



## COMPLIANCE SERVICES Alert



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# Trump administration creates two new types of HRAs ... but when is the juice worth the squeeze?

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Federal officials have finalized regulations creating two new types of health reimbursement arrangements (HRAs), opening the door for more employers to use an HRA to reimburse employees for premium expenses for individual health insurance policies in lieu of group medical insurance. The rules thus invite employers to consider a pure “defined contribution” approach to medical insurance for their employees.

But the new rules add such complexity to the HRA landscape that many employers, even those willing to consider an HRA to defray individual market premium costs, may find the rules too difficult to embrace. For example, employers subject to the ACA employer mandate will find that ensuring the HRA benefit is adequate to render individual market coverage “affordable” to an employee is a complex, employee-by-employee calculation necessitating information about coverage costs in specific areas.

Still, for some employers with certain categories of employees the rules might be attractive. Employers with large populations of part-time, seasonal or temporary employees, for example, can use an HRA to help these employees buy individual policies on a tax-favored basis.

*Lockton comment:* The new regulations are designed to largely reverse rules put in place during the Obama administration. Those rules were intended to prohibit the use of HRAs as a way to satisfy aspects of the Affordable Care Act’s (ACA) employer mandate. They prohibited stand-alone medical expense-reimbursing HRAs for active employees. Congress later allowed smaller employers – those too small to be subject to the ACA’s employer mandate – to use HRAs to fund individual market medical insurance policies for their employees, beginning in 2017. These new regulations are designed to extend similar accommodations to larger employers.

Interestingly, the rules allow employers to use HRAs to pay for employees’ Medicare premiums, creating an exception to a longstanding rule against using financial incentives to encourage employees to enroll in Medicare. Although employers are not permitted to overtly single out their Medicare-eligible population for such an incentive, this accommodation opens the door for employers with an older workforce, or an older workforce in a certain classification or location, to incentivize those employees to enroll in Medicare.

The new rules are effective January 1, 2020. We explain the rules generally below, saving additional details, nuances and limitations for a webcast scheduled for July 9. Register for the webcast [here](#).

*Lockton comment:* Although regulators think the recently final regulations will cause nearly a million employers to use HRAs in lieu of group medical programs, that viewpoint overlooks several important factors. Inflation in the individual health insurance markets tends to significantly exceed inflation in the group market, eroding the purchasing power of employers' healthcare dollars significantly faster than group insurance. In a tight labor market, employers using health insurance as an attraction and retention tool would have to increase HRA contributions, year over year, in amounts that would likely far and away exceed the increases they'd pay for equivalent coverage on a group basis.

Employers using HRAs to fund individual market policies would also lose control over health plan design, lose access to health plan-related information on their employees, and largely surrender the ability to drive healthier lifestyles through wellness programs targeting latent or chronic conditions.

## Background: The way we were

Before the ACA, many employers offered HRAs alongside – and sometimes, albeit rarely, in lieu of – major medical coverage. Where the HRA was in lieu of other *group* health coverage, employers typically allowed the HRA to reimburse premium expenses for *individual* market coverage.

Regulations under the ACA dismantled much of that. ACA regulators feared that employers would drop group major medical coverage in favor of HRAs and encourage employees to use those funds to purchase individual policies. This could shift more risk to the ACA marketplaces that were already taking on enhanced risk due to the ACA's ban on pre-existing condition restrictions and the requirement that insurers issue policies to all applicants regardless of health risk.

*Lockton comment:* A medical expense-reimbursing HRA is "minimum essential coverage" (MEC) for purposes of tier 1 of the ACA employer mandate (the obligation to offer at least MEC to 95% or more of the employer's ACA full-time employees). Although the HRA won't satisfy *tier 2* (the obligation to offer minimum value and affordable coverage), an employee enrolled under the HRA – that is, enrolled under a MEC plan – can't trigger a tier 2 penalty against the employer.

ACA regulators said they'd only allow HRAs to survive if they're coupled with (the rules say "integrated with") other *group* medical coverage. An HRA could never integrate with – could never be used to support the purchase of – an *individual* health insurance policy, at least not for active employees.

In 2016, Congress created an exception allowing small employers to offer individual market premium reimbursement through qualified small employer health reimbursement arrangements, or QSEHRAs. These QSEHRAs are subject to a variety of their own rules and restrictions.

The recently released final regulations extend similar accommodations to larger employers. They also add a new kind of HRA, the "excepted benefit HRA."

*Lockton comment:* This brings to at least five the number of HRA variations available to employers in the post-ACA world. We'll explain all five, and their applicability, advantages and disadvantages, in our July 9 webcast.

## The first of the new breed of HRA: The individual coverage HRA

The bulk of the recent regulatory package is devoted to what the rules call an "individual coverage HRA," which we refer to here as an "ICHRA." The ICHRA is designed for one main purpose: *reimburse individual market* health insurance premiums on a tax-favored basis. Here are the key aspects of ICHRAs:

- An employer isn't required to offer anyone an ICHRA, but if it offers an ICHRA to its employees, or a subset of its employees, it cannot also offer traditional health insurance to the employees offered the ICHRA. "Traditional health insurance" includes, generally speaking, any health plan other than dental or vision coverage, or a health flexible spending account. Thus, the employer must choose between offering *either* an ICHRA *or* group medical coverage to the employees. The employer cannot offer both to the same employee class.

*Lockton comment:* This requirement makes sense of the rule allowing employers to offer an ICHRA that reimburses Medicare premiums. Because there's no other employer-sponsored group plan in the picture, there's no other group plan that would pay primary to Medicare.

- If the employer decides to offer only *some* employees an ICHRA, while offering a traditional medical plan to other employees, the employer is limited as to how it may define the groups. Permissible classifications include:
  - Full-time employees.
  - Part-time employees.
  - Salaried employees.
  - Non-salaried (e.g., hourly) employees.
  - Seasonal employees.
  - Temporary employees of staffing firms.
  - Bargaining unit employees.
  - Non-resident aliens with no US-source income.
  - Employees working the same geographic location (generally, the same insurance rating area, state or multi-state region).
  - Employees who have not met the employer's waiting period for medical coverage.
  - Any group of employees formed by *combining* two or more of these classes.

In addition, an employer may offer *current* employees in a classification traditional coverage, and *newly hired* employees in the classification an ICHRA.

In defining "full-time," "part-time" and "seasonal" employees, the employer may adopt the definitions applied under the ACA, or may use slightly more liberal definitions under section 105(h) of the tax code. For example, while the ACA defines a full-time employee as one credited with an

average of at least 30 hours of service per week, section 105(h) uses 35 hours per week (and sometimes more than that, depending on circumstances).

*Lockton comment:* We suspect employers subject to the employer mandate will apply the ACA's definitions, as their payroll systems likely already distinguish between ACA full-time and part-time employees based on the 30 hours of service per week standard.

If the employer offers traditional group coverage to some employees but an ICHRA to others, and the distinction is based on full-time versus part-time, salaried versus non-salaried, or location (smaller than a state), the classes offered the ICHRA must meet certain minimum size requirements based on the size of the employer:

Employer size:	<100 employees	100-200 employees	>200 employees
Minimum class size:	10 employees	10% of employees	20 employees

*Lockton comment:* If there are multiple companies in the corporate family tree, employer size for this purpose is determined at what the rules call the "common law" level (essentially, the EIN level), not the controlled group level.

- Employees in a permissible class who are offered an ICHRA must receive the same HRA benefit, although the employer can vary the benefit based on age or family size. If the benefit varies by age, the benefit for the oldest employee can't be more than three times the benefit for the youngest employee.

When assessing whether ICHRA-covered employees receive the same benefit, the employer disregards rollovers of prior year balances and transfers from other HRAs sponsored by the employer.

*Lockton comment:* If the HRA had to take into account any rollovers from prior years (or transfers from other HRAs), that would seriously undermine much of the value of an HRA, from the employee's perspective, by effectively penalizing the employees who had not utilized much of the HRA in the prior year (or much utilized the prior HRA).

An ICHRA may include rules allowing for prorated benefits for employees joining the ICHRA midyear, and for new dependents added midyear. Proration rules should be described in the HRA document and the notice (discussed below) supplied to employees, and must be decided upon before the ICHRA plan year begins.

- Employees and their dependents covered by the new HRA must actually enroll in individual market health insurance coverage (or Medicare Parts A and B, or Part C) before their ICHRA coverage can begin, and certify that other coverage. The final regulations offer a model certification. The certification must be repeated each time the employee submits a claim to the HRA.

*Lockton comment:* Just about any individual medical coverage other than dental or vision coverage is adequate to allow for the employee's (and dependents') coverage under the ICHRA. Student health insurance, if fully insured, is also considered adequate. However,

coverage under a health care sharing ministry is *not* adequate, nor is short-term limited duration medical insurance.

If a dependent's individual market coverage were to lapse, the ICHRA coverage for that individual also lapses. If the employee and all dependents lose individual market coverage, the employee forfeits the HRA benefit. However, the ICHRA must allow a reasonable time for the submission of reimbursable claims incurred while the ICHRA coverage was still in force.

*Lockton comment:* The lapse of ICHRA coverage on account of loss of individual market coverage is not a COBRA-qualifying event. However, an ICHRA is a group medical plan. Therefore, the loss of ICHRA coverage because of an event that is a COBRA-qualifying event, such as the employee's death, termination of employment or reduction in hours, triggers a COBRA right.

- Employees enrolled under an ICHRA must have the opportunity to opt out at least once a year.
- Employers sponsoring one of the new HRAs must provide eligible employees an extensive notice about the HRA, its benefits, its conditions, and the effect of the HRA coverage on the ability of the employee to qualify for federal subsidies in an individual market health insurance exchange, or marketplace. The final regulations include a model six-page notice.
- ICHRAs are designed to reimburse premium for individual market medical insurance but may also reimburse other healthcare expenses, such as out-of-pocket medical expenses whether covered or not covered by the employees' (or their dependents') medical insurance.

## ICHRAs and the ACA's employer mandate

For employers subject to the ACA's employer mandate, it will be possible -- but challenging -- to use ICHRAs to meet the employer mandate obligation of offering to their ACA full-time employees adequate and affordable coverage.

The IRS intends to issue regulations on precisely how an employer can use an ICHRA and individual market coverage to satisfy the employer mandate, but based on earlier IRS guidance here's how we expect that will work:

- New contributions for a given year credited to any individual ACA full-time employee's ICHRA must be adequate to allow the employee to buy an "affordable," silver-level policy (70% actuarial value coverage) in the individual market rating area in which the employee lives or works.
- Affordability will be determined by calculating the premium the employee would pay for self-only coverage under the lowest-cost silver plan available to the employee in the employee's rating area, and then deducting from that amount the ICHRA benefit available to pay that premium. The remaining premium, net of the ICHRA benefit, must be small enough to be considered "affordable" under the ACA standards (i.e., generally, not more than about 10% of adjusted gross income). We expect all the current affordability safe harbors to apply.

## Is the individual health insurance subsidized by the employer considered an ERISA plan?

Generally, if an employer pays even a small portion of the cost of individual coverage, the coverage will be viewed as an ERISA plan maintained by the employer. The new regulations permit the ICHRA to defray the cost of individual insurance policies without causing those policies to be considered ERISA plans maintained by the employer, as long as the employer satisfies five requirements including a new notice obligation.

*Lockton comment:* This same safe harbor from ERISA applicability applies to individual policies purchased in part with dollars from HRAs offered to fewer than two active employees (e.g., a retiree-only HRA) or QSEHRAs.

In addition, the Labor Department has clarified that where an employer allows an HRA enrollee the opportunity to pay the balance of their premium for individual market coverage on a pre-tax basis under the employer's cafeteria plan, that employer involvement doesn't trigger ERISA coverage of the individual policy as long as the employer meets the same five requirements alluded to above.

Note, however, that under ACA rules this pre-tax avenue for the payment of the premium balance is only available if the individual policy is purchased outside of an ACA marketplace; that may not be possible in all states.

## Does an ICHRA disqualify an employee from making HSA contributions?

If structured properly, the ICHRA will not disqualify a participant from making HSA contributions. For example, if the ICHRA merely reimburses individual market or Medicare premium expenses, the ICHRA is not HSA-disqualifying coverage (although the Medicare enrollee cannot make HSA contributions, and an individual covered by a non-high deductible health plan in the individual market would not be HSA eligible either).

But if the ICHRA also reimburses out-of-pocket medical expenses (beyond dental and vision), and does so before the enrollee has met an HSA-compatible high deductible, then the ICHRA coverage would disqualify the enrollee from making HSA contributions. In short, the ICHRA would itself be HSA-disqualifying, low-deductible coverage.

## The second new form of HRA: The "excepted benefit HRA"

Under federal law, some benefits are considered "excepted" from key requirements, particularly with respect to HIPAA and ACA requirements. These tend to be very modest or limited benefits, such as typical

dental and vision coverage, critical illness and similar indemnity-type insurance, and most health flexible spending accounts.

The final regulations create a new HRA called an “excepted benefit HRA,” designed to permit an employer to use an HRA to allow employees to purchase, on a tax-favored basis, individual policies of dental, vision and similar “excepted benefit” coverage. But these HRAs are interesting in at least a couple other ways.

First, unlike the ICHRA, the excepted benefit HRA may be offered to an employee even if the employer offers group medical coverage, and even if the employee is not enrolled in any individual market healthcare coverage or Medicare.

An excepted benefit HRA may reimburse out-of-pocket medical, or other healthcare expenses, and premiums for individual market or group excepted benefit coverage (e.g., dental and vision coverage) and even short-term limited duration medical insurance policies. However, the ability to reimburse the cost of such short-term policies can be limited if federal officials conclude that such reimbursements have caused significant harm to a state’s small group market. The excepted benefit HRA cannot reimburse premiums for group medical coverage (except COBRA premiums) nor Medicare premiums.

An employer may credit no more than \$1,800 per year (adjusted annually for inflation) to an excepted benefit HRA. Amounts carried over from one year to the next don’t count against that next year’s contribution maximum.

If the employer offers an excepted benefit HRA to any employee, it must offer it on the same terms to “similarly situated” employees.

*Lockton comment:* The regulations do not impose upon excepted benefit HRAs the same classification restrictions (for eligible employees) imposed upon ICHRAs, but the results are nevertheless similar. Generally speaking, two employees are “similarly situated” if they’re in the same reasonable classification the employer uses for non-benefits purposes, such as full-time versus part-time, regular versus seasonal or temporary, bargaining unit versus non-bargaining unit, employees in different locations, etc.

Finally, sponsors of excepted benefit HRAs must satisfy any applicable ERISA disclosure rules, such as providing a summary plan description.

## Don’t forget nondiscrimination

The guidance originally establishing HRAs indicated that they are self-insured healthcare plans, and as such are subject to nondiscrimination rules in section 105(h) of the tax code. That remains the case. A discussion of those rules is beyond the scope of this Alert, but generally speaking an HRA would be considered impermissibly discriminatory if it were made available primarily to the top 25% of employees ranked by pay.

*Lockton comment:* While the uniform availability rules hard-wired into the ICHRA and excepted benefit HRA schemes would make it difficult for an employer to create a section 105(h) problem,

the demographics of some employers might make a section 105(h) issue possible depending on the group to whom the employer offered the HRA.

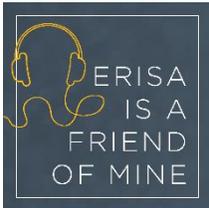
## Conclusion

So there you have them, two new HRAs to consider for 2020 or beyond. Our sense is that these new HRAs will hold little appeal, for no small reason due to their complexity, for most large employers and mid-sized employers. But some smaller employers – and perhaps some larger employers too -- may find them worth considering, if not for all their employees perhaps for employees in one or more of the permitted classifications, such as part-time employees or employees in a given location.

Please join us for our webcast on July 9 where we'll explore these rules in greater detail and walk through the growing dazzling array of HRA options available to employers. Register for the webcast [here](#).

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