Designing a Compliant Health Reimbursement Arrangement

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Contents

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SECTION 1 - INTRODUCTION

This Health Reimbursement Arrangement ("HRA") plan guide was created to provide a basic, but practical, summary of the major HRA plan compliance rules. It provides information on:

- Design Basics
- Eligibility & Funding
- Reimbursement Rules
- Nondiscrimination Requirements
- Impact of Other Federal Laws
- Implementation Issues

We also include a few general comments on administrative issues such as carrier rules and employer administrative concerns. This guide has been designed for use in creating a new HRA program; there is no discussion of the special grandfather rules for HRAs that were in existence prior to 2014. To further assist you when creating a new HRA program, we also include a sample implementation checklist beginning on page 50.

What this guide does **NOT** do:

- Although we have included some information relative to retiree-only HRAs, that information is included only as a contrast to the rules for HRAs for active employees. This guide does not cover the rules and issues involved in creating retiree-only HRAs. This guide focuses solely on HRAs being established for active employees.
- We include a few comments on consulting issues, but do not include a comprehensive discussion of consulting concerns such as what to consider when selecting a basic design type, determining employer contributions, or determining what expenses will be covered.
- We do not include a discussion of state laws that might impact an insured HRA or a self-insured HRA for plans not subject to ERISA.

This guide is intended to provide a basic, working knowledge of HRA plan rules. It is not an exhaustive discussion of all of the IRS or other rules or nuances. It is intended to be a starting point.

SECTION 2 - DESIGN BASICS

Below is a definition of a Health Reimbursement Arrangement ("HRA") followed by a brief description of the three types of HRAs that are the focus of this Guide.

A. Basic Definition

Generally, a Health Reimbursement Arrangement is an employer-sponsored account that reimburses an employee for certain medical expenses incurred by the employee and the employee's spouse, child, or tax dependent. The plan must be in writing (i.e., a formal plan document is required). The HRA reimburses employees for substantiated, qualified medical expenses up to the employee's account balance. HRA reimbursements for qualified medical expenses are excluded from employees' taxable income and therefore not subject to federal income taxes or employment taxes. To receive reimbursement, the individual must have HRA coverage in effect at the time the expense is incurred.

Any amounts that the employee does not use during the plan year are not automatically forfeited. Rather, the unused amounts may be rolled over (in full or in part) for use in future years, as determined by the employer. In other words, HRAs are not subject to the "use or lose" rule for amounts over $500 as health FSAs are. Under no circumstances may unused HRA amounts be cashed out.

B. Types of HRAs

The passage and implementation of the Patient Protection and Affordable Care Act ("PPACA") required employers to change the way they traditionally offered HRAs because of the prohibition on annual and lifetime dollar limits for essential health benefits. The IRS, DOL, and HHS identified four acceptable HRA plan designs that do not violate PPACA's annual or lifetime limit rule. To be PPACA compliant, HRAs are required to meet one of these plan designs:

(1) Stand-alone HRAs that provide only excepted benefits;
(2) HRAs integrated with minimum value health coverage (as part of a larger group health plan);
(3) HRAs integrated with health coverage that does not provide minimum value, where the HRA reimburses for limited expenses only (e.g., cost-sharing amounts such as deductibles, excepted benefits, and required contributions); or
(4) Retiree-only HRAs.

The 21st Century Cures Act (the "Cures Act") passed in 2016 provides an exception for "Qualified Small Employer Health Reimbursement Arrangements" ("QSEHRAs") from PPACA and certain other laws and regulations dependent upon the definition of a "group health plan" under Section 9831 of the Internal Revenue Code. The exception applies to plan years beginning after December 31, 2016. See below for a discussion of QSEHRAs.

(In this Guide, we discuss plan designs for integrated HRAs, stand-alone HRAs that provide only excepted benefits and QSEHRAs. Designing a retiree-only HRA is outside the scope of this Guide.)

Stand-alone HRAs

Stand-alone HRAs are different from integrated HRAs in that stand-alone HRAs permit employees to participate in the employer's HRA without requiring the employee to participate in the employer's primary group medical plan. Stand-alone HRAs that provide only "excepted benefits" do not provide coverage for essential health benefits. Therefore, a stand-alone HRA covering only excepted benefits will not violate PPACA's annual or lifetime limits or preventative services mandate. The term "excepted benefits" generally includes coverage for: limited-scope dental, limited-scope vision, fixed indemnity insurance, supplemental disease-specific coverage, certain supplemental coverage, accident only (including AD&D), travel-related products that provide only incidental health benefits, and disability insurance. However, due to IRS regulations regarding what expenses are reimbursable under an HRA, an HRA may not reimburse premiums for certain fixed indemnity insurance policies or disability insurance (e.g., long-term disability). Although limited wraparound benefits that satisfy the requirements in the March 18, 2015 regulations will qualify as excepted benefits, limited wraparound coverage must not consist of an account-based reimbursement arrangement.

Integrated HRAs

Under current IRS guidance, HRAs may **not** reimburse employees for health insurance premiums in the individual market for policies that provide coverage for essential health benefits – unless the HRA qualifies as a QSEHRA (as discussed below). These arrangements are considered to be group health plans under current guidance regardless of whether or not the employer gets involved with an employee's selection or purchase of an individual health insurance policy. HRAs that do not qualify as QSEHRAs that reimburse employees for individual market policies that provide coverage for essential health benefits violate PPACA's prohibition on annual dollar limits and the requirement to provide certain preventive services without cost sharing (non-grandfathered plans). As a result, this arrangement could potentially trigger penalties of $100 per person per day.

In order to satisfy PPACA's requirements, an HRA that is not a QSEHRA, stand-alone HRA, or a retiree-only HRA, must be integrated with a group health plan using one of two methods. These are the only two permissible methods as described below.

HRA Integrated with Minimum Value Group Medical Coverage

An HRA that is integrated with a primary group medical plan will be complaint so long as the primary group medical coverage by itself complies with PPACA (i.e., provides minimum value). When an HRA is integrated in this manner, the HRA may reimburse any type of permissible medical expense. This design does not violate PPACA's annual

limit rules because the combined HRA and primary group medical plan satisfy the requirements. For an HRA to be integrated, the following requirements must be met:

(1) The employer must offer to the employee a group medical plan that provides minimum value;
(2) Individuals receiving the HRA reimbursements must be enrolled in a group medical plan that provides minimum value;
(3) The HRA is only available to employees enrolled in a group medical plan (which could be the spouse's employer's plan, or a combination of both) that provides minimum value; and
(4) Employees (and former employees) must be given the opportunity to permanently opt out of and waive future reimbursements from the HRA at least once a year. (Upon termination of employment, the HRA must be forfeited or employees must be allowed to permanently opt out and waive future reimbursements.)

The HRA can be integrated with another employer's group medical plan (e.g., spouse's employer or a combination of group medical plans) as long as employee attests that he was actually enrolled in another employer's plan and that the other employer's plan provides minimum value. Note that all individuals receiving reimbursement from the HRA must be enrolled in group medical plan coverage, whether the employee's, or another group medical plan, such as the spouse's, or for example, a combination of both the employee's and spouse's plans.

HRA Integrated with Non-Minimum Value Group Medical Coverage

IRS and DOL guidance also allows an HRA to be integrated with group medical coverage that does not provide minimum value provided that the HRA only reimburses limited expenses. Those limited expenses that are reimbursable by the HRA are:

- Copayments;
- Coinsurance;
- Deductibles;
- Premiums under the non-HRA coverage with which the HRA is integrated; and
- Medical care expenses for non-essential health benefits.

In this type of arrangement, the HRA cannot reimburse for other expenses that would be otherwise permissible. For example, an employer's High Deductible Health Plan ("HDHP") may limit the number of visits for certain services such as physical therapy. When the limit is exceeded, then the employee must pay for the care himself. An HRA integrated with a minimum value medical plan could reimburse for physical therapy services when the maximum number of visits covered under the HDHP has been exceeded; however, an HRA integrated with a non-minimum value group health plan cannot.

In order for this limited reimbursement HRA to be integrated, the HRA must meet the same requirements as HRAs integrated with minimum value group medical plans:

(1) The employer must offer a group medical plan (other than an HRA) that does not consist solely of excepted benefits;
(2) The HRA is only available to employees enrolled in a group medical plan (which could be the spouse's employer's plan) the does not consist solely of excepted benefits;
(3) Individuals receiving the HRA reimbursements must be enrolled in a group medical plan that does not consist solely of excepted benefits; and
(4) Employees (and former employees) must be given the opportunity to permanently opt out of and waive future reimbursements from the HRA at least once a year. (Upon termination of employment, the HRA must be forfeited or employees must be allowed to permanently opt out and waive future reimbursements.)

HRAs may have a separate plan document, plan administrator, and Form 5500 (if required) or they may be included in the same plan document and Form 5500 filing as the employer's primary group medical plan. Moreover, the employer may use the same administrator that it uses for the primary group medical plan or a different plan administrator.

QSEHRAs

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 **not**:

(1) Be an Applicable Large Employer under PPACA. This means that the employer must have fewer than 50 full-time and full-time equivalent employees.
(2) Offer any group health (including excepted benefits such as dental) coverage to any employee.

The HRA 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 HRA 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 $5,150 ($10,450 in the case of an arrangement that also provides for payments

or reimbursements for family members of the employee) in 2019 (values indexed in future years); and
(4) The HRA must be provided on the same terms to all eligible employees of the employer.

Eligible employees include all employees of the employer, except that the following employees may be (they 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 HRA 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 which 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 which are covered under the HRA.

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 $2,575 ($5,150/12 x 6) if only the employee is covered, or $5,225) ($10,450 12 x 6) if the employee's family is also covered (2018 values). The reimbursement caps will be adjusted annually for by the federal cost-of-living adjustment.

Employers sponsoring QSEHRAs must also provide a notice to employees at the start of each year, as well as, notice to those who become eligible during the course of the year. The notice must include the following:

(1) The amount of the eligible employee's permitted benefit under the HRA for the year;
(2) A statement that the eligible employee should provide information about the HRA to any health insurance exchange to which the employee applies for advance payment of the premium assistance tax credit; and
(3) A statement that, if the employee is not covered under minimum essential coverage for any month, the employee may be subject to a tax under Section 5000A for that month and reimbursements under the HRA may be includible in the employee's 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. A transitional provision states that employers will not be assessed penalties for failing to provide proper notice within 90 days of the enactment of the law.

Employers eligible for and sponsoring QSEHRAs are required to report the total amount of permitted benefits for each employee on employee Forms W-2. Further, QSEHRAs will not be subject to COBRA continuation even if an employer would otherwise be subject to COBRA for sponsoring a health plan.

QSEHRA requirements apply on a controlled group basis (IRC Section 414).

SECTION 3 - ELIGIBILITY & FUNDING

This section briefly summarizes eligibility rules for HRAs along with funding methods and requirements.

A. Eligibility

An HRA can be designed to cover all or part of an employer's workforce. For example, employers could limit eligibility in an HRA to full-time employees, active employees, or employees who work in a specific geographical location. Employers must be mindful of Section 105(h) nondiscrimination rules when excluding certain employees from eligibility to participate in the HRA. See Section 5 – Nondiscrimination Requirements, for more information.

Under IRS rules, HRAs may reimburse for substantiated, qualified medical expenses incurred by eligible individuals on a tax-favored basis. Employers have the option to restrict whose expenses are eligible for HRAs reimbursement (e.g., employee and children only). However, the overwhelming majority do not limit individuals eligible for reimbursements. Eligible individuals include:

- Employees or former employees (including retirees);
- Employee's spouse;
- Employee's child(ren) under the age of 27 on December 31; and
- Employee's tax dependent(s) under Code Section 152 or Code Section105(b).

Terminated employees can continue to be reimbursed for qualified medical expense after termination, until the balance is depleted, if allowed by the plan design (i.e., if the plan includes a spend-down provision).

With respect to children, the following individuals under the age of 27 as of the end of the calendar year are considered an employee's child for purposes of an HRA:

- Biological child;
- Stepchild;
- Legally adopted child (or child placed for legal adoption by the employee); or
- Eligible foster child.

A child under the age of 27 at the end of the calendar year is not required to be the employee's tax dependent in order for the employee to receive HRA reimbursements. However, the tax dependent status of the child will be important if HRA coverage is provided to an employee's child after the end of the year in which the child attains age 26 (e.g., if a child over the age of 27 is covered as a disabled dependent).

Status as a tax dependent is also relevant when determining whether a domestic partner or domestic partner's child can be covered by the HRA. To be considered a tax dependent, a domestic partner needs to qualify as a "qualifying relative" of the

employee, meaning that the domestic partner: (1) has the same principal residence as the employee and is a member of the employee's household; (2) receives over half of his/her support from the employee; and (3) is not anyone's qualifying child. Generally, a domestic partner will fail to meet one or more of these criteria and therefore will not be the employee's tax dependent. Moreover, children of a domestic partner are almost never an employee's tax dependent because the child would most likely be the domestic partner's tax dependent, not the employee's. As a result, the child will not be the employee's tax dependent unless the employee has legally adopted the domestic partner's child. However, even if a domestic partner and/or domestic partner's child is not the employee's tax dependent, based on informal IRS guidance the HRA can pay for their qualified medical expenses on a tax-favored basis as long as the fair market value of the coverage is included in the employee's taxable income. It appears that income must be imputed each year, not just the years in which the domestic partner or domestic partner's child has expenses reimbursed.

Individuals Who May Not Participate

Self-employed individuals (e.g., sole proprietors, partners, and more-than-2% Subchapter S corporation shareholders) are not eligible to participate in their employer's HRA. Unlike the rules for domestic partners (addressed above), based on informal IRS guidance, it does not appear that an HRA may reimburse expenses for non-employees even if the value of coverage is included in taxable income. However, HRAs may cover a self-employed individual as a dependent when that person is the spouse, tax dependent, or child of an employee who is an HRA participant.

B. Funding

HRAs are funded solely by employer contributions and the unused amounts may be carried over from year to year (depending on the plan design). Under no circumstance may HRAs be funded through employee salary reductions or otherwise through a cafeteria plan, either directly or indirectly. There is no statutorily defined maximum or minimum contribution to an HRA unless the HRA is a QSEHRA, which means the employer decides the maximum amount it wishes to contribute. Additionally, HRAs are typically unfunded or "notional" accounts, meaning that the funds are held in the general account of the employer and not in a trust. Most HRAs are self-insured plans subject to Section 105(h) nondiscrimination requirements. Some may be fully insured and not subject to the nondiscrimination requirements under Section 105(h), but will be subject to nondiscrimination requirements under PPACA when the IRS issues regulations. As of January 2019, the IRS has not issued regulations. (See Section 5 for more about nondiscrimination.)

HRAs may still be offered in conjunction with a primary group medical plan that is offered under a cafeteria plan where the employees' portion of the primary group medical plan premium (i.e., employee contribution) is paid with pre-tax salary reductions. When an HRA is integrated with a primary group medical plan where the primary group medical plan is part of a cafeteria plan, the HRA may not be directly or

indirectly funded by employee salary reduction amounts. For an integrated HRA and primary group medical plan to be compliant (i.e., the HRA may not be part of the cafeteria plan), the salary reduction election allocable to the employee's primary group medical plan contribution must be less than or equal to the COBRA applicable premium for such coverage without the 2% administrative charge permitted by COBRA. For example, if the COBRA applicable premium for the primary medical coverage is $2,000 per year ($2,040 per year with the permissible 2% COBRA administrative charge), for the integrated HRA and primary group medical plan to be compliant, the annual salary reduction election for that coverage must $2,000 or less. Additionally, the salary reduction election form must clearly state that salary reductions will be used only to pay for the primary medical coverage and not for any part of the HRA.

The Internal Revenue Code does not contain any dollar limits on the maximum amount that may be accrued or reimbursed under an individual's HRA. This means employers are free to contribute as little or as much as they would like to their employees' HRAs. Additionally, employers have a choice about when to credit employees' HRAs. For example, an employer could credit an employee's HRA accounts once at the beginning of the year (e.g., $1,200), on a monthly pro-rata basis (e.g., $100 per month), or even on each pay day (e.g., $46.15 biweekly). Each design brings its own benefits and negatives. For example, limiting credits to a monthly basis protects employers from providing coverage to employees who may terminate employment, but this could create cash flow issues for participants who incur expenses early in the year.

Permitted Carryover of Unused HRA Amounts

Employers have the ability to restrict or permit participants to carry over unused HRA amounts to be used in future years. IRS regulations do not mandate that all unused HRA amounts be carried over; nor is the amount of any carry-over amount limited to $500 as it is for health FSAs that are part of a cafeteria plan. However, employers have the flexibility to cap the amount that employees are allowed to carryover year to year. Employers may even establish rules governing how the carryover amount may be used in future years. For example, an employer could design its HRA to permit employees to carryover a maximum of $1,000 into the subsequent year with any unused portion of the carried-over amount forfeited if not used in the subsequent year.

Prohibited Funding Arrangement

HRAs may not be funded indirectly through a cafeteria plan. As indicated in IRS guidance, there are at least three plan designs that would constitute indirect HRA funding through a cafeteria plan. Each is described below.

Positive Correlation between HRA and Salary Reduction Not Allowed

According to IRS guidance, indirect HRA funding through a cafeteria plan occurs when there is a positive correlation between the HRA and required salary contribution amounts. This occurs when:

(1) Employees may choose between two or more health/accident plans; and
(2) A direct positive correlation exists between the maximum reimbursement under the HRA and the salary reduction amount for the health/accident plan (i.e., the maximum HRA amount increases when the required salary reduction amount increases).

Even if the salary reduction amount is less than or equal to the cost of the health/accident coverage, this plan design is still not permitted.

Example: Employer offers family medical coverage worth $4,500. The employee has the option to reduce his salary by either $2,500 or $3,500 to contribute towards this coverage. If the employee elects to reduce his salary by $2,500, then employee's HRA will be credited with $1,000. If the employee elects to reduce his salary by $3,500, then the employee's HRA will be credited with $2,000. This plan design would be impermissible under IRS guidance.

However, it is permissible for an employer to charge a higher salary reduction amount for family coverage than for employee-only coverage under an integrated HRA and primary group medical plan, even if the employee-only coverage has a lower HRA amount.

Example: Employer offers employee-only primary medical coverage with an annual deductible of $2,000 that is integrated with an HRA worth $1,000 (COBRA applicable premium for employee-only primary medical coverage is $1,800). Employer also offers family coverage with an annual deductible of $4,000 that is integrated with an HRA worth $2,000 (COBRA applicable premium for family primary medical coverage is $4,500). This plan design is permitted under IRS guidance.

Although an HRA may not have a positive correlation between the maximum reimbursement under the HRA and the employee's required salary reduction amount for primary medical coverage, the rules appear to be flexible enough to permit different HRA contributions for different benefit options. For example:

	Option 1	Option 2
Deductible	$3,000	$4,000
Primary Medical Premium	$2,000	$1,500

	Option 1	Option 2
Salary Reduction Amount for Primary Medical	$500	$300

Similarly, an employer should be able to make an HRA contribution using the same dollar amount under options with different deductibles. For example, an employer could offer a medical plan with different deductibles –e.g., $1,000, $2,000, and $3,000 and contribute a flat $500 for every employee eligible for an HRA.

HRAs May Not Pay for Coverage That Could Be Funded Under Cafeteria Plan

IRS guidance prohibits HRAs from being used to pay for an employee's share of health plan premiums (primary medical or other type of health plan) in lieu of cafeteria plan salary reduction contributions.

Example: The employee's share of the annual premium for a health plan is $500. Under this design, employees have a choice to use either their HRA funds ($1,000 employer contribution per year) or salary reduction election through the cafeteria plan to pay for the premium. Because an employee may use the HRA to pay a portion of the premium in lieu of electing to salary-reduce, the HRA is indirectly funded pursuant to salary reduction and is not permissible. *(Note: Reimbursing the employee the amount of salary reductions for coverage from the HRA creates the same net result and is also not permissible.)*

Relationship between HRA Amount and FSA Forfeitures Not Permitted

Under IRS guidance, employers are prohibited from basing the amount credited to an employee's HRA (either directly or indirectly) on the amount the employee forfeited in his health FSA (i.e., unused FSA balance at the end of the plan year).

SECTION 4 - REIMBURSEMENT

The attraction of HRAs for employers and employees is the favorable tax treatment of reimbursements that are made for substantiated claims of permissible expenses. Employers are entitled to a deduction for reimbursements made under an HRA, and employees generally are not taxed on the value of their HRA coverage or on reimbursements that they receive from the HRA. The expenses that may be reimbursed by an HRA are broad, but not unlimited. HRAs may reimburse only substantiated medical (health) expenses described in Internal Revenue Code Section 213(d) that have not been reimbursed elsewhere.

A. General

An HRA may reimburse medical care expenses only if they were incurred by employees or former employees (including retirees) and their spouses (including spouses of former or deceased employees), tax dependents, and children who are under age 27 as of the end of the taxable year. HRA coverage must be in effect for such person(s) at the time the expense is incurred. Based on informal IRS guidance, an HRA may reimburse qualified health care expenses for an employee's domestic partner who is not the employee's tax dependent and the domestic partner's children as long as the cost of HRA coverage is imputed as income to the employee. It does not appear that the plan may do so for other ineligible individuals such as self-employed individuals (e.g., sole proprietors or partners).

An arrangement that reimburses the qualifying health care expenses of other individuals is not an HRA, and **all** reimbursements of qualifying medical expenses paid under such an arrangement — whether to employees, their spouses, children under age 27, and dependents, or to other beneficiaries — will be includible in the employees' income.

B. Reimbursable Expenses

The type of HRA – stand-alone or integrated – and how the HRA is integrated with a primary group medical plan determine what expenses may be reimbursed by the HRA. (See Section 2 - Design Basics for more information on types of HRA and integration.) If the HRA is stand-alone – i.e., not integrated with a primary group medical plan – reimbursement must be limited to excepted benefits such as separate dental and vision benefits and premiums for excepted benefits.

If the HRA is integrated with a primary group medical plan, the type of primary group medical plan determines what expenses may be reimbursed from the HRA. An HRA that is integrated with a primary group medical plan that does not provide minimum value is limited to reimbursing cost-sharing amounts such as deductibles, copays, and coinsurance; premiums for the primary group medical plan (but not as an alternative to a salary reduction); and health care expenses for non-essential health benefits. An HRA that is integrated with a primary group medical plan that provides minimum value is generally able to reimburse medical expenses described in Internal Revenue Code

Section 213(d). The discussion of reimbursable expenses that follows focuses on an HRA is integrated with a primary group medical plan that provides minimum value, but includes comments about HRAs integrated with a primary group medical plan that does not provide minimum value.

While both HRAs and health FSAs often reimburse the same medical care expenses, HRAs are not subject to all of the rules that apply to health FSAs. For example, health FSAs are subject to a 12-month uniform coverage requirement (requiring the full annual election amount to be available at the start of the plan year rather than made available throughout the year), while an HRA is not subject to the uniform coverage requirement. Reimbursements from an HRA may be limited to the balance in the account when the claim is submitted.

Out-of-Pocket Medical Expenses

The out-of-pocket medical expenses that may be reimbursed by an HRA that is integrated with a primary group medical plan that provides minimum value are very similar to those that may be reimbursed by a health FSA under a cafeteria plan. Reimbursable expenses may include cost sharing amounts such as deductibles, copayments, and coinsurance and may also include deductible expenses that are not covered under the employer's medical plan – such as Lasik surgery. However, some employers will limit the types of expenses reimbursable by the HRA to something less than all of the expenses permitted under IRS rules. For example, some employers may reimburse medical and prescription drug expenses from an HRA, but not dental or vision expenses. HRAs that are integrated with primary group medical plans that do not provide minimum value are limited to reimbursement of cost-sharing amounts, premiums under the primary group medical plan with which the HRA is integrated, premiums for other non-HRA group coverage, and expenses for non-essential health benefits.

Employers may also wish to exclude some expenses even if IRS rules permit reimbursement. For example, some employers may wish to exclude expenses such as the following:

- Cost-containment penalties – e.g., a $500 reduction in benefits if an elective hospital confinement is not pre-certified.
- Increased coinsurance (or copayments) for non-emergency services received from a non-network provider.
- Increased coinsurance (or copayments) for brand name drugs not on the formulary.
- Expenses that are specifically excluded under the employer's primary group medical plan.

Over-the-Counter Drugs

Expenses for over-the-counter medicines and drugs (other than insulin) are only reimbursable if they are prescribed. A prescription for a medicine or drug is a written, electronic, or other order that satisfies the legal requirements for a prescription in that state. To demonstrate that an over-the-counter drug has been prescribed, HRA participants must submit the prescription or other documentation, along with the other independent third-party substantiation as required under IRS rules. An HRA integrated with a primary group medical plan that does not provide minimum value is limited to reimbursement of prescription drug coinsurance, prescription drug copayments, and prescription drug expenses that are used to satisfy the deductible under the primary group medical plan.

Long-Term Care ("LTC") Expenses

If the HRA is not a flexible spending arrangement as defined in section 106, and the expense is "qualified," it may be reimbursed from an HRA. A long-term care expense is "qualified" if a licensed health care practitioner certifies that the individual is "chronically ill." In the absence of such certification, it appears that long-term care expenses are not deemed "qualified" and, therefore, would not be eligible for reimbursement by an HRA.

If an HRA is also a "flexible spending arrangement," the HRA may **not** reimburse expenses for qualified long-term care services. Under Internal Revenue Code Section 106, an HRA is a "flexible spending arrangement" if it 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 which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage. Because of the carryover feature of HRAs, which allow 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.

For example, if the value of an HRA (COBRA premium minus the 2% permitted administration charge) is $2,000 and the HRA account balance is $11,000, the HRA is not a "flexible spending arrangement" as defined under Internal Revenue Code Section 106 because the maximum reimbursement available – $11,000 – is more than five times the value of the account. Qualified long term care ("LTC") expenses could be reimbursed from this HRA. If the balance is below $10,000, however, the HRA would not be permitted to reimburse qualified LTC expenses.

Although an HRA that is **not** a flexible spending arrangement as defined in Section 106 is permitted to reimburse long term care expenses – e.g., nursing home care, adult day care, and assisted living – up to a specified dollar maximum, HRAs typically do not reimburse these expenses. If an employer does not already pay these costs under a LTC program and these expenses are not excluded from the HRA, an employer may unintentionally increase its cost because an employee could have no medical expenses that would be reimbursable by the plan, but could use a $1,000 employer contribution to pay for long term care expenses – for example, long term care expenses for the employee's parent who is the employee's tax dependent. In this scenario, the employer's cost for this employee is $1,000; had long term care expenses been excluded, the employer's cost would have been $0 because the employer would not have reimbursed the employee for any long term care expenses.

Insurance Premium Reimbursement

Health Insurance Premiums

An HRA – whether integrated with a plan that provides minimum value or one that does not provide minimum value - may not provide reimbursement for individual medical insurance premiums for current employees (premiums for individual medical insurance may be reimbursed from a retiree-only HRA) unless the HRA is a QSEHRA. An HRA may reimburse premiums for excepted benefits such as stand-alone dental or vision coverage. An HRA, regardless of the integration method, may be used to pay the employee's share of premiums under the primary group health program. However, an HRA **cannot** be used to pay the employee's share of premiums for any employer group health coverage if the employee has the **choice** to pay those costs on a pre-tax basis through the employer's cafeteria plan. Such an arrangement would violate the prohibition on HRAs being directly or indirectly funded through cafeteria plan pre-tax salary reductions.

Fixed indemnity insurance policies are policies that reimburse a fixed amount per day of hospitalization or illness (or other time period) regardless of the amount of expense incurred or the amount that may be paid by another health plan. The IRS has ruled that these insurance policies do not qualify as medical coverage under Internal Revenue Code Section 213. Premiums for fixed indemnity policies, such as cancer or hospital policies, and premiums for long-term disability coverage are generally not Section 213(d) deductible coverage and not reimbursable under an any HRA.

In 2014, the Department of Health and Human Services ("HHS") issued new guidance for individual fixed indemnity insurance to qualify as an excepted benefit under PPACA. This new definition is broader than the definition of "fixed indemnity insurance" under the Internal Revenue Code. Under the HHS definition, an insurance policy that pays benefits on a per service basis – for example, $30 per office visit – could qualify as an

excepted benefit under PPACA. In October 2016, the Departments of Labor, Health and Human Services and the Treasury issued final regulations on excepted benefits under PPACA, but did not address fixed indemnity plans as excepted benefits and indicated that they would issue such guidance at a later date. Although no guidance has been provided by the IRS as of January 2019, it would appear that a fixed indemnity policy that qualifies as an excepted benefit under PPACA and is not limited to a per diem (or other time period) reimbursement may qualify as "medical coverage" which would enable premiums to be reimbursed by an HRA. The employer could not, however, give employees a choice between paying these premiums on a pre-tax basis under a cafeteria plan or by having them reimbursed by the HRA.

Long Term Care Insurance Premiums

Long Term Care ("LTC") insurance premiums may be reimbursed, but only up to a specified dollar amount, which varies by age. Only premiums paid during a taxable year that do not exceed the indexed annual limit (i.e., "eligible long-term care premiums") are deductible and eligible for reimbursement under an HRA. Premiums may be reimbursed by any HRA since LTC insurance is an excepted benefit. Eligible long-term care premiums should be reimbursable even if the HRA is a flexible spending arrangement under Section 106 and subject to the prohibition on reimbursing qualified long-term care expenses.

Many employers do not include LTC premiums as an eligible expense under their HRAs. If an employer does not already pay or subsidize premiums for LTC coverage, and these LTC premiums are not excluded from the HRA, an employer may unintentionally increase its cost. For an example, an employee who has no medical expenses that are reimbursable by the plan could have long term care premiums paid by the plan – for example a 41-year old employee could request reimbursement of long term care premiums up to the statutory limit of $790 (2019 value). In this case, the employer's cost without long term care premiums would be $0, but the employer's cost with long term care premiums would be $790 because it would have reimbursed the employee for the cost of the premiums.

Administrative Costs

Employers that sponsor an HRA that reimburses cost-sharing amounts such as copayments and deductibles may choose to hire a vendor that provides a debit card that the employee may swipe to cover cost-sharing amounts when the medical service is received. Some employers will pay the cost of the debit card directly (debit cards typically have an initial set-up fee plus monthly card maintenance fees). Some employers may want to have the monthly maintenance fees for the debit card deducted from the HRA account. In addition, an HRA is permitted to charge administrative costs needed to maintain HRA coverage for retirees or others after termination of

employment. The HRA may also provide that any maximum reimbursement amount available after retirement, or other termination of employment, is reduced for any administrative costs of continuing such coverage. However, the administrative costs must be reasonable. Informally, Treasury officials have indicated that it is permissible for an HRA to fund administrative costs to maintain HRA coverage for active employees.

C. Prohibited Reimbursements

An HRA may not be used to reimburse current employees for the cost of individual medical insurance that is not an excepted benefit unless the HRA is a QSEHRA. A retiree-only HRA may include medical insurance premiums (even individual medical insurance premiums) as an eligible expense.

HRAs are not permitted to reimburse expenses that have been reimbursed by another plan or pay for other coverage on a pre-tax basis – in other words, double-dipping is not allowed. In an attempt to prevent double-dipping, an HRA may not reimburse a medical care expense that is attributable to a deduction allowed under Section 213 for any prior taxable year.

An employer may **not** give employees the option to use HRA funds to pay for health coverage that may be offered on a pre-tax basis through its cafeteria plan. The HRA also may not reimburse an employee for pre-tax contributions that were used to pay for coverage under the employer's health plan.

HRAs – other than retiree-only HRAs or possibly QSEHRAs – may not reimburse Medicare premiums – Part 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 Medicare Secondary Payer ("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.

Limited Wraparound Benefits

On March 18, 2015, the Departments of Treasury, Labor, and Health and Human Services published final rules that amend the excepted benefit rules related to limited wraparound coverage. Employees, such as part-time employees, who are not offered affordable group health coverage that provides minimum value from their employer may be able to purchase individual coverage through a Marketplace which covers the required EHBs and may qualify for a premium tax credit, but the Marketplace plan may not cover the additional benefits or larger network that typically are provided by an employer's plan. In such cases, some employers may want to offer limited wraparound coverage to employees such as part-time employees that supplements coverage purchased by the employee through a Marketplace to align with more generous coverage typically provided by the employer.

The final rules include detailed requirements under which limited benefits provided through a group health plan that wraps around either "eligible individual health insurance" or coverage under a Multi-State Plan (limited wraparound coverage) must satisfy to qualify as an excepted benefit. Under the final rules, limited wraparound coverage was permitted under a pilot program for a limited time. Specifically, this type of limited wraparound coverage could have been offered as an excepted benefit for coverage that is first offered no earlier than January 1, 2016 and no later than December 31, 2018 and that ends on or before the later of: (1) the date that is three years after the date wraparound coverage is first offered; or (2) the date on which the last collective bargaining agreement relating to the plan terminates after the date limited wraparound coverage is first offered (determined without regard to any extension agreed to after the date the wraparound coverage is first offered).

Note: Although limited wraparound benefits that satisfy the requirements in the March 18, 2015 regulations will qualify as excepted benefits, limited wraparound coverage must not consist of an account-based reimbursement arrangement.

HRA May Not Offer Cash-Outs

HRA participants that find themselves with remaining amounts in their HRAs may not cash-out the leftover HRA balances. In order to be a qualified HRA, no participant should have the right to receive cash or any other taxable or non-taxable benefit from the HRA other than the reimbursement of qualifying health care expenses. If an HRA participant receives cash or other benefit, other than as a reimbursement of health expenses, **all** distributions in the current tax year to **all** participants from the HRA will be included in gross income. This includes amounts paid to reimburse eligible health care expenses.

The rule against offering cash-outs also applies to arrangements that exist outside of the HRA that are tied to the participant's compensation or receipt of another benefit. Any adjustments to compensation or other benefits will be considered in a determination of whether a participant is receiving impermissible payments as a result of amounts that may remain in an HRA account. For example, if an employee receives a bonus at the time of retirement that is related to the employee's remaining HRA amount, that practice will cause the HRA to be disqualified and for all reimbursements to all participants to be taxed.

D. Timing of Expenses

Several general timing rules apply to all reimbursements. Following is a brief description of the rules.

Expenses Must be Incurred while HRA Coverage is in Effect

Health care expenses must be incurred while HRA coverage is in effect in order to be reimbursable. An HRA is not permitted to reimburse a medical expense that is incurred:

- Prior to the date that the HRA began, or
- Prior to the date an employee (or spouse or dependent) first becomes covered under the HRA.

If the HRA offers dependent coverage, the dependents must be eligible dependents under the HRA at the time an expense is incurred in order for it to be reimbursed.

Shoebox Rule: Claims that are incurred, but not reimbursed, in one year (for example, because the HRA account balance was exhausted) may be reimbursed in a later coverage period – called the "shoebox rule." Under the shoebox rule, the delayed reimbursement is permissible if the participant was covered by the HRA when the claim was incurred and remains covered in the later period when the reimbursement occurs. Plan sponsors may, however, design HRAs to limit the period of time for submitting claims. For example, an HRA could be designed to require that all claims be submitted within 90 days after the close of the plan year in which the expense was incurred, or within two years after the expense was incurred.

Expenses after Retirement or Termination of Employment

An HRA may continue to reimburse former or retired employees for medical care expenses after termination of employment or during retirement (without regard to whether the employee elects COBRA continuation coverage). Employers may offer this type of provision – usually called a "spend-down" provision as an alternative to COBRA continuation coverage under the HRA. The HRA could be designed in such a way as to permit a former or retired employee to be reimbursed for medical care expenses only up to the unused reimbursement amount remaining at the termination of employment or retirement (or a smaller amount). However, there is no requirement that HRAs be designed to permit employees to spend down any amount that remains in an HRA account after coverage ends. In any event, COBRA must be offered if the HRA is subject to COBRA. (Section 6 Impact of Other Federal Laws has more information on HRAs and COBRA requirements.)

Claims Incurred after Loss of Underlying Integrated Coverage

As discussed in Section 2, PPACA requires an HRA (that does not qualify as a stand-alone HRA, retiree-only HRA, or a QSEHRA) to be integrated with non-HRA group health plan coverage that is not limited to excepted benefits in order to avoid violating the prohibition against annual or lifetime dollar limits on essential health benefits and the requirement to reimburse preventive services with no cost-sharing that applies to non-grandfathered plans. A question arises as to what happens to the remaining HRA account balance if the non-HRA group health plan coverage is discontinued. Any amounts that were credited to the HRA during the period while the HRA and the non-HRA group health plan were integrated may still be used after the HRA ceases to be integrated due to the termination of the non-HRA group health coverage - except for individual medical insurance premiums or unless a former employee. *Note: As long as there is an available balance in the HRA that is not a stand-alone HRA, QSEHRA, or*

retiree-only HRA, the employee has "minimum essential coverage" even if the employee is not covered by any other medical plan and would not be eligible for a premium subsidy.

E. Expense Substantiation

Health expenses must be substantiated through auto-adjudication (e.g., debit card) or reviewed by a claim administrator in order to be reimbursed by an HRA. Even though HRAs are exempt from many of the cafeteria plan health FSA requirements, the same substantiation requirements that apply to health FSAs under the 2007 proposed cafeteria plan regulations also apply to HRAs. Moreover, although the 2007 proposed cafeteria plan regulations do not specifically discuss HRAs in the rules that apply to electronic payment cards (debit cards), those rules can probably be relied upon for payments from HRAs.

Debit Cards

HRAs are permitted to use debit cards with any provider or vendor if every expense is substantiated and claims are adjudicated. Auto-adjudication is where payment is made from the HRA at the time the payment card is swiped at the point of purchase – without the need for substantiation.

Under IRS guidance, auto-adjudication may occur:

- At merchants and service provider with healthcare Merchant Category Codes ("MCCs") (e.g., a doctor's office), or
- At merchants without MCCs as long as a compliant inventory information approval system is in place to ensure that the payment cards are used only for eligible medical care expenses (e.g., pharmacy).

HRA debit cards may be used to purchase medicines and drugs at merchants with an inventory information approval system provided that the following requirements are met: (a) prior to purchase, a prescription is presented to the pharmacist; (b) the pharmacy or other vendor retains a record of the prescription number, the name of the purchaser or patient, and the date and amount of the purchase in a manner that meets IRS recordkeeping requirements applicable to card programs; (c) the records are available to the employer or its agent upon request; (d) the card system will not accept a charge for an over-the-counter drug unless a prescription number has been assigned; and (e) the existing IRS requirements regarding card programs are satisfied. Debit card transactions that meet all of the above requirements will be considered fully substantiated at the time and point of sale.

Claims that may be reimbursed using auto-adjudication are:

- Claims that exactly match copayment amounts (e.g., a $25 claim at a doctor's office where the plan's copay is $25);

- Claims where the amount is recurring and exactly matches a previously approved claim (e.g., $30/visit coinsurance to a physical therapist) where the individual has the same service from the same healthcare provider on an ongoing basis; or
- Claims that have real-time verification (e.g., purchasing prescription drugs at a pharmacy where the copayment is not a flat dollar amount or recurring, but the pharmacy determines the copayment when it processes the prescription expense under the primary group medical plan).

Recouping Overpayment or Improper Payments

IRS guidance provides the following procedures that the HRA administrator must use to recoup from participants any overpayments (or ineligible expenses mistakenly paid) that are made using the debit card:

- Until the amount of the improper payment is recovered, the debit card must be de-activated and the employee must request payments or reimbursements of health expenses from the HRA by submitting claims manually (e.g., paper claims or faxed claims);
- The employer requires the employee to repay the amount improperly paid;
- If the employee fails to repay the improper payment after a demand is made, the employer withholds the amount of the improper charge from the employee's pay or other compensation, to the full extent allowed by applicable law;
- If any portion of the improper payment remains outstanding, the employer may then offset the remaining amount against any future claims; and
- If the employee remains indebted to the employer, the employer will treat the improper payment as any other business indebtedness, consistent with business practices (and include on Form W-2).

Other Transactions

All other claims must be substantiated and adjudicated by the claims administrator. The payment card may be used to pay for the service at the time the service is received and substantiation submitted to the claims administrator at a later date. In the event that a claim is not approved, the plan is required to take a series of specified steps to recoup any overpayment amount.

SECTION 5 - NONDISCRIMINATION REQUIREMENTS

HRAs that are self-insured are subject to the nondiscrimination rules under Internal Revenue Code Section 105(h). PPACA added nondiscrimination requirements for non-grandfathered insured health plans, but those rules have been delayed until the IRS issues guidance. Since the vast majority of HRAs are self-insured and we do not have rules for fully insured group health plans, our discussion of nondiscrimination requirements covers only the rules in Section 105(h). Moreover, since HRAs may not be offered through a cafeteria plan, HRAs are not subject to cafeteria plan nondiscrimination rules under Section 125. HRAs found to be discriminatory may cause some or all of the reimbursements to Highly Compensated Individuals ("HCIs") to be taxable.

A. General

Under Section 105(h), a self-insured group health plan may not discriminate in favor of Highly Compensated Individuals ("HCIs"). There are two nondiscrimination tests under Section 105(h) that an HRA must satisfy to demonstrate that it does not discriminate in favor of HCIs – the Eligibility Test and the Benefits Test

Similar to the rules for cafeteria plans, the nondiscrimination rules under Section 105(h) apply on a controlled group basis – the controlled group (or affiliated service group) is determined based on Internal Revenue Code Sections 414 (b), (c), (m), and (o). *Comments: One area in which the IRS has not provided guidance is how to determine the controlled group for plan sponsors that are not private employers – e.g., nonfederal governmental plan sponsors. Congress recently addressed controlled group status for plan sponsors that are churches as part of the Protecting Americans from Tax Hikes ("PATH") Act. Church plan sponsors should consult with legal counsel to determine whether controlled group requirements apply.*

HCIs under Section 105(h)

The Section 105(h) definition of HCIs includes the following:

- *Five highest paid officers* - Whether an individual is an officer is determined on the basis of all the facts and circumstances, including: the source of the person's authority, the term for which he or she is elected or appointed, and the nature and extent of the individual's duties. If more than five individuals are identified as "officers," it will be necessary to determine each officer's level of compensation, to identify the five highest paid. An employee's compensation is determined on the basis of the employee's compensation for the plan year.
- *Shareholders who own more than 10% of the employer's stock* - The constructive ownership rules under Internal Revenue Code Section 318 apply. In general, this means that an employee is considered to own stock that is owned by certain family members such as his or her spouse, parents, children, and grandchildren.

The determination of who is more than a 10% shareholder is made for the plan year in which the benefit is provided.

- *The highest paid 25% of all non-excludable employees* – In determining the highest-paid 25% of all employees, a reasonable definition of compensation must be used and the number of employees included is rounded up to the next highest number. As with the five highest paid officers, under the regulations, the level of an employee's compensation is determined on the basis of the employee's compensation for the plan year.

Excludable Employees under Section 105(h)

The regulations allow employers to exclude certain employees from testing. The following employees may be excluded from testing under Section 105(h):

(1) Employees who have not completed three years of service as of the first day of the plan year.
(2) Employees who have not attained age 25 prior to the first day of the plan year.
(3) Part-time employees - employees who customarily work less than 25 hours per week may be treated as part-time. Employers may use up to 35 hours to determine part-time status, but only if the employer has other employees doing similar work who have substantially more hours. If the employer does not have other employees in similar work, then similar work in the same industry or location may be used.
(4) Seasonal employees - employees who work fewer than 7 months may be treated as seasonal. Employers may use up to 9 months to determine seasonal status, but only if the employer has other employees doing similar work who have substantially more months. If the employer does not have other employees in similar work, then similar work in the same industry and location may be used.
(5) Collectively bargained employees **that are not included in the plan where health benefits were the subject of good faith bargaining.**
(6) Nonresident aliens who receive no U.S. source earned income.

IRS informal guidance has stated that the employer may exclude employees in classes 1, 2, 3, and 4 above (e.g., employees with less than 3 years of service) only if these employees are not eligible under the plan. If, for example, the employer's plan has a 3-month service requirement, only employees with less than 3 months of service are excludable.

All other employees are "non-excludable" meaning that they must be included in testing.

B. Section 105(h) Eligibility Test

The purpose of the Eligibility Test is to ensure that a reasonable number of non-HCIs benefit from the HRA. If not enough non-HCIs benefit, then the HRA will fail the Eligibility Test. There are three tests that may be used to satisfy the Eligibility Test:

- The 70% Test;
- The 70%/80% Test; or
- The Nondiscriminatory Classification Test.

The 70% Test

The first way for a self-insured health plan to satisfy the Eligibility Test is to demonstrate that the plan benefits 70% or more of all non-excludable employees. In this context, to "benefit" under the plan means to be enrolled in the plan (i.e., to have the ability to make a claim, not necessarily to have made a claim).

If the plan fails the 70% Test, then the 70%/80% Test should be performed.

The 70%/80% Test

The second way for a self-insured health plan to satisfy the Eligibility Test is to demonstrate that the plan benefits 80% or more of all the non-excludable employees that are eligible to participate under the plan if at least 70% of all non-excludable employees are eligible to benefit under the plan. The first step in running this test is to determine whether at least 70% of employees are eligible under the plan. If that initial threshold is met, then the next step is to determine whether at least 80% of those eligible employees (i.e., 80% of the 70%-or-more figure) actually participate in the plan. An employer can satisfy the 70%/80% Test with a lower participation level than would be required to pass the 70% Test — the participation level could be as low as 56% (70% eligible, with 80% of the 70% participating).

Example: Company A has 100 non-excludable employees, 70 employees are eligible and 63 of those employees participate. This plan cannot pass the 70% test, since only 63% of all non-excludable employees are enrolled. However, since 70% of non-excludable employees are eligible (70 of 100 non-excludable employees = 70%) and 90% (63÷70=90%) of the eligible employees participate, this plan passes the 70%/80% test.

If the plan fails the 70%/80% test, the nondiscriminatory classification test should performed.

Nondiscriminatory Classification Test

The third possible way for a self-insured health plan to satisfy the Eligibility Test is by demonstrating that the plan benefits employees that qualify under a classification set up by the employer and found by the IRS not to be discriminatory in favor of HCIs. This is often referred to as the Safe Harbor and Unsafe Harbor Test.

In general, if the percentage of non-HCIs participating in the plan is at least 50% of the percentage of HCIs participating, the plan will pass – for example if 90% of the HCIs are participating, the plan will pass if at least 45% of the non-HCIs are also participating. If the percentage of non-excludable non-HCIs enrolled is below 50%, the employer will need to determine if the plan passes or fails by comparing the percentage of non-excludable HCIs participating in the plan to the percentage of non-excludable non-HCIs participating in the plan and compares that ratio to a ratio in a chart under Section 410(b) regulations.

Some practitioners believe that it may be permissible to run a test called a "Fair Cross Section Test." The Fair Cross Section Test was a test available to pension plans under Section 410(b) prior to enactment of the Tax Reform Act of 1986. Employers that want to use the fair cross section test for their HRAs should discuss their situation with their legal advisor.

Failing the Eligibility Test

If the plan fails all of these tests, it fails the Eligibility Test and therefore discriminates in favor of HCIs. If the plan discriminates on the basis of eligibility, then some portion of the HCI's benefit is treated as taxable income and the employer is required to determine and report the amount of taxable income on the employee's Form W-2. Non-HCIs are not affected, meaning they will not have taxable income.

The amount that will be taxable income for HCIs = (amount reimbursed to HCI) x (total amount reimbursed to all HCIs ÷ total amount reimbursed to all employees)).

Example: Assume that John works for Employer and is an HCI. Assume Employer paid a total of $50,000 in reimbursements ($30,000 to HCIs and $20,000 to non-HCIs) and John personally received reimbursement of $4,500 for health expenses. John's excess reimbursement is calculated by his reimbursement amount ($4,500) multiplied by the total amount reimbursed to all HCIs ($30,000) divided by total amount reimbursed to all employees ($50,000). John's excess reimbursement is $2,700 ($4,500 x ($30,000 ÷ $50,000)).

C. Section 105(h) Benefits Test

The Benefits Test under Section 105(h) determines whether all participants under the plan are eligible for the same benefits on the same basis. A self-insured health plan does not satisfy the Benefits Test unless all the benefits that are provided to HCIs are also provided to all non-HCI plan participants on the same terms and conditions. In addition, all the benefits available for the dependents of HCIs must also be available on the same basis for dependents of all non-HCI participants. Basically, the Benefits Test is meant to ensure that HCIs are not receiving enhanced benefits.

The Benefits Test has two components: testing for discrimination on the face of the plan and testing for discrimination in operation.

Discrimination on the Face of the Plan

A plan will satisfy the requirement that it be nondiscriminatory on its face if it includes several important design features:

- The HRA maximum benefit level cannot vary based on age, years of service, or compensation. For example, tying the amount of benefit or employer contributions to years of service (including, it would seem, partial years of service) will probably cause the HRA to fail the Benefits Test.
- The same type of HRA benefits must be offered to both HCIs and non-HCIs. The Benefits Test also examines the type of benefits subject to reimbursement. Consequently, the types of health expenses that are reimbursable must be available to non-HCIs on at least as favorable terms as they are for HCIs. For example, an HRA cannot exclude orthodontia expenses for non-HCIs while covering them for HCIs.
- Disparate waiting periods cannot be imposed. For example, an employer cannot require non-HCIs to wait 30 days to enter the HRA after becoming eligible, while allowing HCIs to enter the HRA immediately upon becoming eligible.

Discrimination in Operation

An HRA must not discriminate in favor of HCIs in actual operation, which is a facts and circumstances determination. Discrimination in operation may occur where the duration of a particular benefit coincides with the period during which an HCI utilizes the benefit. Thus, if an HRA (or a benefit provided by the HRA, such as coverage for certain types of medical expenses) is amended or terminated such that the duration of the benefit favors HCIs, the plan would be discriminatory. For example, assume that an employer's HRA that previously excluded vision reimbursements was amended to permit reimbursements for vision expenses. During that year, an HCI (who is the owner of the company) receives Lasik surgery which is reimbursed by the HRA. In the next year, the HRA is amended to exclude vision expenses. This design discriminates in operation.

Similarly, discrimination in operation could arise if an HRA administrator approves certain claims for medical expenses for HCIs while denying them for non-HCIs (in the absence of justifiable reasons for treating them differently).

Restructuring

As noted above, an HRA will fail the Benefits Test if HCIs receive an HRA accrual (or benefits) that is greater than the accrual (or benefits) provided to non-HCIs. In some cases, though, benefit differences may be desirable for nondiscriminatory business reasons (e.g., because of union/nonunion status, employment by different affiliates or legacy companies, or employment in different geographic regions). In those cases, it may be possible to "restructure" the HRA so that each HRA arrangement can be tested separately as if each were a separate plan. If each "restructured" plan separately passes the Eligibility Test, then the nondiscrimination requirements would presumably be satisfied. It should be noted that restructuring based upon an impermissible criteria under the Benefits Test (e.g., age, compensation, position, or years of service) would not be permissible.

It further appears to be permissible to disaggregate plans for testing and if all segments of the plan pass the tests, then the plan overall satisfies the tests. The IRS has not issued any guidance indicating if plans may be aggregated for testing. Employers that want to combine plans for testing should consult with their legal counsel.

Note: Under current 105(h) regulations, if an employer sponsors a self-insured HRA and a fully insured primary group medical plan, the HRA and insured medical plan may not be combined for testing. The HRA must be tested separately. The only circumstance under which an insured health plan may be combined with a self-insured health plan for testing is when an employer offers a fully insured HMO as an option under its self-insured primary group medical plan.

Failing the Benefits Test

What happens if the HRA fails the Benefits Test and is found to be discriminatory as to benefits? The result will be that the amount reimbursed to an HCI for the discriminatory benefits will be included in the HCI's gross income (i.e., excess reimbursement).

Example: Employer B sponsors a self-insured HRA, which covers all employees. Annual accruals are the same for all eligible employees, but eligible expenses are different. The HRA will reimburse both medical and dental expenses for HCIs, but only medical expenses for non-HCIs. If an HCI receives a reimbursement of $3,000 for dental expenses, the $3,000 reimbursement is taxable.

In some cases, the determination as to which benefits are "excess" may be fairly straightforward. For example, if a benefit is available only to one or more HCIs and not to all other participants (as in the example above), the total amount reimbursed to the

HCIs for that benefit is includible in gross income (i.e., it is all excess reimbursement). The analysis is more complicated, however, when HRA accruals are greater for HCIs. Unfortunately, there is no IRS guidance on this issue.

Note: A literal reading of the rules suggests that the taxable excess reimbursements under an HRA with discriminatory coverage are based on the benefits actually paid for the year, and not on the accruals credited to HRA accounts. However, the actual application of the Section 105(h) nondiscrimination requirements to HRAs is unclear because HRA benefits — unlike most other employer-provided health benefits — may accrue contributions during one year that are paid out as benefits across one or more later years.

SECTION 6 - IMPACT OF OTHER FEDERAL LAWS

Many other federal legal/regulatory requirements apply to HRAs because they are considered to be group health plans. This section provides an overview of how the following federal laws generally apply to HRAs:

- COBRA
- ERISA
- FMLA
- HIPAA Nondiscrimination and GINA
- HIPAA Privacy & Security
- Medicare Secondary Payer (MSP)
- Patient Protection and Affordable Care Act (PPACA)

Some federal laws such as the Mental Health Parity and Addiction Equity Act ("MHPAEA"), Qualified Medical Support Orders, and Pregnancy Discrimination Act also apply to HRAs and must be complied with but typically do not create compliance issues for HRAs. Although these laws would generally not create compliance issues for a typical HRA, they must be taken into account when designing an HRA. For example, if the HRA reimburses coinsurance for out-of-network services, it may not exclude reimbursement for certain types of out-of-network services such as treatment of substance use disorder because that would violate MHPAEA.

COBRA

HRAs sponsored by employers that are subject to COBRA's requirements must offer continuation coverage to a qualified beneficiary when a qualifying event occurs. For example, HRAs must offer COBRA continuation coverage for all COBRA qualifying events, such as a divorce or a child reaching age 26. However, QSEHRAs are not subject to COBRA continuation and thus are not required to follow the rules set out in this section. Otherwise, HRAs must offer COBRA continuation coverage even if the plan permits qualified beneficiaries to access the funds after a qualifying event – i.e., to spend down the balance after a qualifying event of termination of employment. Therefore, even if the plan continues to reimburse eligible expenses to an employee after termination of employment, COBRA must still be offered. In some ways the application of COBRA to an HRA is more complicated than the application of COBRA to a primary group medical plan.

COBRA Coverage Determination

One of the more challenging aspects of COBRA continuation coverage is determining the "benefit amount" that must be made available. "Benefit amount" is the maximum benefit payable for eligible expenses. (Note that determining the benefit amount for an HRA is a different calculation than determining the COBRA Applicable Premium. See the next subsection for information on calculating the Applicable Premium for an HRA.)

The determination may be straightforward when the event is the employee's termination of employment or reduction in hours, but is not as easy to determine for other qualifying events such as divorce. Factors such as whether or not claims were incurred before the qualifying event, and by whom, will affect the determination. If an unmarried employee with no dependents has a qualifying event, the benefit amount will be the account balance on the date of the qualifying event. See Section 7 – Implementation Issues – for examples.

Note: If the balance in the HRA is exhausted before the qualifying event, the amount available would be $0, but COBRA must still be offered because of the annual contributions. An individual who experiences a qualifying event late in the year and anticipates significant health expenses early in the following year might elect COBRA and pay premiums for one or two months in order to get the annual allocation.

Calculating COBRA Premium Amounts

A second aspect that is more complicated is determining the COBRA "premium" for an HRA once a qualifying event occurs. Calculating the COBRA cost for a fully insured HRA, is much simpler than determining the cost for a self-insured HRA (the majority). The premium for an insured HRA would be an amount up to 102% of the premium charged by the insurance carrier.

COBRA regulations provide two methods for calculating COBRA premiums for self-insured plans: the past-cost method and the actuarial method. Under the past-cost method, the applicable premium equals the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period adjusted by the percentage increase or decrease in the implicit price deflator of the gross national product. The past-cost method cannot be used when there is any significant difference between the determination period and the preceding determination period (in coverage under or in employees covered by the plan).

Under the actuarial method for determining the applicable premium for a self-insured HRA, the HRA must charge the qualified beneficiary an amount equal to a reasonable estimate of the cost of providing coverage to a group of individuals who are similarly situated and most closely related to the qualified beneficiary. New HRAs must use the actuarial method since they do not have past costs. Some HRAs that have been in existence for a few years might be able to use the past cost method if coverage levels do not vary significantly from year to year. However, since the statute states that the past-cost method is unavailable if there is a significant difference in coverage from one year to the next, this method may not be permissible for many HRAs.

One view of how the actuarial method may be used to calculate a COBRA rate uses a "blended" rate for all HRA qualified beneficiaries regardless of their account balances – e.g., a qualified beneficiary with a $10,000 account balance would pay the same premium as a qualified beneficiary with a $100 balance. This method, however, may create two potential problems: (1) how to calculate the actual blended premium, and (2)

it may not be acceptable to the plan sponsor or palatable to the qualified beneficiary - or both. The “blended” approach appears to be a safe harbor. Other methods, which charge higher premiums for higher balances, may be permissible.

In February 2015, the Treasury Department and IRS issued Notice 2015-16 which discusses possible methods of determining the cost of health coverage for purposes of the Cadillac Plan tax. Although the Notice focuses on the Cadillac Plan tax, the text indicates that future guidance on determining the COBRA applicable premium is likely to harmonize with the Cadillac Plan tax rules to the extent practicable. As a result, we may see additional guidance on calculating COBRA premiums in the near future.

Until the IRS provides more guidance, employers with HRAs should consult with their legal counsel when selecting a method to use and in many, if not most, cases would be well advised to have an actuary calculate the rates.

ERISA

HRAs sponsored by private employers (not governmental or non-electing church employers) are also subject to the same ERISA requirements that apply to other health plans such as primary medical. Key requirements are: (1) disclosure – SPD, SMM, SMR, SBC (in many cases these are combined with the medical plan with which the HRA is integrated); (2) reporting – Form 5500 (often combined with the primary group medical plan); (3) claims & appeals rules covering the process and timing; and (4) fiduciary obligations. Note that governmental and church plans must also comply with SBC disclosure requirements. QSEHRAs are not ERISA plans.

FMLA

The coverage continuation rules that apply to other health coverage such as primary medical, dental, and vision also apply to HRAs. HRAs that are integrated with a medical plan will generally apply the FMLA rules to the medical plan and HRA as a package. Plan sponsors with a permissible stand-alone HRA – generally limited to an HRA that reimburses only excepted benefits such as dental and vision – must still comply with the FMLA requirements such as continuing coverage during an FMLA leave.

HIPAA and Genetic Information Nondiscrimination Act (“GINA”) Nondiscrimination

HIPAA nondiscrimination requirements apply to HRAs, except QSEHRAs, stand-alone HRAs, and retiree-only 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 or 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; and disability.

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, premiums or employer contributions. Genetic information is also considered protected health information and is subject to the HIPAA Privacy, Security, and Breach Notification rules.

HIPAA Privacy and Security

The HIPAA privacy and security requirements, including the breach notification rules, apply to all HRAs the same as they apply to any health plan. *(Note: There is no exception for permissible stand-alone HRAs that are limited such as those that reimburse excepted benefits or cover only retirees or are QSEHRAs.)*

Medicare Secondary Payer ("MSP")

The MSP rules that apply to medical plans also apply to HRAs. 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 and spouses of active employees enrolled in Medicare based on age (employer with 20 or more employees), individuals enrolled in Medicare because of end stage renal disease (employer with 1 or more employees), and individuals enrolled in Medicare based on disability (employer with 100 or more employees).

Note: The employer would be primary and Medicare would be the secondary payer for an active employee's spouse when enrollment in Medicare is based on the spouse's age. Medicare would be the primary payer for the employee's domestic or civil union partner if the domestic or civil union partner is enrolled in Medicare based on the domestic or civil union partner's age. The employer would be primary if the employee's spouse or domestic or civil union partner is enrolled in Medicare based on either end stage renal disease or disability.

HRAs, except potentially QSEHRAs, may not reimburse Medicare premiums - Parts A, B, C, or D (Part C is Medicare Advantage) for any individual for whom the employer sponsoring the plan is the primary payer under the Medicare Secondary Payer law. Nor may the HRA reimburse premiums for supplements such as a Medigap policy. Reimbursing these premiums would be considered giving these individuals a financial incentive to enroll in Medicare rather than the employer's plan in violation of the Medicare Secondary Payer rules. Where the employer is the secondary payer under the Medicare Secondary Payer law, the HRA may reimburse Medicare premiums. Medicare is almost always primary for retired employees and dependents of retired employees (there is an exception in certain cases involving the first 30 months of Medicare eligibility based on end stage renal disease). Medicare is generally primary for small

employers – i.e., employers with fewer than 20 employees on a controlled group basis – except where Medicare eligibility is based on end-stage renal disease.

HRAs are also subject to the Medicare secondary reporting requirement that applies to group health plans. The health insurance carrier is responsible for reporting under an insured plan. If a self-insured HRA uses a TPA for claims administration, the TPA is the entity responsible for reporting to CMS. If the HRA is self-insured and self-administered, the entity sponsoring the HRA (usually the employer) has the responsibility. The entity responsible for reporting must provide CMS with specified information for all active employees and their dependents. HRAs that are integrated with a medical plan may not use combined reporting; the HRA must be reported separately. However, there is an exemption for an HRA account with a balance below $5,000 at the beginning of the year.

Patient Protection and Affordable Care Act ("PPACA")

Unless the HRA is not subject to PPACA – i.e., the HRA is restricted to excepted benefits such as stand-alone dental and vision, is only provided to retirees, or is a QSEHRA – PPACA's requirements apply. In general, an HRA that is subject to PPACA must satisfy the following:

- 90-day maximum on waiting periods (plus an orientation period not to exceed one month)
- Provide coverage for children to age 26
- Not include any pre-existing condition limitation (virtually no HRAs contain this type of limitation)
- Prohibition against rescission of coverage except in very limited circumstances such as fraud
- Provide a Summary of Benefits & Coverage (may be combined with medical when integrated)
- Comply with the claims and appeals process requirements (non-grandfathered plans)

Additional requirements such as the prohibition on preauthorization for emergency room care or routine obstetrical/gynecological care that apply to non-grandfathered health plans are unlikely to affect HRAs which typically do not include restrictions that would violate the PPACA rules. Coverage of preventive services required by PPACA should be covered by the primary group medical plan with which the HRA is integrated.

Stand-alone and Integrated HRAs

As the result of regulatory guidance issued by the IRS in 2013, a stand-alone HRA must be limited to reimbursement of excepted benefits (e.g., dental and/or vision expenses) or for retirees only. Other HRAs must be integrated with a primary group medical plan in order to satisfy PPACA's requirement. The reason is that an HRA by itself cannot satisfy PPACA's requirement that there be no annual or lifetime dollar maximum on any

essential health benefit. Nor can a stand-alone HRA provide reimbursement of required preventive care procedures with no cost sharing (for grandfathered plans only). HRAs that are not limited to excepted benefits or retirees must be integrated with a primary group medical plan that satisfies those requirements. See page 3 for more information on integration rules.

Reporting

Although HRAs constitute minimum essential coverage ("MEC"), because they are integrated with other medical coverage using one of the two integration methods permitted under IRS rules, separate reporting for HRAs is generally not required under Section 6055. The primary group medical plan will already be reported as MEC for the individual. It is not clear if applicable large employers must report HRAs on the applicable large employer report under Section 6056 when the employer also provides an integrated HRA and the primary group medical plan is being reported. An eligible small employer that provides a QSEHRA is not required to report under Section 6055 or 6056.

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 that HRAs will need to be included when the cost for the employer-provided coverage is reported on Form W-2. In addition, employers sponsoring QSEHRAs are subject to Form W-2 reporting. Detailed guidance is provided in IRS Notice 2017-67.

PPACA Fees

Like other health plans, HRAs must pay the PCORI fee. (It appears that QSEHRAs will also be subject to the PCORI fee. Guidance on this issue would be appreciated.) If the medical plan is insured and the HRA is self-insured, the insurance carrier must pay the fee for the insured medical plan; the employer sponsoring the HRA must pay the fee on behalf of the HRA. If both the medical and HRA are self-insured, the employer sponsoring the plan must pay the fee, but may combine the plans to determine the amount of the fee as long as both plans have the same plan year.

Effect of HRAs on Minimum Value and Affordability Determinations

An employer that integrates an HRA with its own primary group medical plan may count amounts newly made available for the year when calculating minimum value or affordability for that year, 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 group medical plan, then those amounts may be counted when determining minimum value. If the employee has a choice between using the funds to reimburse cost-sharing

amounts or using the funds to pay contributions, then those amounts may count toward the affordability requirement.

Because an HRA balance constitutes MEC, an HRA must permit an employee to opt out annually and upon termination of employment so that participation in a HRA by itself does not make the employee ineligible to receive a premium tax credit for individual medical insurance coverage purchased in a Marketplace.

Cadillac Plan Tax

Because an HRA is a group health plan, the cost of an HRA (including a QSEHRA) must be included when determining if the plan is subject to the Cadillac Plan tax. On February 23, 2015, Treasury and the IRS issued Notice 2015-16, which discusses several methods of determining the cost of coverage. IRS and Treasury requested public comments on the suggested methods. As of January 1, 2019, the IRS has not issued final guidance on this issue. Because the Cadillac Plan tax has been delayed until 2022, the IRS may not provide guidance in the near future. However, under the Cures Act, for Cadillac Plan tax purposes, the value of the coverage under a QSEHRA is the maximum amount of permitted benefit available under the arrangement to the employee and not the specific amounts reimbursed.

SECTION 7 - IMPLEMENTATION ISSUES

The process of implementing a new HRA has three key components: (1) determining the basic structure and design elements of the plan; (2) setting up plan administration; and (3) developing plan documentation and communication materials. Each of these components along with some key steps are outlined below. At the end, we include a few tips about several design problems to avoid.

A. Basic Structure and Design Elements

There are two basic structures for an HRA – stand-alone or integrated with a primary group medical plan. If an HRA limits reimbursable expenses to excepted benefits" such as dental and/or vision expenses, the employer may establish a stand-alone HRA. If the HRA will reimburse any essential health benefits, then the HRA must be integrated with a primary group medical plan using one of two IRS approved methods (see page 5 for more information about permissible integration methods), unless it is a QSEHRA.

Employers may also choose to limit the scope of reimbursable benefits. If the primary purpose is to give employees funds that those employees can use to pay for certain expenses, such as dental and/or vision without setting up additional plans, a limited purpose HRA may be appropriate. For example, an employer may limit HRA reimbursements to claims for dental and vision expenses. One advantage to establishing a limited purpose HRA is that the employer must only establish one plan and can limit its commitment to a flat dollar amount rather than be tied to the cost of separate dental and/or visions plans that provide specified levels of benefits. The employee has the flexibility to determine when and how to use the available funds. And, as noted above, an HRA that only provides coverage for excepted benefits does not have to be integrated with primary medical coverage. One disadvantage of using a limited purpose HRA rather than separate dental and/or vision plans is that HRAs typically do not come with networks that have discounts.

However, employers may wish to provide broader purpose HRAs. The broader purpose HRA may permit a greater scope of medical expenses to be reimbursed. For example, an employer may want to establish more of a defined contribution approach that permits employees to choose how the funds are used. In this case, the employer could establish an HRA that covers all or almost all IRS permitted expenses and employees can choose how to use the funds. Some employees might use the HRA to be reimbursed for cost-sharing amounts under the primary group medical plan, others may obtain reimbursement for expenses not covered by the primary group medical plan such as Lasik surgery, and still others may choose to be reimbursed for dental or vision expenses. The employee is able to decide how to use the money, while the employer's cost is limited to the dollar amount of its contribution.

Once the basic structure has been determined – stand-alone or integrated – design elements need to be selected. Major design elements include: (1) eligible employees, (2) eligible expenses, (3) integration method, and (4) employer contributions.

Eligible Employees

Employers have considerable flexibility in determining which employees will be eligible. It could be all full-time employees, or eligibility could include some part-time employees, or even be limited to employees in a specific geographic location. Although employers have significant flexibility in deciding who will be eligible, there are limits to that flexibility because the plan will need to satisfy nondiscrimination requirements. (See Section 5 - Nondiscrimination Requirements for more detailed information). However, eligibility must be limited to employees (and former employees); non-employees such as sole proprietors or partners may not be participants.

In addition to employees, employers may choose to design the HRA to reimburse eligible expenses for the employee's spouse and children. If children are included, coverage to age 26 is required. Non-tax dependents such as domestic partners or a domestic partner's children may also be covered, but only if the value of coverage is treated as taxable income to the employee.

Defining Eligible Spouses

Employers should specifically identify who is an eligible "spouse" under the HRA plan and will probably want to use the same definition of "spouse" as used by their primary group medical plans.

Eligible Expenses

One of the most important elements in a HRA plan design is what types of expenses will be eligible for reimbursement under the HRA. This is particularly important if cost containment is an important goal for the employer. If the HRA reimburses all deductible medical expenses, the goal of containing medical costs may not be fully realized. For example, if all deductible medical expenses are eligible for reimbursement, the employee would be free to use the HRA funds to be reimbursed for any of the following:

- Penalties for not pre-certifying a hospital stay
- The additional cost for using an out-of-network provider
- Care that exceeds plan limits (e.g., physical therapy visits over a maximum number of visits under the primary medical plan)
- Types of treatment that are specifically excluded by the primary group medical plan (e.g., off-label prescription drug use)

If the employer does not want the HRA to reimburse such expenses, the employer can limit reimbursable expenses to something less than all deductible expenses. For example, the HRA could be structured to reimburse only cost-sharing amounts under the primary group medical plan such as deductibles, copayments, and coinsurance. The HRA could also be designed to reimburse only expenses that are not excluded under the primary group medical plan. The employer may choose to cover less than the IRS permitted list, but may not cover more.

Additional circumstances may arise whereby an employer may wish to limit a certain type of benefits under their non-grandfathered plans. For example, employers that have an exemption or an accommodation that permits them to exclude coverage for some or all contraceptives – such as churches – may want to ensure that the HRA does not reimburse those expenses.

Another decision for employers is to determine whether long term care expenses may be reimbursed, and if so, whether the employer wishes to reimburse such expenses through its HRA. HRAs that qualify as flexible spending arrangements under Section 106 of the Internal Revenue Code, may reimburse premiums up to a specified dollar amount for qualified long term care coverage. Generally, an HRA that has a maximum reimbursement that does not exceed 500% of the cost of the coverage (i.e., the COBRA premium minus the 2% administrative load) will be a Section 106 flexible spending arrangement. Whether an employer does or does not want to include long term care insurance premiums as an eligible expense under an HRA will often depend on the employer's purpose in establishing the HRA. Most long term care insurance contracts are paid for by employees; the majority of employers do not pay any part of the cost. Permitting the HRA to reimburse those costs results in the employer paying a portion of the premium for the coverage. Employers that do not want to reimburse long term care insurance premiums will want to make sure that those premiums are excluded in the plan document and in communication materials provided to employees.

Note: Although employers have considerable flexibility in determining what expenses the HRA will or will not reimburse, other laws such as the Mental Health Parity and Addiction Equity Act put some limits on the employer's decision.

One of the reasons some employers implement an HRA rather than a health savings account (HSA) is the ability to restrict the types of expenses that may be reimbursed. HSA rules prohibit an employer from including any restrictions other than a reasonable minimum claim amount (such as $50 per claim) or claim frequency (such as monthly). Another reason is that employers have more flexibility when designing the primary group medical plan. For example, there are no minimum deductibles required under the primary group medical plan for an HRA as there are for an HSA-eligible primary medical plan.

Another consideration arises from the reimbursement of premiums through an HRA. Although HRA funds can generally be used to pay "premiums," there are two restrictions that must be followed. First, the HRA may not be used to purchase individual health insurance that is not an excepted benefit unless the HRA is a QSEHRA or a retiree-only HRA. Second, an HRA is not a qualified benefit under a cafeteria plan and may not be tied to a cafeteria plan directly or indirectly. Employees may pay contributions (or premiums) from an HRA for primary medical coverage or other plans such as dental or

vision, but employees **may not** be given a choice between paying required contributions (or premiums) from their HRA or paying required contributions via salary reduction since that indirectly ties the HRA to the cafeteria plan.

In addition, where the employer is the primary payer under the Medicare Secondary Payer law, the HRA may not reimburse premiums for Medicare Part A, B, C, or D or for Medicare supplements such as Medigap. (See page 18.)

Some employers have both an HDHP/HSA combination and a primary medical/HRA plan and permit employees to select one of the two. Employers that choose this route will want to design the primary medical/HRA carefully so that an employee who wants to change to the HDHP/HSA combination is not precluded from doing so because of a balance in the HRA. Including a provision permitting an employee to suspend participation in an HRA may eliminate this problem.

Integration Method

Under IRS guidance, an HRA that is not limited to excepted benefits, such as dental and vision coverage, must be integrated with a primary group medical plan using one of two methods unless it is a retiree-only or QSEHRA. (See Section 2 - Design Basics for more information on permitted integration methods.)

IRS regulations require the employee to be enrolled in another group health plan, but do not require the employee to be enrolled in the group health plan of the employer sponsoring the HRA. The employee could be enrolled in another group health plan such as a group health plan sponsored by the employee's spouse's employer.

While not clear in the regulations, it appears that the integration rules for an employee whose primary medical coverage is with the spouse's employer would be dependent on the spouse's employer's plan. If the spouse's employer's plan does not provide minimum value, then it appears that reimbursement under the HRA would need to be limited to cost-sharing amounts and non-essential health benefits for that employee. As a result, an employer sponsoring an HRA that has a minimum value medical plan but permits integration with other employers' medical plans would have several options:

- Operate two HRAs – one for employees with minimum value coverage and a second HRA for those whose primary medical coverage does not provide minimum value;
- Operate a single HRA with reimbursement restricted to cost-sharing amounts and non-essential health benefits; or
- Limit HRA participation for employees whose primary coverage is under a spouse's employer's plan to situations where the spouse's plan provides minimum value.

A similar issue would arise if the employer sponsoring the HRA has a primary group medical plan that does not provide minimum value. However, under those circumstances, the employer's HRA would already be limited to reimbursing cost-sharing amounts and non-essential health benefits. The employer would still need to confirm enrollment in the spouse's employer's plan.

While IRS rules permit integration with another employer's primary medical plan, there are several practical issues that employers should consider. When the employee's primary group health plan is provided by the employee's spouse's employer, the employer sponsoring the HRA should determine if the other employer's plan provides minimum value and must confirm that the employee is actually enrolled in the other employer's medical plan. The employer sponsoring the HRA will need a process to make an initial check and one on an annual basis. The employer sponsoring the HRA would also need to have a requirement that the employee notify the employer of certain changes – such as dropping coverage under the spouse's employer's plan. The employer would need to do this for each spouse's employer's plan.

The employer sponsoring the HRA would also need to determine what type of documentation it will require – for example, will an employee statement be sufficient or should the employer require a copy of the other plan's SBC to determine minimum value. Similarly, what documentation will the employer require to confirm that the employee is actually enrolled in the spouse's plan?

If the HRA is integrated with a plan offered by another employer, the HRA does not count toward the minimum value or affordability of the plan offered by the other employer

Opt-Out Provision

Under IRS rules, HRAs that are not limited to excepted benefits must include an opt-out provision regardless of the integration method selected. Under the terms of an HRA, an employee (or former employee) must be permitted to permanently opt out of and waive future reimbursements from the HRA at least annually. Upon termination of employment, either the remaining amounts in the HRA must be forfeited or the employee must be permitted to permanently opt out of and waive future reimbursements from the HRA. One question that has not been addressed is the potential impact of an HRA balance on a family member such as a spouse. A balance available in an HRA constitutes minimum essential coverage which makes the individual ineligible for a premium tax credit – which is the reason an opt-out provision is required for the employee (or former employee). Since HRAs typically cover all members of the employee's family, a balance in the account would appear to make all family members

ineligible for a premium tax credit. What is unclear is whether or not a waiver for non-employees should be included in an HRA.

Employer Contributions to the HRA

Probably the most important design decisions will be those related to employer contributions to the HRA. Only employer funds are permitted in an HRA. The employer has a lot of flexibility in determining how much money it chooses to spend; however, nondiscrimination rules (e.g., in favor of highly compensated employees or based on health factors) must be satisfied (see section 5 on nondiscrimination for more detailed information). Unlike a health savings account (HSA), or a health FSA there is no statutory limit on annual employer contributions to an HRA, except for QSEHRAs.

The employer will need to make decisions such as:

- **How much to contribute** – Will it be a flat amount per employee? Different amounts for employees that are single and those that have one or more family members? Different amounts based on the size of the family? As long as the employer can satisfy applicable nondiscrimination rules, the amount may also vary based on other factors such as union/nonunion or salaried/hourly.
- **Carry-over amounts** – Will employees be permitted to carry over all amounts unused at the end of the year to the next plan year? Will the employee be permitted to carry over unused amounts up to a specific dollar maximum? Will the carry over amount vary based on family status? Will the carry over amount be based on a percentage of the unused amount instead of a specific dollar value?
- **Timing** – When will the annual contribution be "credited" to the HRA? Will it be provided as a lump sum amount at the beginning of the plan year? Provided in equal installments at specified times such as monthly or quarterly?
- **Spend-down provision** – Will the HRA include a spend-down provision that permits an employee whose participation in the HRA has ended (typically at termination of employment) to access the funds to reimburse eligible expenses incurred after termination? If a spend-down provision is to be included, will the entire "balance" be available or will a percentage of the amount be available?

Many employers will include a limit on the maximum amount of money available in an HRA – either by including a dollar cap with no contributions added once that cap is reached, or by limiting the amount that may be carried over from a prior plan year. If the purpose of the HRA is to help the employee pay the required cost-sharing amounts such as deductibles and copayments, permitting an account balance to exceed the maximum out-of-pocket level may not be desirable. For example, in some cases it could adversely impact costs by affecting utilization (e.g., if the HRA financially rewards the use of out-of-network providers or more expensive brand-name drugs not on the formulary under the employer's primary medical plan).

Some employers credit wellness program rewards to an employee's HRA account. While employers are free to do so, there are several rules that must be kept in mind – plans generally may not discriminate in favor of highly compensated employees, and HIPAA and PPACA rules on wellness programs must also be followed.

Moreover, plan design elements such as carry-over and spend-down provisions may have an impact on the employer's COBRA obligations. A carry-over provision increases the account balance and the COBRA liability. Employees who are permitted to spend down an HRA balance after termination of employment may be less likely to select COBRA. See Section 6 and below for a more detailed discussion of COBRA rules for HRAs.

COBRA

Determining the HRA "benefit amount" that must be offered is one of the more challenging aspects of COBRA administration. "Benefit amount" is the coverage that is provided when the qualified beneficiary elects COBRA; it reflects the type of expenses that are reimbursable under the plan, the account balance, and annual (or other time frame) employer contributions. The determination can be especially complicated when an employee has eligible dependents. *Comment: QSEHRAs are not subject to COBRA.*

Following are a few examples outlining the issue. The first example involves a single employee.

Example: If an employer provides $1,000 per year under the HRA and Employee A has been in the plan for 3 years and has a $3,000 balance, the benefit amount will be $3,000. If that employee had been reimbursed for $1,000 in eligible expenses and had a $2,000 balance when the qualifying event occurred, the benefit amount would be $2,000. If the employee elects COBRA, the employee will also be eligible to receive the same employer contribution amount that is provided to active participants.

Next are two examples involving an employee with an eligible family member.

Example #1: Employer contributes $2,000 per year to employees with families ($1,000 per year to employees with no eligible family members). An employee with a spouse has a $6,000 balance in an HRA when they divorce. Neither the employee nor the spouse has ever had claims reimbursed by the HRA. The employee's now ex-spouse elects COBRA. There are two views on the "benefit amount" available to the ex-spouse and the HRA balance and accruals for the employee for future years (until the ex-spouse drops or exhausts COBRA).

- The ex-spouse may elect the entire $6,000 and will receive the $2,000 annual family allocation in the future; or
- The $6,000 balance is allocated on a 50/50 basis and the ex-spouse may elect $3,000 and receive future annual contributions of $1,000. The employee's HRA balance would be reduced to $3,000 and the employee would also receive future annual allocations of $1,000.

Which view the employer adopts will impact the amount available to the qualified beneficiary, the amount of future annual contributions, and the premium charged for COBRA coverage.

Example #2: Employer contributes $2,000 per year to employees with families ($1,000 per year to employees with no eligible family members). An employee with a spouse has a $3,200 balance at the beginning of the year. During the year the employee incurs $500 of eligible expenses and the spouse incurs $1,500 in eligible expenses so that once the claims are paid the balance will be $1,200. Similar to Example #1, there are different views on the "benefit amount" available to the ex-spouse and the HRA balance and accruals for the employee for future years (until the ex-spouse drops or exhausts COBRA).

- The entire $1,200 balance is the benefit amount available for COBRA. The ex-spouse may elect COBRA, have the $1,200 amount available, and receive annual additions of $1,000 per year in the future. The employee would also have a $1,200 balance and receive $1,000 annual additions.
- The amount available would be the full balance reduced by the qualified beneficiary's own expenses incurred prior to the qualifying event (this is the informal IRS view). In this example, the ex-spouse would be able to elect $1,700 (the $3,200 balance at the beginning of the year minus the ex-spouse's $1,500 in incurred claims) and would receive future annual allocations of $1,000. The employee would have a balance of $2,700 ($3,200 minus the employee's $500 in claims) and would also receive $1,000 annual allocations.
- Under a third view, the ending balance would be split equally – the beginning balance would be reduced for claims incurred prior to the split. Under this view, the amount available would be $1,200 ($3,200 minus $2,000 in claims) with $600 allocated to the employee and $600 available for COBRA for the ex-spouse. As an alternative, the balance might be split based on claims incurred before the qualifying event with the amount available for COBRA reduced by claims incurred. Under this view, the $3,200 beginning balance would be "split" into $1,600 for the employee and $1,600 for the spouse. Claims of $500 employee and $1,500 spouse would be subtracted from their respective "allocations" with the result being an amount of $100 available for the ex-spouse ($1,600 minus $1,500 in claims) and $1,100 for the employee ($1,600 minus $500 in claims). Both would be able to receive $1,000 annual allocations in the future.

Some of the potential problems that may be caused by COBRA can be ameliorated through plan design. For example:

- Many employers package the primary group medical plan and HRA so that they do not need to permit qualified beneficiaries to take COBRA for the HRA alone. This can reduce the potential for adverse selection where a beneficiary pays a few months of a fairly modest HRA COBRA premium, but receives reimbursement for substantial medical expenses after the qualifying event.
- Offer a spend-down provision as an alternative to COBRA when termination of employment is the qualifying event. COBRA must still be offered, but the qualified beneficiary may prefer a free spend-down to paying for COBRA and the plan sponsor would not need to provide future annual contributions if the employee chooses the spend-down instead of COBRA.
- Limit the amount of money that can be carried over each year. For example, the plan may permit a carryover only until a specified amount is reached – e.g., $10,000 for a single person and $20,000 for a family. This could limit the plan's COBRA liability. *(Comment: Does the employer want to enable an employee to accumulate a balance that exceeds the employee's maximum in-network out-of-pocket limit? If the employee does accumulate more funds, it could have some impact on utilization.)*

B. Plan Administration

Setting up the administration of a new HRA involves determining the funding method, establishing a process and rules for expense reimbursement, determining who will adjudicate claims, and creating plan documents and communication materials.

Funding

HRAs are typically self-insured rather than insured. Employers that self-insure HRAs must decide whether or not to fund the plan or to treat the HRA "account" as a bookkeeping entry with payments made from the employer's general assets. If the plan is to be funded, the employer will need to select a funding vehicle – such as a VEBA trust – and obtain needed legal and actuarial assistance. Employers that pay HRA claims from general assets will generally not need a trust, but must handle bookkeeping requirements such as tracking account balances and projecting expected expenses for budgeting purposes (and calculation of COBRA premiums).

An employer that elects to purchase insurance will want to know how premiums will be determined in the first and subsequent years and what happens when the insurance contract terminates. When a typical group health insurance contract, such as major medical terminates, the carrier is often only responsible for paying run-out claims - i.e., claims incurred before the date of termination, but submitted later. Will the current carrier pay run-out claims under the HRA? Generally, the succeeding carrier will be responsible for new claims. If employees have significant balances after several years

and the employer changes carriers, the new carrier may charge a higher premium to cover the potentially higher level of HRA claims.

Claims Adjudication

Another important decision is who will review and pay claims under the plan. Reimbursements under health plans – including HRAs – require third party substantiation of expenses. Most employers will purchase claims adjudication services from a Third Party Administrator ("TPA"). The TPA is then responsible for reviewing claims, making payments, providing necessary forms, and responding to claim appeals. Alternatively, an employer may choose to adjudicate its own claims, but will need to perform the same claims functions internally. Determinations such as medically necessary are generally made under the primary group medical plan rather than the HRA. If the HRA is non-grandfathered and subject to PPACA, the expanded claim appeal rules from PPACA would apply, and if any reimbursements do involve medical decisions such as medical necessity, the requirement to the use Independent Review Organizations would apply.

Claims adjudication for an HRA is often less complicated than for a primary medical or dental plan. If reimbursement is limited to cost-sharing amounts such as deductibles and copayments, substantiation of expenses can usually be satisfied with a copy of an Explanation of Benefits form ("EOB"). However, the employer will still need to create necessary forms and processes and handle any appeals. In addition, the employer will need to assign these responsibilities to someone (probably someone in HR) and some employees may be uncomfortable submitting claims to the HR department.

Reimbursement Ordering Rules

Employers must ensure that the Medicare Secondary Payer rules are followed. For an active employee group, the group health plan – including the HRA – will generally be required to pay before Medicare (see page 33 for more information on Medicare Secondary Payer rules). The employer will also want to ensure that another health plan does not designate the HRA as the primary payer under a Coordination of Benefits ("COB") provision, and the employer must also decide upon the ordering of payments if an employee has both an HRA and an FSA. The plan document and communications to employees should indicate the payment ordering rules.

Because of the limited carry-over amount permitted under a health FSA (maximum $500), many employers will want to have the HRA make reimbursements after the health FSA has been exhausted in order to reduce the potential for employee forfeitures under the health FSA.

Because an HRA is a group health plan, but is virtually never intended to provide primary health coverage, it would be prudent to include a COB provision designed to reflect the fact that the plan is an HRA. The model COB provision – which is used by most states and employer-sponsored group health plans - has an established procedure for determining who pays first, second, third, etc. when an individual has coverage under more than one contract or plan. Under the model COB provision, any group health plan that **does not** contain a COB provision is automatically first. However, the COB provision should be modified so that the HRA pays after other primary group medical plans. An HRA that adopts the model COB provision "as is" may find that it is being designated as the primary payer based on the standard COB rules.

C. Plan Documentation and Communication

The employer implementing the HRA must create the necessary plan documentation and communication materials. A formal, written plan document is necessary to meet IRS requirements. The HRA plan document should include all of the details of the plan design, appropriate plan administration language (e.g., COB, funding, claims & appeals, COBRA), and include crucial standard provisions such as plan amendment and termination provisions. If the plan is established by an employer subject to ERISA the appropriate ERISA language such as fiduciary language must be included.

Employers will also need to include appropriate language in the SPD for the primary medical (or similar document for non-ERISA plans) or create a separate SPD for the HRA. Changes must be communicated via a summary of material modification or material reduction (or similar document for non-ERISA plans). The SBC for the medical plan may be modified to include information about the HRA.

D. Design Problems to Avoid

There are a few types of plan designs that employers should either avoid or handle carefully since they may (in some cases will) create a compliance problem. A few potential design problems are described below.

Service or Salary-Related Contribution Amounts

Some employers have wanted to make HRA contributions that were a percentage of an employee's compensation or that provided higher contributions for longer service employees. HRAs that are self-insured are subject to the nondiscrimination requirements under Section 105(h), which prohibits discrimination in favor of highly compensated individuals (generally the top 25% by compensation of non-excludable employees). Under IRS regulations, the employer contributions to an HRA must be uniform for all participants (they may vary based on a limited number of factors such as family status) and may not be modified by reason of a participant's age or years of service. In addition, if the employer contribution or type or amount of benefits eligible for reimbursement are in proportion to employee compensation, the plan will be discriminatory.

PPACA added a nondiscrimination requirement for non-grandfathered fully insured health plans that is to be "similar" to the requirements under Section 105(h). Implementation of this requirement is currently delayed until the IRS issues regulations. Employers may want to avoid implementing a plan that will need to be terminated or significantly redesigned once the IRS issues regulations. The potential penalty for failing to satisfy the nondiscrimination requirement under a fully insured plan is substantially different than under a self-insured plan. If a self-insured plan is discriminatory, the result is taxable income to some (or potentially all) highly compensated employees. If an insured plan is discriminatory, the penalty is a $100 per day per affected person non-deductible excise tax on the employer.

Ineligible Individuals

Employers must be careful to restrict participation to employees and employees' tax dependents. An employer may choose to reimburse expenses for individuals such as an employee's domestic partner who is not the employee's tax dependent, but only if the value of coverage is included in the employee's taxable income. If the HRA reimburses expenses of an ineligible participant such as a self-employed individual the plan does not qualify as an HRA under section 105. If the plan reimburses expenses for a non-tax dependent such as a domestic partner or a domestic partner's child without imputing income to the employee, the plan does not qualify as an HRA under Section 105. If the plan does not qualify under Section 105, all amounts paid to all participants will become taxable income.

Cash Outs

An HRA may include a "spend-down" provision that permits former participants to be reimbursed for eligible expenses after termination. An HRA may not include a provision that permits an employee to receive cash from the HRA. Nor may a plan purchase certain life insurance policies that have cash value in order to permit the employee to receive any part of an unused balance in cash. If the HRA permits a cash payment – directly or indirectly – it does not qualify as tax exempt under Section 105 and all reimbursements become taxable income.

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HRA IMPLEMENTATION CHECKLIST

The checklist below includes major plan provisions along with funding, communication and administration decisions that should be a part of the process of implementing a new HRA, or modifying an existing one. It lists plan provisions and implementation issues such as communications, but does not discuss why a particular provision should or should not be included. A discussion of those issues is contained in other places in this guide. The far right column in the checklist indicates the page number where each design, compliance, communication, or administrative element is discussed.

Health Reimbursement Arrangements – Implementation Checklist		Pages
Plan Provisions		
1. Select Basic Structure	☐ Stand-alone* ☐ Integration method ☐ Minimum value ☐ Non-minimum value ☐ Integrate with other group health plan? ☐ QSEHRA	2-7 37-41
2. Determine Eligible Employees	☐ All full-time employees ☐ Other	8-9 23-26 38 49
3. Determine Eligible Dependents	☐ Spouse ☐ Children to age 26 ☐ Older child not tax dependent (e.g., age 29) ☐ Domestic partner (define – e.g., same-sex only) ☐ Domestic partner's children ☐ Other tax dependents	8-9 38 49

Health Reimbursement Arrangements – Implementation Checklist		Pages
4. Decide Eligible Expenses	☐ All IRS permitted expenses ☐ Expenses under primary group medical plan ☐ Non-essential health benefits (e.g., dental) ☐ Cost-sharing amounts, premiums and non-essential health benefits ☐ Premiums (as permitted) ☐ Long-term care expenses (as permitted) ☐ Other	13-20 27-29 38-41
5. Identify Specific Exclusions	☐ Cost containment penalties ☐ Out of network expenses (except emergency) ☐ Expenses other than cost-sharing, premiums and non-essential health benefits** ☐ Primary group medical plan exclusions ☒ Expenses not permitted under IRS rules (must be excluded) ☐ Premiums (specify) ☐ Dental ☐ Vision ☐ Long-term care expenses ☐ Other	13-20 27-29
6. Opt-out Provision	☐ Included ☐ HRA reimburses only excepted benefits	41-42

Health Reimbursement Arrangements – Implementation Checklist		Pages
7. Employer Contributions		
a. Annual Dollar Amount	☐ Single	6
	☐ Family	10-12
	☐ Wellness credits	42-43
	☐ Other basis	46
b. Frequency	☐ Annual	
	☐ Quarterly	
	☐ Monthly	42
	☐ Other	
	☐ Timing (e.g., begin/end of quarter)	
c. Carry-over Amount	☐ Dollar value	
	☐ Percentage	10
	☐ No limit	42-43
	☐ No carry-over	
d. Spend-down Provision	☐ Full amount	8
	☐ Dollar limit	20
	☐ Percentage	42-43
	☐ Time limit (e.g., within 2 years)	46
	☐ No spend-down	49
8. Reimbursement Ordering Rules	☐ HRA then FSA	
	☐ FSA then HRA	47-48
	☐ Modified COB Provision	
9. Reimbursement Timing	☐ Time limit for claim submission	19-20
10. Determine COBRA Options	☐ Combined with primary group medical plan	30-32
	☐ Separate offer and election	43-46

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Health Reimbursement Arrangements – Implementation Checklist		Pages
Funding, Communications, and Administration		
1. Select Financing Option	☐ Payments from general assets ☐ Funded – separate account or trust (legal assistance recommended) ☐ Insured	9-12
2. Select Claims Administrator	☐ TPA or carrier acting as TPA ☐ Internal ☐ Carrier (Insured)	17-18 21-22 46-47
3. Review Agreement(s)	☐ TPA agreement ☐ Insurance contract	
4. Create Plan Document	☐ Completed ☐ In progress	48-49
5. Create Employee Materials	☐ SPD (or similar) ☐ SMM/SMR ☐ SBC ☐ Announcement/other communication	32 48
6. Create Needed Forms (e.g., claims & waiver forms)	☐ Use TPA or carrier forms ☐ Completed ☐ In progress	4-5 41-42
7. Establish Funding (if applicable)	☐ Completed ☐ In progress ☐ Not Applicable	9-12
8. MSP Reporting	☐ TPA/carrier reports ☐ Plan sponsor reports	33-34
9. HIPAA Privacy & Security	☐ Include with primary group medical plan ☐ Separate documents, policies & procedures	33

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Health Reimbursement Arrangements – Implementation Checklist		Pages
10. Develop COBRA Rates	☐ TPA or carrier calculates ☐ Plan sponsor calculates	31-32
11. Modify COBRA Notices & Forms (for non-QSEHRA)	☐ General Notice ☐ Election Notice ☐ Forms	
12. Modify FMLA Procedures	☐ Completed ☐ In progress	32
13. Impute Income as Needed (e.g., domestic partner coverage)	☐ Completed ☐ N/A	8-9 13 49
14. Form 5500 Filing & SAR (if applicable)	☐ Completed ☐ In Process	5 32
15. Develop HRA Termination Steps (for future if/when needed)	☐ Completed ☐ In Process	

** May be used only for retiree-only HRA, HRA that reimburses only excepted benefits, or QSEHRA*

*** Required if integrated with a primary group medical plan that does not provide minimum value*

Reviewed by _____ Date: _____