Health Reimbursement Arrangements

Frequently Asked Questions

Disclaimer

We share this information with our clients and friends for general informational purposes only. It does not necessarily address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues and application of these rules to your plans should be addressed by your legal counsel.

Benefits &
Human Resources
Consulting

Gallagher

Insurance | Risk Management | Consulting

Gallagher

Insurance | Risk Management | Consulting

Contents

Gallagher

Insurance | Risk Management | Consulting

HRAs in General

1. What is a Health Reimbursement Arrangement?

A health reimbursement arrangement (HRA) is an employer-funded arrangement that reimburses employees for certain health care expenses incurred by employees and their spouses, dependents, and children who are under age 27 as of the end of the employee's taxable year. HRAs may also reimburse substantiated medical expenses of an employee's domestic partner, the domestic partner's children, and children over the age of 26, but income must be imputed. See Q&A 7. Under IRS Notice 2002-45, an HRA is defined as an arrangement that:

(1) Is paid for solely by the employer and not provided pursuant to salary reduction election or otherwise under a Section 125 cafeteria plan;
(2) Reimburses the employee for medical care expenses (as defined by Section 213(d) of the Internal Revenue Code) incurred by the employee and the employee's spouse and dependents (as defined in Section 152); and
(3) Provides reimbursements up to a maximum dollar amount for a coverage period and any unused portion of the maximum dollar amount at the end of a coverage period may be carried forward to increase the maximum reimbursement amount in subsequent coverage periods.

Generally, employers create unfunded (often called "notional") accounts for participating employees. An employee is then reimbursed for qualifying medical expenses up to the employee's HRA account balance.

2. What are some of the basic differences between an HRA and a health flexible spending account (health FSA)?

Similar to HRAs, a health FSA is an employer-sponsored benefit program under which employees receive reimbursement for qualified medical expenses. Both employers and employees may contribute to a health FSA; only employers may fund an HRA. Moreover, although the employee is not required to be covered under another medical plan in order to enroll in a health FSA, the employee must be *eligible* for another medical plan sponsored by the employer in order for the FSA to qualify as an "excepted benefit" not subject to the Patient Protection and Affordable Care Act's (ACA) market reforms (e.g., prohibitions against annual dollar limits). For some types of HRAs, an employee is required to enroll in another medical plan in order to be covered by an HRA. (See Q&A 12.) As noted in Q&A 13, additionally, for certain types of HRAs, the HRA must be integrated with primary medical coverage in order for the HRA to fall outside of the ACA market reform requirements. However, HRAs may also be health Flexible Spending Arrangements. See Q&A 3 for more information. Under a health FSA there is a $500 limit on amounts that may be carried forward to a future year. Under an HRA, the employer may permit the entire account balance to be carried forward.

3. Can an HRA also be a health Flexible Spending Arrangement?

Yes. An HRA can meet the definition of a health Flexible Spending Arrangement. A health Flexible Spending Arrangement is not the same as a Health Flexible Spending Account (FSA). Under Internal Revenue Code Section 106, a flexible spending arrangement is a benefit program which provides employees with coverage under which: (1) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and (2) the maximum amount of reimbursement that is reasonably available to a participant for such coverage is less than 500% of the value of such coverage.

However, because of the carryover feature of HRAs, which allows unused reimbursement amounts for each year to be carried over to subsequent years, an HRA that has been in effect for several years, with large amounts that have been carried over, may have a maximum reimbursement amount that is greater than 500% of the value of that HRA coverage and thus cease to be a Flexible Spending Arrangement.

If an HRA is also a Flexible Spending Arrangement, it cannot reimburse long-term care expenses. It will, however, not be subject to additional rules pertaining to health FSAs offered through a cafeteria plan (e.g., the uniform coverage rule) because it is not a "qualified benefit" for purposes of the cafeteria plan rules. (HRAs are "nonqualified benefits" under the cafeteria plan rules because of the carryover provision; this means that they cannot be offered through a cafeteria plan.)

4. What are some of the basic differences between an HRA and a health savings account (HSA)?

An HSA is a tax-exempt trust or custodial account created to pay for the qualified health expenses of the account holder and his or her spouse or dependents. Unlike an HRA, both employers and employees may contribute to an HSA. In addition, an HSA is not considered to be a health plan, but an HRA is considered to be a self-insured health plan. Moreover, only individuals covered solely under a qualified high-deductible health insurance plan may establish HSAs (the individual must not be covered under a health plan that is not a qualified high-deductible plan). Individuals eligible for an HRA are not required to specifically enroll in a high deductible health plan, but, for some types of HRAs, must be enrolled in other medical coverage. See Q&A 14 for additional information on integration with primary medical coverage under the ACA.

5. Can employees contribute to HRAs?

No. HRAs must be solely funded by employers. Employees cannot make contributions through a salary reduction agreement, a Section 125 cafeteria plan, or otherwise.

6. Can an HRA be funded with pre-tax contributions through a cafeteria plan?

No. An HRA cannot be funded with pre-tax contributions through a cafeteria plan. It may only be funded with employer contributions.

Eligibility

7. Whose expenses can be reimbursed under an HRA?

Only medical expenses incurred by common law employees or former common law employees (including retirees), their spouses, tax dependents, their children who are under age 27 as of the end of the taxable year, and the spouses and dependents of deceased employees can be reimbursed under an HRA. HRAs may also reimburse substantiated medical expenses of an employee's domestic partner, the domestic partner's children, and children over the age of 26, but income must be imputed.

Based on informal guidance from the IRS, an HRA may reimburse expenses for the employee's domestic partner who is not the employee's tax dependent and the domestic partner's children as long as the cost of the coverage is imputed as income to the employee. This is similar to the rule that applies to other group health coverage such as primary medical. The cost of coverage will be the COBRA rate (minus the 2% permitted administrative load). *Note: While informal guidance indicates that a domestic partner's expenses must be reimbursed if the cost of coverage is included in income for the employee, it does not appear possible to apply this rule to a non-employee such as a partner. Expenses for non-employees such as partners may not be reimbursed under an HRA.*

8. Which expenses can be reimbursed under an HRA?

Only substantiated medical expenses described in Internal Revenue Code Section 213(d) that have not been reimbursed elsewhere can be reimbursed through an HRA. Generally, such expenses include out-of-pocket medical expenses and certain insurance premiums (e.g., COBRA premiums or Medicare Part B or Part D insurance premiums under a retiree HRA, Qualified Small Employer HRA (QSEHRA), or Individual Coverage HRA (ICHRA)); however, the types of expenses that may be reimbursed are subject to plan design limitation. See Q&As 9, 10, 11 and 14 for or additional information on limits and plan designs.

9. Is an employer required to reimburse employees for all substantiated medical expenses permitted under Internal Revenue Code Section 213(d)?

No. An employer may limit the types of benefits reimbursable through its HRA. Benefits may be limited to out-of-pocket expenses such as copayments, coinsurance, and deductibles, or excepted benefits such as dental or vision, or to certain expenses not covered by the employer's primary medical plan such as infertility treatment. Employers

may also exclude services that are not covered under a primary medical plan such as cost containment penalties (e.g., a $500 reduction in benefits for failure to pre-certify a non-emergency hospital confinement).

Employers with non-grandfathered primary medical plans that are permitted to exclude coverage for some or all contraceptives under the primary medical plan - such as churches – may also exclude those expenses under their HRA.

10. Can an HRA reimburse premiums for long-term care insurance premiums?

An HRA may reimburse insurance premiums for long-term care insurance premiums up to a maximum annual amount that varies by age and is indexed each year. For 2020 the maximum amounts are: up to age 40 - $430, more than age 40, but less than or equal to age 50 - $810, more than age 50, but less than or equal to age 60 - $1,630, more than age 60, but less than or equal to age 70 - $4,350, and more than age 70 - $5,430.

11. Can an HRA reimburse medical expenses incurred before an individual is eligible for coverage under the HRA?

No. An HRA may neither reimburse a medical care expense that is incurred before the date the HRA is in existence nor reimburse a medical care expense that is incurred before the date an employee first becomes enrolled under the HRA.

12. Must an employee be enrolled in a primary medical plan in order to enroll in an HRA?

Yes, for certain types of HRAs. After the passage of the ACA, additional rules became effective for HRAs because, by their very nature, HRAs impose annual dollar limits on Essential Health Benefits. Exceptions exist for the following:

- HRAs that are integrated with primary medical coverage or that are integrated with individual coverage. See Q&A 14 and Q&A 19 for additional information.
- HRAs that are limited reimbursement of excepted benefits such as limited scope dental and vision benefits. See Q&A 17 for more information.
- Retiree-only HRAs. See Q&A 15 for additional information.
- QSEHRAs. See Q&A 16 for more information.
- EBHRAs. See Q&A 20 for more information.

Design Considerations

13. What HRA design options are available?

Due to requirements arising from the ACA, employers have fewer design options available than were available prior to the implementation of ACA market reforms (e.g.,

restrictions on annual dollar limits). Generally, HRAs will fall within one of several plan designs: (1) integrated with primary medical coverage; (2) retiree-only; (3) providing only excepted benefits; (4) QSEHRA (5) integrated with individual coverage; or (6) Excepted Benefit HRA.

14. How can our HRA be integrated with primary group medical coverage?

IRS Notice 2013-54 provides two methods by which an HRA may be considered to be "integrated" with primary group medical coverage.

- **Integration with group medical coverage that does not provide minimum value.**

Under the first method, the primary group medical coverage is not required to have "minimum value" (as that term is defined under the ACA), but the following requirements must be met: (1) the employer must offer a group health plan that does not consist solely of excepted benefits (other than the HRA) to the employee; (2) the employee receiving the HRA must actually be enrolled in a group health plan (other than the HRA) that does not consist solely of excepted benefits, regardless of whether the employer sponsors the plan (non-HRA group coverage); (3) the HRA must be available only to employees who are enrolled in non-HRA group coverage, regardless of whether the employer sponsors the non-HRA group coverage (for example, the HRA may be offered to employees who do not enroll in the employer's group health plan but are enrolled in other non-HRA group coverage, such as a plan maintained by the employer of the employee's spouse); (4) the HRA must be limited to reimbursement of one or more of the following—co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care that does not constitute essential health benefits; and (5) under the terms of the HRA, an employee (or former employee) must be permitted to permanently opt out of and waive future reimbursements from the HRA at least annually and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA.

- **Integration with minimum value group medical coverage.**

Under the second method, the following conditions must be met: (1) the employer must offer a group health plan that provides Minimum Value (MV) to the employee; (2) the employee receiving the HRA must actually be enrolled in a group health plan that provides minimum value, regardless of whether the employer sponsors the plan (non-HRA MV group coverage); (3) the HRA must be available only to employees who are actually enrolled in non-HRA MV group coverage, regardless of whether the employer sponsors the non-HRA MV group coverage (for example, the HRA may be offered to employees who do not enroll in the employer's group health plan but are enrolled in other non-HRA MV group coverage, such as a plan maintained by an employer of the employee's spouse); and (4) under the terms of the HRA, an employee (or former

employee) must be permitted to permanently opt out of and waive future reimbursements from the HRA at least annually, and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA.

15. Must retiree-only HRAs be integrated with primary medical coverage?

No. Retiree-only HRAs are not required to be integrated with primary medical coverage, regardless of whether any applicable coverage has minimum value. For these purposes, a retiree-only plan is a plan that, on the first day of the plan year, covered fewer than two participants who were current employees. The ACA permits retiree-only stand-alone HRAs because the annual dollar limit prohibition and the preventive services mandate do not apply to plans with fewer than two participants who are current employees on the first day of the plan year. Thus, retiree-only stand-alone HRAs are permissible and need not be integrated with primary medical coverage.

16. What is a Qualified Small Employer HRA (QSEHRA)?

Through QSEHRAs, an eligible small employer may offer a health reimbursement arrangement, funded solely by the employer, that would reimburse employees for qualified medical expenses **including individual health insurance premiums**. To be eligible, an employer must:

(1) Not be an Applicable Large Employer (ALE) under the ACA. This means that the employer must have fewer than 50 full-time and full-time equivalent employees in the preceding calendar year.
(2) Not offer any group health coverage to any employee.

The QSEHRA must also meet the following criteria:

(1) Be funded solely by an eligible employer (employees may not be permitted to make salary reduction contributions, either directly or indirectly);
(2) Upon an eligible employee producing proof of coverage, the QSEHRA must provide payment or reimbursement for the medical expenses (as defined in section 213(d) of the Internal Revenue Code) incurred by the eligible employee or the eligible employee's family members (as determined under the terms of the arrangement);
(3) The amount of payments and reimbursements for any year cannot exceed, for 2020, $ 5,250 ($10,600 in the case of an arrangement that also provides for payments or reimbursements for family members of the employee); and
(4) The HRA must be **provided** on the same terms to all eligible employees of the employer. (Opt-outs or waivers are not permitted.)

The employer must also provide notice to employees within 90 days of the beginning of the plan year explaining: 1) the amount available for reimbursement under the

QSEHRA; 2) that the notice should be provided to the Marketplace when the employee applies for premium assistance tax credits; and 3) if the employee is not covered by Minimum Essential Coverage (MEC) for any month, any QSEHRA reimbursement during that month may be included in their gross income. Failure to provide proper notice to employees, unless it is shown that the failure is due to reasonable cause and not willful neglect, will result in a $50 penalty per employee per incident, with a cap of $2,500 per employer, per calendar year.

Eligible employees include all employees of the employer, except that the following employees may be (but are not required to be) excluded:

(1) Employees who have not completed 90 days of service
(2) Employees under the age of 25
(3) Employees that are either part-time or seasonal
(4) Employees that are provided with accident and health benefits through a collective bargaining agreement
(5) Employees that are nonresident aliens that do not receive any earned income from the employer that would constitute U.S.-sourced income

The requirement that the QSEHRA be provided on the same terms to all eligible employees allows for differences based upon variation in the price of an insurance policy in the relevant individual health insurance market because of either: (i) the age of the eligible employee and, in the case of an arrangement that covers medical expenses of the eligible employee's family members, the age of the family members, or (ii) the number of family members of the eligible employee that are covered under the QSEHRA.

The reimbursement maximum will be prorated on a month-by-month basis if an employee is not covered by a QSEHRA for an entire calendar year. For example, if an employee is only covered under a QSEHRA for six months, then that employee's reimbursement would be limited in that calendar year to payments and reimbursements of not more than $2,625 ($5,250/12 x 6) if only the employee is covered, or $5,300 ($10,600 /12 x 6) if the employee's family is also covered. The reimbursement caps will be adjusted annually for by the federal cost-of-living adjustment.

Note: QSEHRA rules apply on a controlled group basis (IRC Section 414.)

17. What is an HRA that provides only excepted benefits?

An HRA may be structured so as to provide only "excepted benefits" as that term is used under the HIPAA portability rules. In other words, the HRA would only reimburse expenses for excepted benefits. "Excepted benefits" under those rules include, among other things, limited-scope dental and vision benefits, certain specified benefits (e.g., accident and liability insurance coverage), and certain independent, non-coordinated benefits (e.g., specified disease or illness-only coverage). Final regulations issued in

May 2014 provide that certain individual fixed indemnity insurance policies may also qualify as "excepted benefits." In addition, under proposed regulations, certain wraparound coverage for individuals who are eligible for employer-sponsored group health coverage may qualify as an excepted benefit. However, based on March 18, 2015 regulations, limited wraparound coverage cannot be solely an account-based reimbursement arrangement. *Note: Wraparound coverage was permitted under a pilot project that permitted employers to implement plans from January 1, 2016 through December 31, 2018. No plans may be created after 2018.* (See also Q&A 20 regarding Excepted Benefit HRAs.)

18. If our HRA only reimburses dental or vision benefits, will it be an excepted benefits HRA?

Maybe. If an HRA only reimburses dental or vision benefits, it may meet the requirements for a HIPAA-excepted benefit under an exception for certain limited-scope benefits. The limited-scope exception requires either that the benefits be provided "under a separate policy, certificate, or contract of insurance" or that the benefits otherwise not be "an integral part of a group health plan." Because HRAs are almost always self-insured, they generally must thus satisfy the requirement that they not be an integral part of a group health plan. An HRA that reimburses only limited-scope dental and/or vision benefits can satisfy this requirement and qualify as an excepted benefit if it either: (1) offers participants the ability to decline coverage, or (2) is administered under a separate claims administration contract than other health plan benefits (e.g., the employer has different administration contracts for administration of its medical plan and HRA.).

19. Can HRAs' be integrated with individual health insurance policies?

Yes. In the past, an HRA that was not integrated with a group health plan could not satisfy the prohibition against an annual or lifetime dollar limit on EHBs or the required coverage of specified preventive health care without cost-sharing. Final regulations issued in June, 2019, however, permit an employer to offer an HRA that is integrated with individual health insurance. This individual coverage HRA (ICHRA) may be used to reimburse individual health insurance premiums (including Medicare and Medigap premiums) and/or medical expenses reimbursable under IRC Section 213(d) and it is deemed to be MEC.

The ICHRA must be funded solely with employer money and generally must be offered on the same terms and conditions to all eligible employees. Distinctions based on class are permitted only for the following classes:

- Full time employees

- Part-time employees
- Seasonal employees
- Employees working in the same geographic area (generally a Marketplace rating area)
- Union employees
- Employees who have not satisfied a service requirement
- Non-resident aliens with no U.S.-based income
- Salaried workers
- Non-salaried workers
- Temporary workers

Combinations of these classes – such as full-time union and part-time union – are permitted. Under certain circumstances, a minimum class size rule applies.

Further, ICHRAs are subject to the following requirements:

- An employer may offer an ICHRA only to employees who are not eligible for the employer's "traditional" group health plan, which is defined as any group health plan other than an account-based plan or a group health plan that consists solely of excepted benefits.
- An employee (and dependents, if covered by the ICHRA) must be enrolled in individual health insurance coverage to be covered under an ICHRA. The employee must substantiate his enrollment (and dependents', if applicable) in individual health insurance both initially and as part of each request for reimbursement. Self-attestation is generally permissible.
- The dollar amount available to employees (which is at the employer's discretion) must be the same for all employees in a particular class, except that the amount may differ based on number of dependents and age of employee.
- Because an ICHRA is MEC, an employee who enrolls in an ICHRA will not be eligible for a Marketplace premium tax credit even if the ICHRA is not affordable. Therefore, employers must give employees the ability to opt out of the ICHRA.

- The employer must provide employees with notice describing the ICHRA and, among other things, explaining the employees' right to opt out.

Because an ICHRA constitutes MEC for purposes of the ACA's employer mandate, an employer can avoid the 4980(H)(a) penalty if it offers an ICHRA to at least 95% of its full-time employees. Whether the employer may be subject to the IRC 4980(H)(b) penalty depends on whether the amount the HRA provides makes coverage affordable. Affordable for this purpose will be determined based on the premium for the lowest cost silver plan in the Marketplace for the individual. (Note that the regulations provide that individual medical insurance is deemed to provide minimum value.)

20. What is an Excepted Benefit HRA?

In addition to creating ICHRAs, the June 2019 regulations created an excepted benefit HRA (EBHRA). (Note that this type of HRA is itself an excepted benefit and differs from the HRA described above that provides coverage only for excepted benefits.) An EBHRA may reimburse healthcare costs that are not limited to excepted benefits such as dental and vision (for example, the plan may reimburse cost-sharing under an individual medical insurance policy) if it meets the following requirements:

- The employer must offer other group health plan coverage (that complies with the ACA's prohibition against dollar limits on essential health benefits and covers specified preventive care services with no cost-sharing) to the participants who are offered the EBHRA. Although they must be offered the group health plan coverage, EBHRA participants are not required to enroll in it.
- The dollar amount available under the EBHRA may not exceed $1,800 per plan year (indexed for inflation for plan years beginning after December 31, 2020). This limit applies only to amounts newly made available under the EBHRA for a plan year.
- The EBHRA may be used to reimburse medical expenses as defined in IRC 213(d), but may not reimburse premiums for individual health insurance, Medicare, or non-COBRA group health insurance. COBRA premiums as well as premiums for dental, vision, and short-term limited duration insurance may be reimbursed.
- The EBHRA must be made available under the same terms to all similarly situated individuals.

An EHBRA is not MEC, but the other group health plan the employer offers would be. As a result, an opt-out provision is not required.

21. Can unused portions of an employee's HRA from one year be carried over to the next year?

Yes. Amounts in an employee's HRA account that are not used to reimburse the employee during a specific coverage period may be carried over into a subsequent coverage period. However, employers may limit the amount that can be carried over from year to year.

22. If an employee is eligible for both an HRA and a health FSA, which benefit pays first?

If an employee, who is eligible for both an HRA and a health FSA, incurs a substantiated medical expense that is reimbursable by either, amounts available under the HRA must be exhausted before reimbursements may be made from the health FSA. However, a health FSA may reimburse substantiated medical expenses not reimbursable by the HRA before all funds in the HRA are exhausted. An HRA that does not reimburse dental expenses is an example. Moreover, if an employer sponsors a health FSA and an HRA, both of which provide coverage for the same medical care expenses, and the HRA plan document includes a provision that the HRA is not available for reimbursements of medical care expenses that are covered by the health FSA until after expenses exceeding the dollar amount of the health FSA have been paid, then those medical care expenses may be reimbursed first from the health FSA and then from the HRA when the amount available under the health FSA is exhausted.

Compliance Concerns

23. Are HRAs subject to any nondiscrimination rules?

If an HRA is self-insured, it is subject to the Internal Revenue Code section 105(h) nondiscrimination rules applicable to all self-insured health plans. Under Section 105(h), self-insured group health plans may not discriminate in favor of highly compensated individuals. The definition of "highly compensated" under section 105(h) is broader than the definition used for cafeteria plans (and qualified retirement plans). Under section 105(h), highly compensated individuals include the top 5 officers, 10% shareholders, and the top 25% of non-excludable employees ranked by compensation. If an HRA is fully insured (rare), it will be subject to the ACA rules for nondiscrimination for fully insured plans (once regulations are released). In addition, HRAs must comply with HIPAA nondiscrimination rules and the Genetic Information Nondiscrimination Act (GINA). See Q&As 24 and 25.

24. How do the HIPAA nondiscrimination rules apply to HRAs?

HIPAA nondiscrimination requirements apply to HRAs the same way that they apply to other group health plans subject to HIPAA (i.e., group health plans that are not limited to excepted benefits, do not constitute QSEHRAs, or are retiree-only plans). Under HIPAA, the plan may not discriminate against any participant on the basis of any of eight health factors: health status; medical condition; claims experience; receipt of health care; medical history; genetic information; evidence of insurability; or disability.

25. How do the GINA rules apply to HRAs?

GINA applies to health plans and health insurance issuers and prohibits discrimination based on genetic information. Neither the plan nor any health insurance issuer may use genetic information for purposes such as determining eligibility or employer contributions. Genetic information is also considered protected health information and is subject to the HIPAA Privacy, Security, and Breach Notification rules. See Q&A 26.

26. Are HRAs subject to the HIPAA Privacy, Security, and Breach Notification rules?

As group health plans, HRAs are subject to the same privacy, security and breach notification rules in the same manner as other health plans. Many employers will include the HRA when they create HIPAA policies and procedures for their other health plans. **Note: There is no exception for HRAs that reimburse only excepted benefits such as dental and vision expenses. Nor is there an exception for retiree-only HRAs or QSEHRAs.**

27. Are HRAs subject to the Medicare Secondary Payer (MSP) rules?

HRAs that reimburse medical care are subject to the Medicare Secondary Payer rules. HRAs may not take into account Medicare eligibility for a current employee, spouse, or family member, and the HRA will be the primary payer for active employees enrolled in Medicare based on age (i.e., age 65 or older) (only applies to employers with 20 or more employees), individuals enrolled in Medicare because of end-stage renal disease (applies to employers of any size), and individuals enrolled in Medicare based on disability (applies to employers with 100 or more employees.) Note: The employer's group health plan is the primary payer for an active employee's spouse (based on employer size as indicated above). In contrast, Medicare would be the primary payer for an active employee's domestic partner when the domestic partner's enrollment in Medicare is based on age. If the domestic partner's enrollment is based on disability or end-stage renal disease, the employer will be primary if based on disability and the employer has 100 or more employees; the employer will be primary if the individual is enrolled in Medicare based on end-stage renal disease regardless of the number of employees.

HRAs – other than retiree-only HRAs, QSEHRAs, and ICHRAs – may not reimburse Medicare premiums – Parts A, B, C or D (Part C is Medicare Advantage) for any employee or dependent for whom the employer sponsoring the plan is the primary payer under the MSP rules. Nor may an HRA reimburse for the cost of supplemental insurance such as Medigap for any employee or dependent for whom the employer is primary payer under the MSP rules.

HRAs are also subject to the MSP reporting requirement that applies to all group health plans. Group health plans must report annually certain information about coverage on employees and dependents who are enrolled in Medicare to CMS and older employees who may be eligible for Medicare (generally employees age 45 and older must be included). If the plan is self-insured and administered by a TPA, the TPA is responsible for reporting. If the plan is self-insured and self-administered (uncommon), the plan administrator is responsible for reporting. If the plan is insured (rare), the carrier has the responsibility. Under current guidance, HRAs must be reported separately, and they may not be combined with primary medical (in the past separate reporting was permitted). There is an exemption for an HRA account with a balance below $5,000 at the beginning of the year.

28. Are HRAs subject to ERISA?

As a group health plan, an HRA sponsored by a private employer – for profit or nonprofit – is subject to ERISA. Governmental and church plans are not be subject to ERISA. Key ERISA requirements are: (1) disclosure – SPDs, SMMs, SMRs, and SBCs (in many cases these are combined with the medical plan with which the HRA is integrated); (2) reporting – Form 5500 (usually combined with the primary medical plan); (3) claims and appeals rules covering the process and timing; and (4) fiduciary obligations. Note that although QSEHRAs are not group health plans, they are likely to nonetheless be subject to ERISA disclosure requirements as employee benefit arrangements.

29. Are HRAs required to have plan documents and summary plan descriptions?

As a group health plan, an HRA subject to ERISA must furnish participants with a summary plan description (SPD) and must have a plan document. Self-insured HRAs (the overwhelming majority) must have a formal plan document. Insured plans may be able to combine an insurance contract with a wrap document. Note that although QSEHRAs are not group health plans, they are likely to nonetheless be subject to ERISA disclosure requirements as employee benefit arrangements and would thus be required to have plan documents and summary plan descriptions. HRAs for non-ERISA plans are not required to furnish an SPD, but self-insured health plans are required to have a written plan document under Internal Revenue Code Section 105.

30. If an employer makes a material change to an HRA, is it required to send out a Summary of Material Modification (SMM) or Summary of Material Reduction (SMR)?

If an HRA is an ERISA plan, the plan administrator is required to provide a summary of material modification or a summary of material reduction as required by ERISA. The summary of material modification must be provided within 210 days after the end of the plan year in which the change was made. The summary of material reduction must be provided with 60 days after the change is formally adopted and before the effective date.

31. Do employers have to continue HRA benefits during FMLA leave?

Yes. HRAs are group health plans. The continuation of coverage rules that apply to other health plans such as medical, dental, vision, and health FSA also apply to HRAs. Stand-alone HRAs that are limited to excepted benefits such as dental and vision are also subject to continuation requirements under FMLA.

32. Are HRAs subject to COBRA continuation?

Generally, yes. An HRA (unless it is a QSEHRA) is a group health plan generally subject to COBRA continuation requirements. If an individual elects COBRA continuation coverage, an HRA complies with COBRA by providing for the continuation of the maximum reimbursement amount for an individual at the time of the COBRA qualifying event and by increasing that maximum amount at the same time and by the same increment that it is increased for similarly situated non-COBRA beneficiaries (and by decreasing it for claims reimbursed).

Employers that are not subject to COBRA requirements for another group health plan, such as primary medical, will not be subject to COBRA for their HRA. In general this is limited to church plans and plans sponsored by employers with fewer than 20 employees on a controlled group basis.

33. How are COBRA premium rates established for HRAs?

If an HRA is self-insured, a plan sponsor may use: (1) a reasonable estimate of the cost of providing coverage, determined on an actuarial basis, or (2) the cost to the plan for the preceding determination period (with a cost-of-living adjustment) if coverage under the plan has not significantly changed from the preceding determination period to the current determination period. If the plan is fully insured, the applicable premium is the cost to the plan for coverage (i.e., the premium charged by the insurance company).

Impact of the ACA on HRAs

34. Are HRAs subject to PCORI fees under the ACA?

If an HRA is self-insured and the primary medical plan is insured, the employer plan sponsor is responsible for paying the PCORI fee based on the number of employees covered by the HRA. The health insurance issuer is responsible for paying the PCORI fee for the insured primary medical plan. Unlike primary medical plans, there is no need to make an adjustment to reflect coverage for the employee's dependents.

If the HRA and the primary medical plan with which it is integrated are both self-insured and have the same plan year, the plan sponsor may pay one PCORI fee using any of the available counting methods (ignoring adjustments for dependents)

QSEHRAs that are self-insured are required to pay the PCORI fee.

Although no guidance has been issued on the PCORI fee (since Congress just extended it late in 2019), it is likely that the insurer will be responsible for a PCORI fee under individual insurance policies that are reimbursed by an ICHRA and it is likely that the PCORI fee will apply to the ICHRA as well. It is unlikely that the PCORI fee will apply to EBHRAs since they are an excepted benefit.

35. Are HRAs included in Form W-2 reporting?

Employers sponsoring group health plans are required to report the cost of those benefits in Box 12 on Form W-2. Because of several unresolved issues related to determining the cost of HRA coverage, the IRS has stated that HRAs are exempt from the reporting requirement under a transition rule. At some future date, it is expected that the IRS will issue additional guidance and HRAs will need to be included when the cost for the employer-provided coverage is reported on Form W-2. QSEHRA benefits must reported in box 12 of Form W-2 using code FF.

36. Are HRAs reported on Forms 1095-B and 1095-C?

Although HRAs (other than QSEHRAs and EBHRAs) constitute MEC, for HRAs that are integrated with other medical coverage using one of the two integration methods permitted under IRS rules, separate reporting under Sections 6055 and 6056 on Forms 1095-B and 1095-C for HRAs is generally not required. The primary medical plan will already be reporting as MEC for the individual. Under FAQs released in early 2017, applicable large employers are not required to report HRAs if an individual is covered under two forms of MEC sponsored by the same organization. Thus, if, for a month, an individual is enrolled in an employer's self-insured major medical group health plan and also has an HRA from the same ALE Member, the ALE Member is not required to report enrollment in coverage under the HRA (Form 1095-C, Part III or Form 1095-B, as applicable) for the individual. If an employee is covered under both arrangements for

some months of the year but drops coverage under the non-HRA group health plan and is covered only under the HRA, then the employer must report coverage under the HRA for the months after the employee drops the non-HRA coverage.

Although the IRS has not yet provided guidance, it appears that employers that are ALEs will be required to report ICHRAs under Section 6056 because ICHRAs are an offer of health coverage. The employer would need to report on the offer of coverage and whether or not the coverage is "affordable" for each employee and whether the employee is enrolled. It is unclear at this time if the IRS will require reporting of ICHRAs under Section 6055. Although an ICHRA is a self-insured health plan, in order to be covered under an ICHRA an individual must have individual medical insurance. Presumably, the insurer will be required to report on the individual health insurance under Section 6055. Since it is not clear if the IRS will limit reporting to the insurer, employers may want to be prepared to report under Section 6055 should it be required.

Retiree-only HRAs are subject to the same rules as active medical plans. HRAs that are limited to excepted benefits are not required to report because they do not provide MEC. Employers are not required to report QSEHRAs.

37. Must a plan sponsor provide a Summary of Benefits and Coverage (SBC) for an HRA?

If an HRA is integrated with a primary medical plan or with individual coverage, an SBC must be provided. Stand-alone HRAs that are limited to excepted benefits, QSEHRAs, and retiree-only HRAs are not required to provide SBCs.

38. If an employer sponsors both an HRA and a primary medical plan, may it include the HRA and the primary medical plan in a single SBC?

If an HRA is integrated with a primary medical plan, the plan sponsor may include information about the HRA when completing the SBC for the primary medical plan. A separate SBC for the HRA is permitted, but is not required. Information about the HRA can be included in the appropriate places on a combined medical/HRA SBC for deductibles, copayment, coinsurance and benefits, if any, reimbursable under the HRA that are not covered under the primary medical plan.

39. How do HRAs impact affordability of health insurance under the ACA?

For an employer that integrates an HRA with its own primary group medical plan, amounts newly made available under an HRA for the current plan year may be used when determining the primary medical plan's minimum value or affordability, but not both. If the employee has a choice between using the funds to reimburse cost-sharing amounts or pay contributions, then those amounts may count toward the affordability requirement.

An ICHRA is affordable for a month if the employee's required ICHRA contribution does not exceed 1/12 of the product of the employee's household income and the required HRA contribution percentage (9.78% in 2020). The employee's required ICHRA contribution is the excess of (1) the monthly premium for the lowest cost silver plan for self-only coverage available to the employee through the Marketplace for the rating area in which the employee resides; over (2) the monthly self-only HRA amount. If the ICHRA is affordable, it is deemed to provide minimum value. In determining affordability, only amounts made newly available for a plan year are considered. Amounts carried over from a previous year or from another HRA are disregarded. Additionally, the premium for the lowest cost silver plan is determined without regard to any wellness program incentive that affects premiums unless the wellness program incentive relates exclusively to tobacco use. In that case, the incentive is treated as earned. If the premium differs for tobacco users and non-tobacco users, the premium for the lowest cost silver plan is the premium that applies to non-tobacco users.

40. How do HRAs impact minimum value calculations under the ACA?

For an employer that integrates an HRA with its own primary group medical plan, amounts newly made available under an HRA for the current plan year may be used when determining the primary medical plan's minimum value or affordability, but not both. If the employee may only use the funds in the HRA to reimburse cost-sharing for covered expenses under the employer's primary medical plan, then those amounts may be counted when determining minimum value.

With respect to an ICHRA, If the ICHRA is affordable, it is deemed to provide minimum value.

41. Are HRAs required to reimburse expenses for children to age 26?

HRAs that are limited to excepted benefits, QSEHRAs, or are retiree-only HRAs are exempt from many of the ACA's market reform requirements, including the requirement to cover children until age 26. All other HRAs that cover children (the overwhelming majority), must cover those children until the child's 26th birthday. See also Q&A 1 and 7 for information about children who are not the employee's – such as the employee's domestic partner's children.

42. How do the prohibitions against annual dollar limits under the ACA impact HRAs?

Group health plans are not permitted to apply either an annual or a dollar lifetime dollar limit to any essential health benefit. Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory

services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Because HRAs, except QSEHRAs, are group health plans, they are subject to this prohibition with limited exceptions – HRAs that only cover retirees (and their dependents), EBHRAs, and HRAs that are limited to excepted benefits such as dental and vision are not required to comply. Because HRAs include a dollar limit, they must be integrated with a primary medical plan or individual coverage that does comply with the ACA's prohibition against annual and lifetime dollar limits on essential health benefits.

HRAs that are not QSEHRAs, EBHRAs, or limited to excepted benefits or retirees, must be integrated with a group health plan using one of two IRS approved methods or with individual coverage in order to comply with this prohibition or they may be subject to the ACA's $100 per day excise tax. See Q&A 14 for more detailed information on integrating HRAs.

ICHRAs are not subject to the prohibition against annual or lifetime dollar limits on essential health benefits. The individual insurance contracts with which the ICHRA is integrated would be subject to this requirement.

43. Are there any other ACA mandates that apply to HRAs?

There are a number of other ACA mandates that apply to HRAs. All HRAs, except retiree-only and QSEHRAs, are subject to the following ACA requirements:

(1) No waiting period greater than 90 calendar days (plus an orientation period not to exceed one month);
(2) No preexisting condition limitation;
(3) The requirement to cover children to age 26;
(4) The limitation on rescission of coverage; and
(5) The prohibition against annual or dollar lifetime maximums on essential health benefits.

See Q&A 41 for more detailed information about coverage of children and Q&A 42 for application of the prohibition against dollar maximums.

Non-grandfathered HRAs are also subject to the following ACA mandates:

(1) Requirement to allow designation of any available primary care provider;
(2) No preauthorization for emergency room services may be required;
(3) No preauthorization for certain routine obstetrical or gynecological care may be required;
(4) Coverage for routine patient care for individuals enrolled in certain clinical trials;

(5) Additional requirements that apply to claims and appeals; and
(6) The requirement to cover specified preventive services without cost sharing.

44. How can I obtain additional information about HRAs?

More detailed information about compliance rules for HRAs is available on federal regulatory websites:

- IRS Notice 2017-67 https://www.irs.gov/pub/irs-drop/n-17-67.pdf
- IRS Notice 2015-87 https://www.irs.gov/pub/irs-drop/n-15-87.pdf
- IRS Notice 2015-17 https://www.irs.gov/pub/irs-drop/n-15-17.pdf
- IRS Notice 2002-45 (Original Guidance): http://www.irs.gov/pub/irs-drop/n-02-45.pdf
- Integration Rules (Notice 2013-54): http://www.irs.gov/pub/irs-drop/n-13-54.pdf
- ACA FAQs: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/aca-implementation-faqs
- IRS Publication 969 (includes HRAs, HSAs and FSAs): www.irs.gov/pub/irs-pdf/p969.pdf
- ICHRA and EBHRA Final Regulations https://www.federalregister.gov/documents/2019/06/20/2019-12571/health-reimbursement-arrangements-and-other-account-based-group-health-plans