination rules are another concern for HRAs that are designed to include premium payment or reimbursement. That is because allowing an HRA to be used to pay or reimburse premiums for individual health insurance policies could cause those policies to be considered to constitute a group health plan subject to HIPAA, but such policies are not typically designed to comply with all of HIPAA's requirements. For example, HIPAA prohibits discrimination by a group health plan on the grounds of specific health status-related factors with regard to eligibility, premiums, or contributions. An HRA that can be used to pay or reimburse premiums for individual major medical coverage could end up impermissibly discriminating with regard to premiums if premiums vary for different employees based on those employees' health status-related factors. As discussed in the section entitled "ERISA Status of Individual Coverage relating to ICHRAs, QSEHRAs, or Salary Reduction Arrangements" under Other Legal Requirements further below, the 2019 Rules establish safe harbor conditions under which an individual insurance policy funded by an ICHRA, QSEHRA, or cafeteria plan will not be considered an ERISA welfare plan and consequently will not be subject to group health plan non-discrimination rules (although the ICHRA itself remains a group health plan subject to those rules).

Claim substantiation rules. The same claims substantiation and debit card rules that apply to health flexible spending accounts (health FSAs) also apply to HRAs. I.R.S. Notice 2006-69. For more information on these requirements, see "Special Rules for Certain FSAs" in Cafeteria Plan Design and Compliance (IRC § 125) — Flexible Spending Arrangements.

Treatment of unused amounts. Any amounts credited to an HRA that remain unused cannot be cashed out to the participant, and the participant cannot receive any other taxable or non-taxable benefit under the HRA other than the payment or reimbursement of eligible health care expenses. Rev. Rul. 2005-24. This restriction applies in all circumstances, including in the event of a participant's death, after which the only permissible uses of any remaining amounts credited to the HRA are to pay or reimburse eligible health care expenses incurred by the participant prior to the participant's death, or to pay or reimburse eligible health care expenses incurred by the participant's dependents covered by the HRA at the time of the participant's death if the HRA has been designed to have a spend-down feature which permits such use by the participant's dependents after the participant's death.

Unused amounts remaining in an HRA at the end of a plan year can be carried over for use during future plan years. I.R.S. Notice 2002-45, pt. I. Most HRAs are designed to take advantage of this permissible carryover feature, but the carryover feature is not a required part of an HRA's design. Employers sometimes place a cap on the amount that can be carried over from year to year and/or impose restrictions on how carryover amounts can be used. Although no formal IRS guidance describes such design features, they are consistent with the permissive nature of the carryover feature generally.

An HRA can be designed to permit continued access to unused amounts following an employee's termination of employment, subject to the opt-out requirements for integrated HRAs, described in the section entitled "Other Rules for Integrated HRAs" under HRAs Integrated with Group Coverage or Individual Coverage below. If access to unused amounts ends upon an employee's termination of employment, COBRA coverage must be made available under the HRA, as described in the "COBRA" section under Other Legal Requirements below.

Coordination of HRA and health FSA coverage. If a participant is covered by an HRA and a health FSA, the IRS has established a default ordering rule which provides that amounts credited to the HRA must be used first before the health FSA can pay or reimburse eligible health care expenses. If an employer wants to reverse this default rule

as a matter of plan design, such that amounts credited to the health FSA must be used before the HRA can pay or reimburse eligible health care expenses, an explicit provision to that effect in the HRA and health FSA plan documents is required. I.R.S. Notice 2002-45, pt. V.

HRA Design Alternatives

Notwithstanding the restrictions imposed on HRAs by the ACA group market reform provisions discussed in the next section, HRAs are still fairly flexible vehicles affording employers a number of different design choices, including those described below.

Crediting Options

Employers have considerable flexibility in determining when and why credits are allocated to participants' HRAs and in what amounts:

- **Frequency.** An employer can credit amounts to participants' HRAs at whatever interval it deems appropriate (e.g., on a monthly, annual, or other periodic basis, or perhaps even on an ad hoc basis if permitted by the written terms of the HRA and administered in a non-discriminatory manner). The uniform coverage rule that applies to health FSAs does not apply to HRAs, so the full amount to be credited to an HRA for a period of coverage does not have to be available on the first day of that period of coverage.
- **Reward.** Some employers link HRA credits to participation in a wellness or disease-management program, or to some other employee behavior or circumstance. With such a design, careful consideration must be given to the I.R.C. § 105(h) non-discrimination requirements, HIPAA non-discrimination requirements, and the prohibition against correlating HRA contributions with salary reductions under a cafeteria plan. For more information on wellness plan considerations, see Wellness Program Design and Compliance.
- **Amount.** Unlike health FSAs and health savings accounts (HSAs), the Code does not impose any limit on the amount that can be credited to an HRA in any given year. However, employers typically choose a dollar limit that helps to control costs and aligns with their comprehensive benefit strategy. In addition to basic credits, some employers also credit interest to participants' HRAs to mimic additional amounts an interest-bearing account might have earned.

Access Options

Employers also have a few different design choices when it comes to how and when participants can access amounts credited to their HRAs:

- **While employed.** Many employers design their HRAs to be used by employees while they are employed. Amounts are credited to participants' HRAs during the course of their employment, and those amounts are available to pay or reimburse eligible health care expenses incurred by participants and their dependents while the participants remain employed. Due to the ACA group market reform provisions described below, these types of HRAs must be integrated with other group major medical plan coverage, provide only excepted benefits such as limited-scope dental and/or vision benefits, qualify as a small employer HRA (QSEHRA), or qualify as an ICHRA or EBHRA under the 2019 Rules.
- **After termination of employment.** Other employers design their HRAs to be used by participants and their dependents **after** termination of employment (e.g., by retirees who have satisfied minimum age and service requirements set by the employer). Amounts are credited to participants' HRAs during the course of employment and/or after termination of employment, but those amounts are not available to pay or reimburse eligible health care expenses incurred by participants and their dependents until after participants' termination of employment. Because these types of HRAs provide coverage only to participants who are former employees and their dependents, they are considered retiree-only HRAs and can be provided on a stand-alone basis as described further below (i.e., they do not have to be integrated with other group major medical plan coverage, provide only excepted benefits or otherwise qualify as a QSEHRA, ICHRA, or EBHRA in the same way as HRAs reimbursing eligible health care expenses incurred while participants are employed).

HDHP/HSA Coordination Options

Employers who sponsor a high-deductible health plan (HDHP) intended to permit HDHP participants to contribute to an HSA should carefully consider whether and how to also offer an HRA. General purpose HRAs that can be used to pay or reimburse HDHP participants' out-of-pocket major medical expenses even before the participants satisfy their HDHP deductibles are considered disqualifying non-HDHP coverage that makes the participants ineligible to contribute to an HSA. (To qualify for tax-favored HSA contributions, participants are generally prohibited from having non-HDHP health coverage as of the first day of the month for which the HSA contribution is being made. I.R.C. § 223(c)(1)(A).) To avoid this result, an employer can provide one or more of the following types of HRAs which are compatible with

HDHP/HSA designs and do not cause participants to become ineligible to contribute to an HSA:

- **Limited-purpose HRA.** An HRA (including an ICHRA) that pays or reimburses only limited-scope dental and/or vision expenses which are not otherwise covered by the HDHP is considered a limited-purpose HRA. Limited-purpose HRAs do not impact HDHP participants' eligibility to contribute to an HSA.
- **Post-deductible HRA.** An HRA that only reimburses out-of-pocket eligible medical expenses incurred after HDHP participants satisfy their HDHP deductible is considered a post-deductible HRA. Because a post-deductible HRA does not provide coverage before the HDHP participants satisfy their HDHP deductibles, it also does not impact HDHP participants' eligibility to contribute to an HSA.
- **Suspended HRA.** Some employers who offer both HDHP and non-HDHP major medical plan coverage options pair a general purpose HRA with their non-HDHP major medical plan coverage option. If participants in the non-HDHP major medical plan coverage option have a balance remaining in their general purpose HRAs at the end of a plan year, and the participants choose to enroll in the HDHP option for the next plan year, the employer can suspend access to the remaining balance in the general purpose HRAs until the participants re-enroll in the non-HDHP option at some future date. Because the participants are not actually covered by the suspended HRA while enrolled in the HDHP option, the existence of the suspended HRA does not impact the HDHP participants' eligibility to contribute to an HSA. Note, however, that suspensions after termination of employment are not permitted for ICHRAs under the 2019 Rules. See 84 Fed. Reg. 28,916.
- **Retiree HRA.** If amounts are credited to general purpose HRAs while HDHP participants are employed, but the participants cannot access amounts credited to the HRAs to pay for eligible health care expenses until after termination of employment as described above, the existence of such HRAs does not impact the participants' eligibility to contribute to HSAs while employed and covered by the HDHP. Employers who offer both retiree HRA coverage and an HDHP option under a retiree major medical plan should consider the impact of such retiree HRA coverage on non-Medicare eligible retirees' eligibility to contribute to HSAs while enrolled in the retiree medical plan's HDHP option. (For more information, see Health Savings Account Design and Compliance — HSA Eligibility Requirements.) An opt-in/opt-out and/or waiver procedure may need to be developed as described in "Opt-In/Opt-Out and/or Waiver Procedures for Integrated HRAs" under HRAs Integrated with Group Coverage or Individual Coverage below to permit retirees to limit access to their general purpose retiree HRAs during periods in which they are enrolled in the retiree medical plan's HDHP option and contribute to an HSA.

Employers can mix and match these options when designing HSA-compatible HRAs. For example, HDHP participants also could be covered by a limited-purpose, post-deductible HRA that they could use to pay or reimburse eligible dental and vision expenses incurred even before they satisfy their HDHP deductible and eligible medical expenses incurred after they satisfy their HDHP deductible.

Effect of ACA Group Market Reform Provisions on HRAs

Because HRAs are group health plans, they generally must comply with the ACA's group market reform provisions, such as the prohibition on lifetime and annual limits on the dollar value of essential health benefits, 100% first dollar coverage of preventive health services, the adult child coverage mandate and the prohibition on rescissions, among others. I.R.S. Notice 2013-54, pt. II.A. Failing to comply with the ACA's group market reform provisions can result in a $100 per day excise tax liability per violation per person under I.R.C. § 4980D(b), as well as DOL enforcement actions and participant lawsuits.

Certain types of HRAs may be able to avoid some or all of the ACA's group market reform provisions, including an HRA that (1) is considered a grandfathered health plan under the ACA (see ACA Grandfathered Plan Rules), (2) is a retiree-only plan, (3) provides only excepted benefits (as defined under ERISA § 733(c)(2) (29 U.S.C. §1191b(c)(2)); I.R.C. § 9832(c)(2)(A); 42 U.S.C. 300gg-91(c)(2)), such as limited-scope dental and/or vision benefits, (4) qualifies as a QSEHRA created pursuant to the 21st Century Cures Act of 2016, or (5) qualifies as an ICHRA or an EBHRA under the 2019 Rules. If an HRA does not qualify for one of these exceptions, then it is subject to all of the ACA's group market reform provisions, but generally will not be able to satisfy these requirements (e.g., because they do not typically provide unlimited essential health benefits or 100% coverage of preventive care). For additional information on the foregoing HRA designs, see HRAs Exempt from ACA Group Market Provisions later in this practice note.

Because of the ACA's group market reform provisions, prior to the 2019 Rules, employers could not generally structure a general purpose HRA to pay or reimburse expenses incurred by participants who are current employees as a stand-alone plan. Instead, such HRAs had to be offered as part of, or integrated with, other group major medical plan coverage,

relying on the other medical plan's compliance with the ACA's group market reform provisions. When the IRS issued rules for this type of HRA integrated with group coverage (see, e.g., I.R.S. Notice 2013-54 and final regulations published in 80 Fed. Reg. 72,192), the IRS, Department of Labor, and Department of Health and Human Services concluded at that time that HRAs could not be integrated with individual health insurance coverage to satisfy the ACA prohibition on annual and lifetime limits and requirement to cover preventive services with no cost sharing.

Then, in October 2018, the regulatory agencies issued proposed regulations intended to expand the options available to employers offering HRA benefits. 83 Fed. Reg. 54,420 (Oct. 29, 2018), finalized without substantial changes in the 2019 Rules (84 Fed. Reg. 28,888). The 2019 Rules provide for:

- **ICHRAs:** HRAs that can be integrated with individual health insurance coverage (or Medicare) so long as certain conditions are met to satisfy the ACA prohibition on annual and lifetime limits and cost sharing rules.
- **EBHRAs:** Stand-alone (non-integrated) HRAs that are subject to an annual reimbursement cap and prohibit reimbursement of health insurance premiums and are treated as an excepted benefit (and therefore exempt from the ACA group market reform provisions).

ICHRAs and EBHRAs are permissible for plan years beginning on and after January 1, 2020. 26 C.F.R. §§ 54.9831-1(c)(3)(viii), 54.9815-2711(d), 54.9802-4.

These new design options do not eliminate or affect the previous guidance for HRAs integrated with group coverage.

The following two main sections summarize the rules applicable for, respectively, integrated HRAs (including HRAs integrated with group coverage and ICHRAs) and HRAs exempt from the ACA group market reform provisions (including QSEHRAs, limited-purpose HRAs, EBHRAs, and retiree-only HRAs).

HRAs Integrated with Group Coverage or Individual Coverage

HRAs Integrated with Group Coverage

For HRAs integrated with group coverage employers can choose one of two different integration methods when designing a general purpose HRA that pays or reimburses expenses incurred by participants who are current employees, one in which minimum value major medical plan coverage is not required for the HRA to be considered integrated, and one in which minimum value major medical plan coverage is required. The requirements for each type of integrated HRA are described in the following sections. Note that such integration does **not** require the HRA and the group major medical plan coverage with which it is integrated to share the same plan sponsor, to have the same plan documents, or governing instruments, or to file a single Form 5500. 26 C.F.R. § 54.9815-2711(d)(2); I.R.S. Notice 2013-54, pt. III.A.1 (parallel guidance was issued by the DOL in EBSA Technical Release 2013-03).

HRA Integrated with Group Coverage—Minimum Value Not Required

An HRA is integrated with other group major medical plan coverage under this method if all of the following requirements are met:

- The plan sponsor offers a group health plan (other than the HRA) to employees that does not consist solely of excepted benefits.
- The employees receiving the HRA are actually enrolled in a group health plan (other than the HRA) that does not consist solely of excepted benefits (referred to here as non-HRA group coverage), regardless of whether the plan is offered by the same plan sponsor.
- The HRA is available only to employees who are enrolled in non-HRA group coverage, regardless of whether the non-HRA group coverage is offered by the plan sponsor of the HRA (e.g., the HRA may be offered only to employees who do not enroll in the HRA sponsor's group major medical plan but are enrolled in other non-HRA group coverage, such as a group major medical plan maintained by the employer of the employee's spouse).
- The benefits under an HRA integrated with group coverage not providing minimum value are limited to reimbursement of one or more of the following:
    - Copayments, co-insurance, deductibles, and premiums under the non-HRA group coverage or
    - Medical care (as defined under I.R.C § 213(d)) that does not constitute essential health benefits.
- Under the terms of the HRA:
    - Participants are permitted to permanently opt out of and waive future reimbursements from the HRA at least annually –and–
    - Upon termination of employment, either (1) the remaining amounts credited to the HRA are forfeited, or (2) the participant is permitted to permanently opt out of and waive future reimbursements from the

HRA

26 C.F.R. § 54.9815-2711(d)(2)(i).

HRA Integrated with Group Coverage—Minimum Value Required

An HRA is integrated with other major medical plan coverage under this method if all of the following requirements are met:

- The plan sponsor offers a group major medical plan (other than the HRA) to employees that provides minimum value.
- The employees receiving the HRA are actually enrolled in a group major medical plan (other than the HRA) that provides minimum value (referred to here as non-HRA MV group coverage), regardless of whether the plan is offered by the plan sponsor of the HRA.
- The HRA is available only to employees who are enrolled in non-HRA MV group coverage, regardless of whether the non-HRA MV group coverage is offered by the plan sponsor of the HRA (e.g., the HRA may be offered only to employees who do not enroll in the HRA sponsor's group major medical plan but are enrolled in other non-HRA MV group coverage, such as a group major medical plan maintained by the employer of the employee's spouse).
- The benefits under an HRA integrated with group coverage providing minimum value are not limited in the same manner as benefits under HRAs integrated with group coverage not providing minimum value, but rather may include any reimbursement or payment of expenses generally covered by HRAs (i.e., for medical care as defined under I.R.C. § 213(d)).
- Under the terms of the HRA:
    - Participants are permitted to permanently opt out of and waive future reimbursements from the HRA at least annually –and–
    - Upon termination of employment, either (1) the remaining amounts credited to the HRA are forfeited, or (2) the participant is permitted to permanently opt out of and waive future reimbursements from the HRA

26 C.F.R. § 54.9815-2711(d)(2)(ii).

Essential Health Benefits Considerations for HRAs Integrated with Group Coverage

An employer should carefully consider its HRA design if the employer's group major medical plan does not cover all categories of essential health benefits. In general, if the group major medical plan with which an HRA is integrated does not cover a category of essential health benefits, but the HRA is available to pay for or reimburse that category of essential health benefits up to the HRA's maximum benefit, then that HRA imposes an annual limit in violation of the ACA's annual dollar limit prohibition.

Note that this potential mismatch in plan design between essential health benefits covered by the group major medical plan and essential health benefits payable from the HRA can only occur if the group major medical plan is either grandfathered, self-funded, or fully insured in the large group market. This situation should not arise for a non-grandfathered group major medical plan that is fully insured in the small group market, because such plans generally must cover all categories of essential health benefits.

Notwithstanding the general result of the plan design mismatch described in the previous paragraphs, the IRS has provided relief from this result for group major medical plans that provide minimum value. Specifically, an HRA integrated with a group major medical plan that provides minimum value will not be treated as imposing an annual limit in violation of the ACA's annual dollar limit prohibition, even if that group major medical plan does not cover a category of essential health benefits and the HRA is available to pay for or reimburse that category of essential health benefits up to the HRA's maximum benefit. I.R.S. Notice 2013-54, pt. III.A.1, Q&A-6

HRAs Integrated with Individual Coverage (ICHRAs)

Prior to the 2019 Rules, a group health plan, including an HRA, generally could not be integrated with health insurance coverage purchased on the **individual** market without violating the ACA's group market reform provisions. Thus, the ACA eliminated previously permissible arrangements, commonly known as employer payment plans, under which employers paid for or reimbursed the individual health insurance premiums incurred by their eligible employees, either on a tax-free or taxable basis. See, e.g., FAQs about Affordable Care Act Implementation, Part XI (Jan. 24, 2013), Q2.

Employers who wanted to pay for or reimburse individual health insurance coverage premiums prior to the effective date of the 2019 Rules only had the following options available to them:

- Pay or reimburse individual medical plan premiums for former employees only under a retiree-only HRA
- Pay or reimburse individual dental and/or vision plan premiums only for current and/or former employees under a limited-purpose HRA

- Provide additional taxable cash compensation to current employees with the intention that such amounts will be used to pay individual medical plan premiums, but without requiring or verifying that such amounts are in fact used in that way –or–
- If eligible, establish a qualified small employer HRA (described further below)

ICHRAs

The 2019 Rules added ICHRAs to the foregoing alternatives as a method for employers of all sizes to integrate an HRA with individual health insurance coverage (other than coverage consisting only of excepted benefits). See 26 C.F.R. § 54.9802-2711(d). The ICHRA rules described below also apply to HRAs that are integrated with Medicare Part A and B coverage or Medicare Part C coverage. 26 C.F.R. § 54.9802-2711(d)(4). For integration with Medicare Parts B and D, see 26 C.F.R. § 54.9802-2711(d)(5).

ICHRAs must meet all of the following conditions:

- The participant and any covered dependents are enrolled in ACA-compliant individual health insurance coverage, Medicare Part A and Part B, or Medicare Part C. For this purpose, ACA-compliant individual coverage can include (1) coverage under a plan acquired in a state that has obtained a waiver under ACA Section 1332, (2) a catastrophic plan, or (3) an ACA grandfathered policy or "grandmothered" policy (certain non-grandfathered coverage for which there is currently a non-enforcement policy with respect to certain ACA group market reform provisions).
- The employer offers the ICHRA only to employees who are not also eligible for employer-sponsored major medical coverage.
- Any ICHRA offered to a class of employees must be offered on the same terms to all members of the class (as further described below).
- Under the terms of the ICHRA:
    - A participant who is otherwise eligible for coverage must be permitted to opt out of and waive future reimbursements from the ICHRA once, and (unlike for HRAs integrated with group coverage) only once, for each plan year –and–
    - Upon termination of employment, either (1) the remaining amounts credited to the ICHRA are forfeited, or (2) the participant is permitted to permanently opt out of and waive future reimbursements from the ICHRA
- The ICHRA must implement and comply with reasonable procedures to verify that participants and dependents are or will be enrolled in individual health insurance coverage for the plan year and that such coverage continues to be in place when each new request for reimbursement of an incurred medical care expense is submitted to the ICHRA. Substantiation compliance is discussed below.
- The employer provides an annual notice to participants of their rights, as described below.

26 C.F.R. § 54.9802-4(c).

Enrollment Substantiation Requirement

Employers must substantiate ICHRA participants' and dependents' enrollment in ACA-compliant individual coverage by a reasonable method prior to the beginning of participation in the ICHRA. Employers may rely on documentation from a third party, such as the health insurance provider, or an attestation from the participant. If a participant's attestation is used as proof of ACA-compliant individual health insurance, the attestation should state the individuals who have coverage under the ACA-compliant individual health insurance coverage, the dates the coverage is effective, and the name of the coverage provider. The employer may rely on a participant's attestation unless the employer has actual knowledge to the contrary. In addition, substantiation of ongoing coverage must be made prior to any reimbursement or payment from the ICHRA (which also may consist of participant attestation). 26 C.F.R. § 54.9802-4(c)(5). Annual and ongoing model attestations are available on the DOL website.

Employee Classes

The condition that a class of employees may not be allowed to choose between an ICHRA and employer-sponsored major medical coverage is to address the concern that employers could steer employees with negative or declining health statuses to individual coverage, while keeping healthier employees on the employer's plan, effectively discriminating on the basis of health status. Therefore, the 2019 Rules require that participants within the same class be offered the same type of medical coverage—either an ICHRA or coverage under the employer-sponsored major medical plan. However, employers may offer employees in different classes different types of medical coverage.

- Employee classes are determined for this purpose, for an entire plan year, based on any of the following categories:
- Full-time employees (determined according to rules under I.R.C. § 105(h) or I.R.C. § 4980H, as elected by the employer)
- Part-time employees (determined according to rules under I.R.C. § 105(h) or I.R.C. § 4980H, as elected by the

employer)

- Employees paid on a salaried basis
- Employees not paid on a salaried basis (e.g., hourly employees)
- Employees whose primary site of employment is the same ACA rating area
- Seasonal employees (determined according to rules under I.R.C. § 105(h) or I.R.C. § 4980H, as elected by the employer)
- Employees within a collective bargaining unit
- Employees who have not satisfied an ACA-compliant waiting period for coverage
- Nonresident alien employees with no U.S. source income from the employer
- Certain temporary employees hired by a third party –and–
- Employees within any of the foregoing classes who are hired after an established new-hire date

26 C.F.R. § 54.9802-4(d)(2), (d)(5).

It also is permissible to make some or all former employees eligible, provided that they are offered the same terms as other employees within the same class (presumably based on their status when they were actively employed). 26 C.F.R. § 54.9802-4(c)(3)(iv).

A minimum class size requirement may apply for any of the first five categories listed above (based on full-time, part-time, salaried, or non-salaried status or ACA rating area). Further, the minimum class size requirement only applies to the full-time/part-time classes if one class is offered an ICHRA and the other is offered group major medical coverage and, in that case, it only applies to the class offered the ICHRA. The minimum class size requirement does not apply to any ACA rating area-based class that is defined by one or more states. For applicable categories, the minimum number of members of the class is:

- 10 for an employer with fewer than 100 employees
- 10% of the total number of employees (rounded down to a whole number) for an employer with 100 to 200 employees –or–
- 20 for an employer with more than 200 employees

26 C.F.R. § 54.9802-4(d)(3).

Same Terms Requirement

For each class of participants offered an ICHRA, participants must be offered coverage under substantially the same terms and conditions. However, an ICHRA does not violate the same terms requirement if it has uniform rules for the class providing for:

- Higher coverage limits based on the number of a participant's dependents who are covered by the ICHRA (which may be, but are not required to be, adjusted on a prorated basis for mid-year changes in the number of covered dependents)
- Higher coverage limits for participants who are older so long as (1) all participants of the same age have the same limit and (2) the highest limit is not more than three times the lowest limit
- Coverage limits for mid-year new participants that are either (1) the same as for all participants within the class or (2) prorated based on the portion of the plan year they are anticipated to participate
- Carryover of unused amounts from one plan year to the next or for transfer of amounts from a different HRA to the ICHRA
- An option between an HSA-compatible ICHRA or non-HSA-compatible ICHRA, so long as both types are available to all class members

26 C.F.R. § 54.9802-4(c)(3).

Notice Requirement

Employers offering ICHRAs must provide a written notice to each participant at least 90 days prior to the beginning of each plan year (or for new employees, as soon as practicable, but no later than the date they become covered). The notice must contain:

- A description of the terms of the ICHRA, including:
    - The maximum dollar amount available for each participant and rules regarding proration of the maximum dollar amount for participants and dependents who are not eligible to participate in the ICHRA for the entire plan year
    - Whether (and which of) the participant's dependents are eligible for the HRA
    - A statement that there are different kinds of HRAs and the HRA being offered is an ICHRA
    - A statement that the HRA requires the participant and any covered dependents to be enrolled in individual health insurance coverage (or Medicare Part A and B or Medicare Part C, if applicable)
    - A statement that the coverage in which the participant and any covered dependents must be enrolled cannot be short-term, limited-duration insurance or consist solely of excepted benefits
    - If the HRA is subject to ERISA, a statement that

individual health insurance coverage in which the participant and any covered dependents are enrolled is not subject to ERISA, if the conditions under 29 C.F.R. 2510.3-1(l) are satisfied

- The date as of which coverage under the HRA may first become effective (both for participants whose coverage will become effective on the first day of the plan year and for participants whose HRA coverage may become effective at a later date)
- The dates on which the HRA plan year begins and ends –and–
- The dates on which the amounts newly made available under the HRA will be made available

- A description of the potential availability of the ACA's premium tax credit if the participant opts out of and waives future reimbursements from the ICHRA (a premium tax credit is not permitted for any employee (or dependent) who is offered ICHRA coverage unless both (1) the ICHRA is deemed not to be affordable coverage and (2) the employee (or dependent) opts out of the unaffordable ICHRA coverage)
- Statements as to:
  - The participant's right to opt out of and waive future reimbursements from the ICHRA
  - The inability of a participant who accepts the ICHRA to claim a premium tax credit for coverage obtained through the ACA marketplace for any month the ICHRA may be used to pay medical expenses
  - The participant's responsibility to inform any ACA marketplace to which the participant applies for advance payments of the premium tax credit of the availability of the ICHRA and the details of its offering
  - The participant's need to retain the notice as it may be required to determine if the participant is eligible for a premium tax credit
  - The mandatory substantiation requirements that must be met before the ICHRA may reimburse any medical care expense
  - The participant's responsibility to inform the ICHRA if the participant or any covered dependent is no longer enrolled in individual health insurance coverage –and–
  - The availability of a special enrollment period to enroll in or change individual health insurance coverage, through or outside of an Exchange, for the participant and any dependents who newly gain access to the HRA and are not already covered by the HRA
- Contact information (including a phone number) for an individual or a group of individuals who participants may contact in order to receive additional information regarding the HRA, as determined by the plan sponsor

26 C.F.R. § 54.9802-4(c)(64).

Special Enrollment Periods and ICHRAs

As group health plans, ICHRAs will generally be subject to the HIPAA special enrollment rules, which among other things typically require plans to allow a current participant to choose to enroll a newly acquired eligible dependent during a 30-day period beginning on the triggering event (e.g., birth of a child or placement for adoption). Special enrollment rights also apply to ACA exchanges, which were amended by the 2019 Rules for ICHRA (and QSEHRA) participants. These individuals typically must exercise their special enrollment right to choose ACA exchange coverage 60 days before the triggering event. However, the period is extended to **60 days before or after** the triggering event if the participant did not receive the annual ICHRA notice at least 90 days prior to the start of the plan year (e.g., because they were a new hire). In this case, there may be a mismatch between the special election periods applicable to the exchange and to the ICHRA (QSEHRAs are exempt from the HIPAA special enrollment rules). Employers offering ICHRAs should clearly communicate the plan's special enrollment rules, particularly where the plan's ICHRA enrollment period is shorter than the exchange's enrollment period due to this mismatch. 84 Fed. Reg. 28, 954.

Other Rules for Integrated HRAs

Forfeiture and Reinstatement Provisions for Integrated HRAs

Under both of the integration methods for HRAs integrated with group coverage, but **not** for ICHRAs, forfeiture or waiver occurs even if the forfeited or waived amounts may be reinstated upon a fixed date, a participant's death, or the earlier of the two events (referred to as the reinstatement event). For this purpose, coverage under an HRA is considered forfeited or waived prior to a reinstatement event only if the participant's election to forfeit or waive is irrevocable. An effective irrevocable election means that, beginning on the effective date of the election and through the date of the reinstatement event, the participant and the participant's eligible dependents have no access to amounts credited to the HRA. Further, upon and after reinstatement, the reinstated amounts under the HRA may not be used to pay or reimburse eligible health care expenses that were incurred during the period after forfeiture or waiver and prior to reinstatement. 26 C.F.R. § 54.9815-2711(d)(3).

Opt-In/Opt-Out and/or Waiver Procedures for Integrated HRAs

Both of the integration methods for HRAs integrated with group coverage and ICHRA integration with individual coverage require that eligible employees be provided an opt-out right and that participants be provided the right to permanently opt out of and waive future reimbursements upon a termination of employment to facilitate HRA participants' management of their HSA eligibility and ACA marketplace subsidy eligibility (as described in the section entitled "Impact of HRA on Marketplace Coverage Subsidy Eligibility," under Other ACA Requirements further below). Consequently, an employer may need to develop an opt-in/opt-out and/or waiver procedure in accordance with the following considerations:

- **Timing:**
  - **Current employees.** For HRAs integrated with group coverage, the opt-out/waiver opportunity that must be provided at least annually is probably best accomplished as part of the employer's regular annual enrollment process each year by providing employees the opportunity to elect to decline HRA coverage for the next plan year. For ICHRAs, the one and only opt-out election opportunity for a plan year generally must be provided prior to the first day of the plan year and in any case prior to the date ICHRA coverage would begin.
  - **Terminating employees.** If the employee's HRA balance is not automatically forfeited upon termination of employment as a matter of HRA plan design, then when an employee terminates employment, the employer must provide the terminating employee the opportunity to elect to opt out of or waive post-termination HRA coverage. If desired, an employer may also be able to provide an annual election opportunity with respect to retiree HRA coverage whereby retirees could elect into or out of retiree HRA coverage on a plan year-by-plan year basis. Note that for ICHRAs, current guidance seems to indicate that terminating employees cannot be given the option of suspending their post-termination ICHRA coverage for a time and then having their ICHRA coverage reinstated at some point in the future.
- **Default rule (opt in or opt out).** When permitting election opportunities for HRA coverage, an employer will need to specify what the default rules are for participants who choose not to make an election. For example:
  - During annual enrollment processes for both current employees and retirees, will current HRA coverage status continue into the next plan year in the absence of a participant's affirmative election (i.e., an evergreen election)? Or will participants have to proactively elect HRA coverage for the next plan year if they want to keep such coverage in place?
  - At termination of employment, will HRA coverage continue for former employees unless they elect otherwise (i.e., opt-out election)? Or must a former employee proactively elect post-termination HRA coverage in order to have such coverage (i.e., opt-in election)?

See 26 C.F.R. § 54.9815-2711(d)(2)(i)(E), (d)(2)(ii)(D), (d)(3) (HRAs integrated with group coverage); 26 C.F.R. § 54.9802-4(c)(4) (ICHRAs).

Spend-Down Provisions

Unused amounts credited to an HRA that is integrated with other group major medical plan coverage may be used to pay or reimburse eligible health care expenses in accordance with the terms of the HRA after a participant ceases to be covered by the group plan coverage without causing the HRA to violate the ACA's group market reform provisions. I.R.S. Notice 2013-54, pt. III.A.1, Q&A-5.

An ICHRA may not reimburse any expense that is incurred by an individual after their eligible individual insurance coverage has terminated. 26 C.F.R. § 54.9802-4(c)(1)(iii). However, participants (and covered dependents) in an ICHRA must be given an opportunity to submit claims for expenses incurred while they were covered by the ICHRA and eligible individual insurance coverage, although the sponsor may limit the time to submit claims to a reasonable period after the coverage ends. If any funds remain in an ICHRA after the participant and all covered dependents lose their individual insurance coverage, the funds must be forfeited (to the extent not used to pay for eligible expenses incurred prior to the loss of coverage). 26 C.F.R. § 54.9802-4(c)(1)(ii).

Coverage of Dependents

HRAs integrated with other group major medical plan coverage can only cover individuals who are enrolled in both the HRA and the employer's other group major medical plan. If a participant's dependents are not enrolled in the employer's group major medical plan coverage, any coverage of these dependents provided under the HRA cannot be integrated with the coverage under the employer's group major medical plan, and the HRA coverage generally would fail to meet the ACA's group market reform provisions.

Note that an HRA integrated with the employer's other group major medical plan could be structured to be continuously integrated and avoid this risk if eligibility for coverage under the HRA automatically applies only to individuals covered under the group plan, so that eligibility for payment or reimbursement of eligible health care expenses would expand automatically if the participant changed coverage from

individual-only coverage to coverage including a dependent (and vice versa, e.g., if the participant changed coverage from family coverage to individual-only coverage). I.R.S. Notice 2015-87, pt. II.A, Q&A-4.

For ICHRAs, each dependent participating in the ICHRA must be enrolled in individual coverage that does not consist solely of excepted benefits (or applicable Medicare coverage) during their period of participation. Note, however, that the ICHRA cannot cover only an employee's dependents without covering the employee. 26 C.F.R. § 54.9802-4(c)(1).

HRA Rules relating to Medicare and TRICARE

Medicare and TRICARE Premium Reimbursement HRAs

Prior to the 2019 Rules, the IRS issued guidance describing how HRAs can be used to reimburse certain Medicare and TRICARE premiums without violating the ACA's group market reform provisions, as described in the following sections. However, employers who are subject to Medicare Secondary Payer and similar TRICARE rules which prohibit offering financial or other incentives for Medicare-eligible and/or TRICARE-eligible employees to decline employer-provided group health plan coverage generally cannot take advantage of this guidance. I.R.S. Notice 2015-17.

As discussed further below, the 2019 Rules allow for ICHRAs to be integrated with Medicare Part A and B or Medicare Part C).

Medicare Premium Reimbursement Arrangements

An arrangement under which an employer reimburses (or pays directly) some or all of Medicare Part B or Part D premiums for participants is essentially a premium-only HRA for Medicare premiums. As a result, if such an arrangement covers two or more active employees, it is subject to the ACA's group market reform provisions. Except as permitted for ICHRAs, an HRA generally may not be integrated with Medicare coverage to satisfy the ACA's group market reform provisions (because Medicare coverage is not a group major medical plan). However, an HRA that pays for or reimburses Medicare Part B or Part D premiums for active employees **is** considered integrated with another group major medical plan offered by the employer for purposes of the annual dollar limit prohibition and the preventive services requirements if all of the following conditions are met:

- The employer offers a group health plan (other than the HRA) to the employee that does not consist solely of excepted benefits and offers coverage providing minimum value.
- The employee participating in the HRA is actually enrolled in Medicare Parts A and B.
- The HRA is available only to employees who are enrolled in Medicare Part A and Part B or Part D.
- The HRA is limited to reimbursement of Medicare Part B or Part D premiums and excepted benefits, including Medigap premiums.

I.R.S. Notice 2015-17, pt. II, Q&A-3.

TRICARE-Related HRAs

Similarly, an arrangement under which an employer reimburses (or pays directly) some or all medical expenses for participants covered by TRICARE constitutes an HRA. As a result, if such an arrangement covers two or more active employees, it is subject to the ACA's group market reform provisions. An HRA may not be integrated with TRICARE to satisfy the ACA's group market reform provisions (because TRICARE is not a group major medical plan for integration purposes). However, an HRA that pays or reimburses medical expenses for active employees covered by TRICARE **is** considered integrated with another group major medical plan offered by the employer for purposes of the annual dollar limit prohibition and the preventive services requirements if all of the following conditions are met:

- The employer offers a group health plan (other than the HRA) to the employee that does not consist solely of excepted benefits and offers coverage providing minimum value.
- The employee participating in the HRA is actually enrolled in TRICARE.
- The HRA is available only to employees who are enrolled in TRICARE.
- The HRA is limited to reimbursement of cost sharing and excepted benefits, including TRICARE supplemental premiums.

I.R.S. Notice 2015-17, pt. II, Q&A-3.

Small Employers Not Subject to Medicare Secondary Payer Rules

For small employers (generally fewer than 20 employees) that are not required to offer their non-HRA group health plan coverage to employees who are Medicare beneficiaries, an HRA that may be used to reimburse premiums under Medicare Part B or D may be integrated with Medicare (and deemed to comply with the ACA group market reform provisions) if all of the following requirements are satisfied with respect to employees who would be eligible for the

employer's non-HRA group health plan but for their eligibility for Medicare (and the integration rules described further above continue to apply to employees who are not eligible for Medicare):

- The plan sponsor offers a group health plan (other than the HRA and that does not consist solely of excepted benefits) to employees who are not eligible for Medicare.
- The employee receiving the HRA is actually enrolled Medicare Part B or D.
- The HRA is available only to employees who are enrolled in Medicare Part B or D.
- The HRA complies with the opt out/waiver integration requirement described for HRAs integrated with group coverage above.

I.R.S. Notice 2015-17, pt. II, Q&A-3; 26 C.F.R. § 54.9815-2711(d)(5).

Medicare/TRICARE Rules for ICHRAs

The 2019 Rules permit an ICHRA to be integrated with either individual health insurance coverage, Medicare Part A and B, or Medicare Part C. Further, an ICHRA may be used to reimburse premiums for Medicare and Medicare supplemental health insurance (Medigap), as well as other medical care expenses.

An ICHRA may be integrated with Medicare Part A and B, or Part C, without violating the ACA's group market reforms provisions, regardless of whether the employer is subject to the Medicare Secondary Payer rules. The agencies took this approach based in part on its consideration that such Medicare enrollees have comprehensive benefit packages consistent with the ACA requirements. See 84 Fed. Reg. 28,929. All of the requirements for ICHRAs generally apply in the same manner regardless of whether the ICHRA is integrated with ACA-compliant individual health insurance coverage or Medicare Part A and B or Part C. See 26 C.F.R. § 54.9802-4(e).

In addition, an ICHRA that is integrated with Medicare Part A and B or Part C also may reimburse premiums for Medicare Part A, B, C, or D, as well as premiums for Medigap policies (in addition to I.R.C. § 213(d) medical expenses), without violating the Medicare Secondary Payer rules, as the agencies concluded that doing so does not create an incentive for a Medicare-eligible participant to decline or terminate enrollment under the ICHRA. Note, however, that an ICHRA may not, under its terms, limit reimbursement only to expenses not covered by Medicare, as such a design could result in a violation of the Medicare Secondary Payer rules. See 84 Fed. Reg. 28,930.

Further guidance from HHS is expected to clarify primary versus secondary payer responsibility and reporting obligations relating to ICHRAs offered by plan sponsors subject to the Medicare Secondary Payer rules.

An ICHRA cannot be integrated with TRICARE, although an individual covered by TRICARE could participate in an ICHRA if they obtained individual coverage in addition to their TRICARE coverage. See 84 Fed. Reg. 28,9296.

HRAs Exempt from ACA Group Market Reform Provisions

The HRA designs discussed in this section—QSEHRAs, limited-purpose HRAs, EBHRAs, and retiree-only HRAs—are exempt from the ACA's group market reforms provisions and do not need to be integrated with other coverage.

Qualified Small Employer HRAs (QSEHRAs)

A provision of the 21st Century Cures Act, signed into law on December 13, 2016 (Pub. L. No. 114-255), permits small employers to provide non-integrated, stand-alone HRAs to their active employees that can be used to pay or reimburse individual medical plan premiums without running afoul of the ACA's group market reform provisions. Such plans are referred to as qualified small employer HRAs, or QSEHRAs, and must meet all of the following requirements:

- Be maintained by an employer that:
  - Is not an applicable large employer, as defined in I.R.C. § 4980H(c)(2) (i.e., an employer that employs fewer than 50 full-time plus full-time equivalent employees) –and–
  - Does not offer a group health plan to any of its employees
- Be provided on the same terms to all eligible employees, which must include any employee of an eligible employer, except that the arrangement may exclude from consideration employees who haven't completed 90 days of service, employees who haven't attained age 25 before the beginning of the plan year, part-time or seasonal workers, employees covered by a collective bargaining unit, and certain nonresident aliens
- Be funded solely by an eligible employer (and without salary reduction contributions)
- Provide for the payment for, or reimbursement of, an eligible employee for expenses for medical care (as defined in I.R.C. § 213(d) (including premiums for individual health

insurance coverage)) incurred by the eligible employee or the eligible employee's family members (as determined under the HRA's terms), subject to the employee's furnishing proof of such coverage or other expenses

- Report on Form W-2 (Box 12, Code FF) the total amount of an employee's eligible benefit under the arrangement for each calendar year (disregarding any carryover amounts)
- Limit the amount of payments and reimbursements to an annual cap, indexed for cost-of-living increases (for 2020, $5,250 for employee-only and $10,600 for family coverage), pro rated for partial-year coverage –and–
- Furnish a notice to its employees at least 90 days before the beginning of the plan year and upon eligibility containing the following information:
    - Amount of the benefit
    - A statement that employees applying for advance payment of a premium tax credit (i.e., a federal subsidy) for health insurance obtained from an ACA marketplace are required to inform the marketplace of the amount of the benefit, that the benefit may affect eligibility for and the amount of the credit and that the employee should retain the notice because it may be needed to calculate the credit on the employee's tax return –and–
    - A statement that employees who do not have minimum essential coverage for any month may become subject to a tax under I.R.C. § 5000A and lose the tax-free treatment of the HRA expenses (note that the tax under I.R.C. § 5000A has been reduced to $0 beginning in 2019, but it appears the IRS has not yet updated this part of the QSEHRA notice requirement)

QSEHRAs are not considered to be a group health plan for almost all purposes under the Code, ERISA, or the Public Health Service Act (PHSA). See, e.g., 29 C.F.R. § 2510.3-1(l). Amounts provided under a QSEHRA cannot be excluded from an employee's income unless the employee has some other minimum essential coverage. Pub. L. No. 114-255 § 18001 (amending I.R.C. § 9831, ERISA § 733 (29 U.S.C. § 1191b), and PHSA § 2791 (42 U.S.C. § 300gg-91)).

The QSEHRA rules generally became effective for years starting after December 31, 2016, with the transitional excise-tax relief described in I.R.S. Notice 2015-17 being extended to apply before that time. For detailed IRS guidance, see I.R.S. Notice 2017-67.

Limited-Purpose HRAs

HRAs that provide only excepted benefits, such as limited-scope dental and/or vision benefits, also are HIPAA-excepted benefits to which the ACA's group market reform provisions do not apply. As a result, HRAs that reimburse only limited-scope dental and/or vision benefits can be provided on a stand-alone basis without being integrated with other group major medical plan coverage or ACA-compliant individual health insurance coverage. However, these HRAs are still group health plans and must comply with other applicable legal requirements in the same manner as other excepted benefits. I.R.S. Notice 2015-87, pt. II.B, Q&A-5.

Excepted Benefit HRAs (EBHRAs)

Under the 2019 Rules, effective for plan years beginning on and after January 1, 2020, a stand-alone HRA that reimburses only medical expenses and certain premiums up to a maximum amount and satisfies certain other requirements also is a HIPAA-excepted benefit, meaning the ACA's group market reform provisions would not apply to such an HRA. These are referred to as excepted benefit HRAs (EBHRAs), but they are a distinct design from the HRAs described above that provide only excepted benefits, like limited-scope dental and/or vision benefits, which are not subject to the same requirements as described in this section.

Because the new EBHRA design is treated as a HIPAA-excepted benefit, participants are not considered to have enrolled in "minimum essential coverage." One advantage of this status is that participants in an EBHRA remain eligible to receive a premium tax credit for medical coverage purchased through the ACA marketplace.

The following requirements apply to EBHRAs:

- The employer must offer participants other group medical coverage that (1) is not limited to excepted benefits and (2) is not an HRA or other account-based plan.
- The maximum amount that may be made newly available for any plan year in the EBHRA and any other account-based group health plan (other than account-based group health plans that reimburse only excepted benefits) may not exceed an inflation-adjusted cap ($1,800 for 2020).
- The EBHRA may be used to reimburse medical expenses and excepted benefit health coverage, but cannot be used to reimburse premiums for other medical coverage (including individual coverage, group coverage, and Medicare), except for premiums for coverage consisting solely of excepted benefits or COBRA premiums. Reimbursement of short-term limited-duration insurance also is also permissible (but may be restricted for small employers in a state if such benefits are found to have an adverse impact on the small group market).
- The stand-alone HRA must be made available on the same terms to all similarly situated individuals.
- The employer must furnish an ERISA summary plan

description, as applicable.

26 C.F.R. § 54.9831-1(c)(3)(viii).

Retiree-Only HRAs

HRAs that have fewer than two participants who are current employees on the first day of the plan year, such as retiree-only HRAs, are considered "small plans" and thus are HIPAA-excepted benefits. The ACA's group market reform provisions do not apply to HIPAA-excepted benefits and, as a result, retiree-only HRAs can be provided on a stand-alone basis and without being integrated with other group or individual major medical plan coverage. However, such retiree-only HRAs are still group health plans and must comply with other applicable legal requirements in the same manner as other HIPAA-excepted benefits that are group health plans. I.R.S. Notice 2013-54, pt. III.B, Q&A-10.

Other ACA Requirements

In addition to the ACA's group market reform provisions, the ACA includes a number of other provisions that either explicitly address HRAs or impact HRAs in some way, as discussed below.

Impact of HRAs on ACA's Employer Mandate Determinations

Under the ACA's employer mandate, applicable large employers may be subject to a penalty tax for failing to offer full-time employees (and their dependent children) minimum essential coverage that is affordable and provides minimum value. HRAs may directly impact the cost of coverage (e.g., if they can be used to pay premiums) and/or the value of coverage (e.g., if they can be used to pay out-of-pocket costs such as deductibles, co-insurance and co-payments) for purposes of the affordability or minimum value assessment.

The sections below describe the currently applicable rules for HRAs integrated with group coverage as well as proposed rules, which may be relied upon pending finalization, relating to ICHRAs' effect on the employer mandate issued in 84 Fed. Reg. 51,471 (Sept. 30, 2019).

HRA Effect on Affordability of Integrated Group Coverage

Amounts made available for the current plan year under an HRA that an employee may use to pay premiums for an integrated group major medical plan, or that an employee may use to pay premiums for such coverage and also may use for cost-sharing and/or for other health benefits not covered by the plan in addition to premiums, are counted toward the employee's required contribution (and thus reduce the dollar amount of that required contribution and make the coverage being offered more affordable).

For HRAs integrated with group coverage, the HRA and the group major medical plan must have the same plan sponsor to be taken into account for affordability purposes in this way. I.R.S. Notice 2013-54, pt. III.B, Q&A-11.

Employer contributions to an HRA count toward an employee's required contribution only to the extent that the amount of the employer's annual contribution to the HRA is required under the terms of the HRA or otherwise determinable within a reasonable time before the employee must decide whether to enroll in the group major medical plan. A contribution that meets this requirement relates to the immediately subsequent period of coverage for which the employee could enroll and use the HRA contribution. The employer contribution to an HRA (and any resulting reduction in the employee contribution) is treated as made ratably for each month of the period to which it relates. 26 C.F.R. 1.36B-2(c)(v)(A)(5), -2(c)(v)(B).

> **Example.** The employee contribution for coverage under an employer's group major medical plan offered is generally $200 per month. For the current plan year, the employer makes newly available $1,200 under an HRA that the employee may use to pay the employee share of contributions for the group major medical plan coverage, pay cost-sharing, or pay toward the cost of vision or dental coverage. The HRA satisfies all requirements for integration with the employer's group major medical plan.
>
> In this example, the $1,200 employer contribution to the HRA reduces the employee's required contribution for the coverage. For purposes of the ACA employer mandate affordability determination, the employee's required contribution for the group major medical plan coverage is $100 ($200 – $100) per month because 1/12 of the $1,200 HRA amount per month is taken into account as an employer contribution whether or not the employee uses the HRA to pay or reimburse the employee's share of contributions for the group major medical plan coverage.

HRA Affordability for ICHRAs

For an ICHRA used to purchase individual coverage in the ACA marketplace, there is a minimum required ICHRA employer contribution amount, determined with reference

to the cost of individual coverage under a marketplace silver plan (regardless of the coverage actually selected). The amount an employee would be required to pay for such coverage for the ICHRA to be considered affordable (the monthly premium amount) is capped at one-twelfth of 9.5% (as adjusted under 26 C.F.R. § 1.36B-2(c)(3)(v)(C); 9.78% for 2020) of the participant's household income for the year. The participant's monthly premium amount would be determined as (1) the monthly premium for the lowest cost individual coverage silver plan available to the participant through the ACA marketplace for the rating area in which he or she lives (or, for purposes of the employer mandate, works), minus (2) the amount made newly available by the employer for the plan year under the ICHRA, divided by the number of months the ICHRA is available to the participant for that year. As long as the participant's monthly premium amount does not exceed the cap, the coverage provided by the ICHRA would be considered affordable. 26 C.F.R. § 1.36B-2(c)(3)(vi)(5).

The IRS has recognized that the group of participants to whom an employer may want to offer an ICHRA integrated with individual coverage acquired through the ACA marketplace may share the same worksite, but reside in different ACA rating areas. This would be problematic for employers desiring to provide such a benefit because the standard for determining whether the benefit satisfies the affordability requirement would require employers to track which ACA rating areas participants reside in and to adjust their ICHRA contribution accordingly. In response, the IRS proposed guidance that would permit employers to determine the affordability of coverage in the form of an ICHRA integrated with individual coverage acquired through the ACA marketplace by using the ACA rating area applicable to a participant's primary worksite, rather than his or her residence, for purposes of determining an employer mandate penalty. Prop. Treas. Reg. 54.4980H-5(f), 84 Fed. Reg. 51,487.

For medical insurance acquired in the ACA marketplace, one factor in determining the premium is the buyer's age. Although the IRS considered additional administrative safe harbor rules allowing employers to streamline ICHRA affordability determinations based on a representative age for the employee class or age bands, rather than each eligible individual's age, it declined to do so in the proposed rulemaking. 84 Fed. Reg. 51,478–79. However, employers are permitted to use as the reference plan for the relevant exchange and location the plan that has the lowest-cost silver plan for the lowest age band, even if a different plan offered has a lower cost at a different age band. Prop. Treas. Reg. 54.4980H-5(f)(7)(iii)(C), 84 Fed. Reg. 51,489. The age to use for affordability determinations is the employee's age at the beginning of the plan year or, for an employee who becomes eligible during the plan year, their age on the date the ICHRA can first become effective. Prop. Treas. Reg. 54.4980H-5(f)(7)(i), 84 Fed. Reg. 51,489.

In an additional nod to administrative convenience, the proposed regulations offer a safe harbor for the timing of affordability determinations for ICHRAs that are integrated with individual coverage acquired through the ACA marketplace. Normally, coverage year costs are not set until a few months prior to the beginning of a coverage year, which for coverage acquired in the ACA marketplace, is the calendar year. Realizing that this would likely be insufficient time for employers to plan and budget their ICHRA contributions, the IRS allows the determination to be based on premiums charged during a lookback month. Specifically, in order to determine affordability for any month of coverage under the ICHRA, employers can use ACA marketplace cost of coverage information for January of the year prior to the coverage year for calendar-year ICHRAs or January of the current year for non-calendar-year ICHRAs. Prop. Treas. Reg. 54.4980H-5(f)(4), 84 Fed. Reg. 51,488

HRA Effect on Minimum Value

Amounts newly made available for the current plan year under an HRA that is integrated with a group major medical plan are counted toward the plan's minimum value percentage for that plan year if the amounts may be used **only** to reduce cost-sharing for covered medical expenses and cannot also be used to pay premiums for coverage under the group major medical plan. The amount counted for this purpose toward the group major medical plan's minimum value calculation is the amount of expected spending from the HRA for out-of-pocket health care costs in a plan year. To be taken into account for minimum value purposes in this way, the HRA and the group major medical plan must have the same plan sponsor. 26 C.F.R. §1.36B-6(c)(4).

Employer contributions to an HRA count toward the eligible employer-sponsored plan's minimum value only to the extent the amount of the employer's annual contribution to the HRA is required under the terms of the HRA or otherwise determinable within a reasonable time before the employee must decide whether to enroll in the eligible employer-sponsored plan. Id.

For an ICHRA integrated with individual coverage acquired through the ACA marketplace, the ICHRA will be deemed to provide minimum value so long as it is affordable, as described above, including as may be determined using any available safe harbor rule. Prop. Treas. Reg. 54.4980H-5(f)(3), 84 Fed. Reg. 51,488.

Impact of HRA on Marketplace Coverage Subsidy Eligibility

General Purpose HRAs

Coverage provided under a general purpose HRA (including an ICHRA) is considered to be an eligible employer-sponsored plan and thus minimum essential coverage under both the ACA's individual and employer mandates. Thus current and/or former employees who have access to amounts under a general purpose HRA (or ICHRA) are considered enrolled in minimum essential coverage and are therefore ineligible for premium tax credits or cost sharing reductions to help pay for individual medical insurance coverage obtained through an ACA marketplace. In addition, an individual who is eligible for a general purpose HRA (or ICHRA) that is deemed to be affordable and provide minimum value is ineligible for a premium tax credit even if the individual opts out of and/or waives the general purpose HRA (or ICHRA) coverage. I.R.S. Notice 2013-54, pt. II.D. 4; 26 C.F.R. §1.36B-2(c)(3)(i)(B).

To avoid this result for former employees, employers can develop an opt-in/opt-out and/or waiver procedure as described above to permit former employees to limit access to their general purpose HRA during periods in which they want to be able to qualify for premium tax credits or cost sharing reductions to help pay for individual medical insurance coverage obtained through an ACA marketplace. Note, however, that current guidance seems to indicate that such a design providing for post-termination coverage suspension periods is not permitted with respect to ICHRAs.

Limited-Purpose HRAs

A limited-purpose HRA that covers only excepted benefits, such as limited-scope dental and/or vision benefits, is not considered minimum essential coverage and does not impact an individual's eligibility for premium tax credits or cost sharing reductions used to help pay for individual medical insurance coverage obtained through an ACA marketplace. Note, however, this is not necessarily the result for EBHRAs (capped-benefit HRAs that are deemed to be excepted benefits under the 2019 Rules). This is because one of the requirements for an EBHRA is that the employer also offers the eligible employee group medical coverage that does not consist solely of excepted benefits. If that other offered coverage is affordable and provides minimum value, then the employee would not be eligible for the premium tax credit.

Other ACA Requirements

W-2 Reporting

Employers filing at least 250 Form W-2s must report in Box 12, Code DD the aggregate cost of applicable employer-sponsored coverage. An employer can, but is not required to, include the cost of coverage under an HRA in determining the aggregate reportable cost. If an employer chooses to include the cost of coverage under an HRA in the aggregate reportable cost, the calculation of the cost of coverage must meet the IRS's generally applicable requirements, and the HRA coverage must constitute applicable employer-sponsored coverage. If the only applicable employer-sponsored coverage provided to an employee by the employer is an HRA (e.g., because the HRA is integrated with coverage provided by the employer of the employee's spouse), the employer is not required to report any amount on the Form W-2 for that employee. I.R.S. Notice 2012-9.

PCORI Fees

Employers sponsoring self-funded group health plans must pay Patient-Centered Outcomes Research Institute (PCORI) fees, which are intended to support clinical effectiveness research. I.R.C. § 4376. Because HRAs are self-funded group health plans, they are subject to the PCORI fee rules unless substantially all of an HRA's benefits are excepted benefits, such as limited-scope dental and/or vision benefits, or unless the HRA is a QSEHRA. 26 C.F.R. § 46.4376-1(b)(ii)(A). The PCORI fee rules do not have an exclusion for small plans, so PCORI fees **do** have to be paid with respect to retiree-only HRAs.

For purposes of calculating PCORI fees:

- **Employers offering an applicable self-funded health plan other than an HRA.** If a plan sponsor provides an HRA and another applicable self-funded health plan that provides major medical coverage, the HRA and the major medical plan may be treated as one applicable self-funded health plan if the HRA and the self-funded plan have the same plan year. As a result, no additional PCORI fees would be due for the HRA coverage in that situation.
- **Employers not offering an applicable self-funded health plan other than an HRA.** If a plan sponsor does not establish or maintain an applicable self-funded health plan other than an HRA, the plan sponsor may treat each participant's HRA as covering a single life (and therefore the plan sponsor is not required to include as lives covered any spouse, dependent, or other beneficiary of the individual participant in the HRA, as applicable).
- **Employers offering HRA integrated with fully insured health plan.** When an employer has an HRA integrated with a fully insured major medical plan, the employer must pay PCORI fees for the HRA, but can use the one-life-per-participant rule described above when determining the amount of PCORI fees due.

26 C.F.R. § 46.4376-1(c)(2)(vi).

For more information on PCORI fees, see ACA Patient-Centered Outcomes Research Institute Fees.

Summary of Benefits and Coverage Disclosure

The ACA created a uniform participant disclosure requirement whereby a standard summary of benefits and coverage (SBC) must be provided for each medical plan and/or medical plan option available to eligible individuals. An SBC is not required for limited-purpose HRAs that provide only excepted benefits, such as limited-scope dental and/or vision benefits, or for retiree-only HRAs, EBHRAs, or QSEHRAs. General purpose HRAs (that are not retiree-only HRAs) are generally subject to the SBC requirements. An HRA integrated with other major medical coverage need not separately satisfy the SBC requirements; the SBC is prepared for the other major medical coverage, and the effects of employer credits to the HRA can be denoted in the appropriate places on the SBC for deductibles, copayments, co-insurance, and benefits otherwise not covered by the other major medical coverage. Preamble to final regulation 26 C.F.R. § 54.9815-2715, 77 Fed. Reg. 8670-71 (Feb. 14, 2012). On the other hand, employers offering an ICHRA will need to furnish a separate SBC since the ICHRA is a group health plan subject to the SBC requirement whose terms will not be incorporated in disclosures for the integrated coverage. See 84 Fed. Reg. 28,920. For background on SBCs, see ACA Summary of Benefits and Coverage Disclosure Rules.

ACA Reporting (I.R.C. §§ 6055 and 6056)

An employer who offers self-funded coverage, including HRA coverage, has an obligation under I.R.C. § 6055 to report information to the IRS about individuals enrolled in that coverage. An applicable large employer subject to the ACA employer mandate has an obligation under I.R.C. § 6056 to report information to the IRS about whether and to what extent offers of minimum essential coverage are made to full-time employees.

Section 6055 requirements are:

- An employer offering a self-funded major medical plan and an HRA is required to report the coverage of an individual enrolled in both types of minimum essential coverage on the applicable IRS form under only one of the arrangements.
- An employer offering an insured major medical plan and an HRA is not required to report the HRA coverage of an individual if the individual is eligible for the HRA because the individual enrolled in the insured major medical plan.
- An employer offering an HRA must report coverage under the HRA for any individual who is not enrolled in a major medical plan of the employer (e.g., if the individual is enrolled in a group major medical plan of another employer (such as spousal coverage) or enrolled in individual coverage with an integrated ICHRA, or if the individual is a former employee).
- An employer offering a limited-purpose HRA that provides only excepted benefits, such as limited-scope dental and/or vision benefits, an EBHRA or a QSEHRA is not required to report that HRA coverage..

Preambles to proposed and final regulations discussing supplemental coverage under I.R.C. § 6055, 78 Fed. Reg. 54,990 (Sept. 9, 2013), 79 Fed. Reg. 13,221 (Mar. 10, 2014). 26 C.F.R. § 1.6055-1(d)(2)(i).

For the Section 6056 requirement, an offer of HRA coverage is an offer of minimum essential coverage, but is not typically an offer of minimum value minimum essential coverage. Most applicable large employers who offer an HRA offer it as an integrated HRA paired with an offer under other major medical plan coverage offered by the employer, in which case Section 6056 reporting should be conducted based on the offer of major medical plan coverage. If an applicable large employer offers HRA coverage only, integrated with other major medical plan coverage sponsored by another unrelated employer, Section 6056 reporting should be conducted based on the offer of HRA coverage. Such an offer may mitigate penalty risk under I.R.C. § 4980H(a), but exposes the employer to penalty risk under I.R.C. § 4980H(b) since the HRA likely does not provide minimum value. I.R.S. Notice 2015-87, Q&A-7.

Section 6056 reporting also applies to ICHRAs. The proposed rules for the interaction of ICHRAs and the employer mandate indicate that the IRS anticipates providing further guidance regarding ICHRA reporting, including forms and instructions. It is expected that employers will be permitted to report the amount of the employee's required contribution based on the Section 4980H safe harbor(s) used by the employer, rather than as determined under the final premium tax credit regulations. 84 Fed. Reg. 51, 482–83.

Other Legal Requirements

In addition to the ACA legal requirements discussed in the preceding sections, an HRA must comply with other group health plan legal requirements, such as ERISA, COBRA, and HIPAA privacy and security requirements, among others. When an HRA is integrated with other group major medical plan coverage sponsored by the same employer, the major medical plan should already have compliance mechanisms in

place for these requirements which the integrated HRA can leverage. However, employers may be required to develop new compliance mechanisms to ensure applicable group health plan legal requirements are satisfied for HRAs that are offered on a stand-alone basis, such as limited-purpose HRAs, retiree-only HRAs, ICHRAs, EBHRAs and, for only a few of such requirements, QSEHRAs. Note, however, as further described below, that the individual coverage paid for via an ICHRA, a QSEHRA, or a salary reduction arrangement will not be treated as an ERISA plan if certain conditions are met.

ERISA

The vast majority of employer-sponsored HRAs are group health plans that must comply with ERISA (the primary exceptions being HRAs sponsored by governmental and church employers that are exempt from ERISA). For information on the types of plans that may be subject to ERISA, see ERISA Coverage of Benefit Plans. Some of the primary compliance obligations under ERISA include having a written plan document, distributing a summary plan description and summaries of material modifications to participants, filing a Form 5500 if there are more than 100 participants in the plan, and following specific claims and appeals procedure requirements. Note that although QSEHRAs are not subject to most of the additional legal requirements that apply to group health plans, QSEHRAs are still considered ERISA-covered employee welfare benefit plans that must comply with these general ERISA requirements (unless sponsored by an employer that is exempt from ERISA).

An HRA that is integrated with a group major medical plan can be folded into the medical plan's compliance with these requirements, by ensuring that the plan document and SPD include HRA provisions. Any stand-alone HRA needs to determine how to comply with these requirements in its own right.

For information about ERISA's requirements, see the other practice notes available under Health and Welfare Plans: ERISA and Fiduciary Compliance, such as ERISA Fiduciary Duties and Disclosure Rules for SPDs, Participant-Directed Plans, Employer Securities, and Blackout Notices.

ERISA Status of Individual Coverage relating to ICHRAs, QSEHRAs, or Salary Reduction Arrangements

Individual health insurance coverage and group coverage are subject to different and sometimes conflicting requirements. Therefore, it would be problematic in many cases for individual coverage paid for via an ICHRA, a QSEHRA or a salary reduction arrangement to be treated as part of a group health plan. To resolve this issue, the DOL established a safe harbor rule that will exclude the individual coverage integrated with an ICHRA or paid for via a QSEHRA or a salary reduction arrangement from being subject to Title I of ERISA so long as certain requirements are met. To qualify for this relief:

- **Voluntary.** The participant chooses the coverage on a completely voluntary basis.
- **No employer endorsement.** The employer does not select or endorse any particular issuer or coverage. Note that while this rule does not prohibit an employer from assisting employees in selecting coverage, it must do so in a strictly neutral manner, without promoting or incentivizing any particular provider. Similarly, coverage offered through a private exchange may be made available; however, the employer needs to take precaution against any actions that can be seen to limit employees' choice of issuer or promote the private exchange over other options.
- **No employer consideration.** The employer receives no consideration in the form of cash or otherwise in connection with the employee's selection or renewal of the coverage.
- **Individual health insurance coverage.** The only non-group health insurance premiums that may be reimbursed or paid for under the plan are premiums for individual health insurance coverage procured on the individual market, as defined in 29 C.F.R. 2590.702-1 (e.g., excluding short-term disability insurance and coverage consisting exclusively of excepted benefits). Medicare premiums also may be covered without violating the safe harbor.
- **Notice requirement.** The employee receives an annual notice that the individual coverage is not covered by ERISA.

29 C.F.R. § 2510.3-1; see 84 Fed. Reg. 28,948–52.

It is only the underlying coverage that is exempt from ERISA Title I. The safe harbor does not affect the ERISA status of the ICHRA or QSEHRA. Salary reduction arrangements under I.R.C. §125 are merely pre-tax funding vehicles and generally are not subject to ERISA in their own right.

COBRA

For employers subject to COBRA, COBRA continuation coverage must be offered with respect to HRAs (other than QSEHRAs). I.R.S. Notice 2002-45, pt. VII. If the HRA is a stand-alone plan, the COBRA election notice provided to qualified beneficiaries at the time of a COBRA qualifying event should list the HRA as coverage that can be continued under COBRA, together with any COBRA premium the employer decides to charge for such coverage. In order to determine the COBRA premiums for continued coverage under an HRA, an actuary may need to be engaged to

determine the fair market value of coverage under the HRA. These rules generally apply to ICHRAs as well; however, the 2019 Rules clarify that a loss of coverage under the ICHRA due to the individual's failure to maintain qualifying individual coverage does not constitute a COBRA qualifying event. 26 C.F.R. §54.9802-4(c)(1)(ii).

If the HRA is integrated with the employer's major medical plan, the COBRA election notice does not need to list the HRA separately. Rather, a COBRA qualified beneficiary's election of COBRA coverage with respect to the medical plan should automatically provide continued coverage under the HRA as well. If desired, an employer can, but is not required to, offer COBRA qualified beneficiaries a choice between electing COBRA coverage with respect to the medical plan only (and paying a lower COBRA premium) or electing COBRA coverage with respect to both the medical plan and the HRA (and paying a higher COBRA premium which takes into account the fair market value of the HRA coverage).

A general rule under COBRA is that a COBRA qualified beneficiary should be treated the same as a similarly situated active employee covered under the plan. Thus, individuals with COBRA coverage under an HRA should receive additional credits to their HRAs at the same time and in the same amount as similarly situated active employees. Because each COBRA qualified beneficiary has an independent right to elect COBRA, this can lead to a mushrooming of liability for the employer if each COBRA qualified beneficiary within a family unit separately elects to continue HRA coverage under COBRA, or if a divorced spouse or aged-out dependent child elect COBRA with respect to HRA coverage that remains in effect for a current employee. In such situations, the employer must create separate HRA accounts for each COBRA qualified beneficiary who separately elects HRA coverage, thereby multiplying the total amount available for use to pay or reimburse eligible health care expenses. However, each COBRA qualified beneficiary could be charged up to 102% of the full cost rate for the HRA coverage they elect in COBRA, so the result may end up being cost neutral for the employer.

For more information about COBRA's requirements, see COBRA Compliance and Enforcement.

HIPAA Privacy and Security Rules

An HRA must comply with HIPAA's privacy and security requirements as a covered entity under HIPAA. Note that QSEHRAs are not excluded from the definition of group health plan for these purposes and must comply with HIPAA's privacy and security requirements unless another exception applies (e.g., as a self-administered plan with fewer than 50 participants). Some of the primary compliance obligations under HIPAA's privacy and security rules include having business associate agreements in place with third party-service providers, providing participants with a privacy notice, maintaining and following HIPAA privacy and security policies and procedures, and notifying individuals of breaches of unsecured protected health information.

An HRA that is integrated with the employer's group major medical plan coverage can be folded into and included in the medical plan's compliance with these requirements. A stand-alone HRA will need to determine how it will comply with these requirements in its own right.

For more information about HIPAA's privacy and security requirements, see HIPAA Privacy, Security, Breach Notification, and Other Administrative Simplification Rules.

Medicare Part D

HRAs are specifically included under Center for Medicare and Medicaid Services (CMS) regulations as group health plans that are subject to Medicare Part D's disclosure and coordination of benefits requirements. 42 C.F.R. § 423.882. HRAs that are integrated with other group major medical plan coverage sponsored by the same employer can be factored into and included with the Medicare Part D notice of creditable coverage provided for the major medical plan. For a stand-alone HRA, an employer likely needs to engage an actuary to determine whether the HRA's prescription drug coverage is creditable or not, and issue the appropriate notice accordingly. In addition, applicable guidance is currently unclear as to whether QSEHRAs are subject to Medicare Part D's disclosure and coordination of benefits requirements. Pending additional guidance, the cautious approach would be to operate a QSEHRA in compliance with those requirements.

For more information about Medicare Part D's requirements, see Health Care Law Sourcebook § 423.464.

Medicare Secondary Payer Requirements

CMS has confirmed that HRAs are group health plans subject to the Medicare Secondary Payer rules and the mandatory reporting requirements that are in place to enforce those rules. However, no reporting is required for an HRA if amounts credited to the HRA at the beginning of the year are less than $5,000. CMS Alert (Sept. 27, 2011). In addition, QSEHRAs fall outside the definition of group health plan that applies when determining whether arrangements are subject to the MSP requirements. See also the discussion above in the section entitled "HRA Rules relating to Medicare and TRICARE Coverage."

For more information about Medicare Secondary Payer reporting requirements, see Guide to Medicare Secondary

Payer Compliance § 2.04.

Non-ACA Group Health Plan Mandates

HRAs (other than QSEHRAs) also are subject to various other federal mandates for group health plans. For example, compliance with laws such as the following should be considered: Newborns' and Mothers' Health Protection Act (NMHPA); Mental Health Parity Act (MHPA), as amended by the Mental Health Parity Addiction Equity Act (MHPAEA); Women's Health and Cancer Rights Act (WHCRA); Family Medical Leave Act (FMLA); the Uniformed Services Employment and Reemployment Rights Act (USERRA); and various employment discrimination laws such as the Age Discrimination in Employment Act (ADEA), American with Disabilities Act (ADA), the Genetic Information Nondiscrimination Act (GINA), and others.

Common HRA Pitfalls and Periodic HRA Compliance Reviews

Some common pitfalls in designing and administering compliant HRAs under currently applicable guidance include the following:

- Permitting employee contributions to fund an HRA, including inadvertently structuring HRA credits in such a way as to create indirect employee funding of the HRA
- Allowing an HRA to pay or reimburse eligible health care expenses incurred by someone who is not a tax dependent without imputing income to the participant for that coverage
- Failing to ensure that the HRA only pays or reimburses eligible health care expenses described in I.R.C. § 213(d), including failure to implement claims substantiation and debit card rules
- Providing a cashout of unused amounts to participants
- Processing claims against a participant's health FSA balance before amounts credited to the participant's HRA are exhausted without having explicit plan provisions that reverse the default rule to require the health FSA amounts to be used first
- Not including sufficient detail in applicable plan documents and SPDs regarding plan design elements, such as how much is credited to the HRA, when those credits occur, who eligible dependents are under the HRA, and what types of expenses the HRA pays or reimburses
- Allowing an individual to be enrolled in both an HDHP and a general purpose HRA and also facilitating HSA contributions by that same individual
- Offering a stand-alone, non-integrated, general purpose HRA to current employees in violation of the ACA's group market reform provisions (outside of a QSEHRA or an ICHRA or EBHRA)
- Providing payment or reimbursement of individual-policy medical insurance premiums for current employees (outside of a QSEHRA, or an ICHRA or EBHRA)
- Failing to restrict HRA reimbursements to expenses incurred by current employees' dependents who are enrolled in the major medical plan with which the HRA is integrated
- Taking HRA amounts into account when determining affordability and minimum value under the ACA's employer mandate when doing so is impermissible
- Failing to recognize or communicate when general purpose HRA coverage makes a former employee ineligible for premium tax credits or cost sharing reductions to help pay for individual medical insurance coverage through an ACA marketplace
- Ignoring HRA coverage when calculating PCORI fees, preparing SBCs, and/or conducting ACA reporting
- Not having an SPD for a stand-alone HRA or failing to include information in a medical plan's SPD about any HRA that is integrated with that plan
- Failing to offer COBRA with respect to an HRA
- Not having a HIPAA business associate agreement in place with third-party service providers, failing to provide a HIPAA notice of privacy practices, and/or failing to comply with HIPAA privacy and security procedures for a stand-alone HRA

Given the complexities and evolving landscape of legal

compliance obligations and available guidance, it is extremely important to thoroughly analyze existing and proposed HRA designs, and to periodically review existing HRA plans, to ensure compliance with all applicable requirements and to mitigate against litigation, excise tax, audit, and/or other enforcement action risks.

Emily D. Zimmer, Partner, Troutman Sanders LLP

Emily D. Zimmer is a partner in the Charlotte, NC office of Troutman Sanders where Emily counsels clients on a wide range of employee benefit and executive compensation issues, including issues related to corporate mergers and acquisitions. She routinely advises on the design, implementation and administration of qualified and non-qualified retirement plans and welfare benefit programs, including wellness programs, health care accounts such as HRAs, Health FSAs and HSAs, adoption reimbursement programs and educational assistance programs. Emily also provides compliance advice, including with reporting and disclosure requirements, ACA compliance obligations, COBRA benefit continuation rights, and HIPAA portability, nondiscrimination, privacy and security issues.

Emily assists clients across diverse industries with a particular emphasis on financial services, energy, higher education and health care. Her work with higher education institutions has included assisting clients with unique issues presented under the ACA's employer mandate, including with respect to student employees. Emily also helps clients in the health care industry navigate complex benefit plan issues arising due to the client's status as both an employer and a provider, including unique provider/plan contracting and fiduciary duty issues and HIPAA privacy and security considerations given HIPAA's impacts on both the client and the client's group health plans as different types of covered entities.

Lynne Wakefield, Partner, Troutman Sanders LLP

Lynne Wakefield regularly assists clients with issues relating to employer-sponsored health and welfare benefits, including the design, implementation and administration of group health plans, cafeteria plans, health savings accounts (HSAs), health reimbursement arrangements (HRAs), wellness programs and retiree medical and private exchange coverage. She also provides compliance advice, including with ERISA reporting and disclosure requirements, ACA compliance obligations, COBRA continuation coverage rights, HIPAA portability, nondiscrimination, privacy and security requirements and Internal Revenue Code qualification issues.

Lynne also regularly advises clients on qualified retirement plan issues, including the design, implementation and administration of 401(k), profit sharing and traditional pension and cash balance plans, compliance with applicable ERISA and Internal Revenue Code requirements and correction of qualified plan defects and related submissions under the Internal Revenue Service and Department of Labor voluntary correction programs.

Lynne assists clients with employee benefit plan governance, including committee structures and charters. She provides fiduciary training and best practices, negotiates vendor contracts and services agreements, responds to participant claims and appeals and assists with benefits issues in plan litigation. She also conducts full-scale benefit plan audits to identify compliance gaps under the myriad of laws impacting employee benefit plans and assists with benefits issues in mergers and acquisitions, including benefits due diligence and post-transaction benefits integration.