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TO: The Council

FROM: Scott Sinder
Kate Jensen

RE: Proposed Rules to Expand Access to Health Reimbursement Arrangements

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Yesterday, the Departments of Treasury, Labor, and Health and Human Services (the "Departments") released proposed rules to expand the use of, and access to, Health Reimbursement Arrangements ("HRAs") and "other account-based group health plans."[1] This is the long-awaited third prong of the President's directive to the Departments to increase flexibility and affordability in the healthcare market (coming on the heels of rules to expand association health plans and short-term limited duration ("STLDI") plans).

Subject to certain conditions, the proposed rule would:

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[1] "Account-based group health plans" are generally defined in the proposal as employer-provided group health plans that provide for reimbursement of medical care expenses (as defined in 26 U.S.C. 213(d)), subject to a maximum reimbursement amount for a given period (e.g., a plan year). HRAs are a type of account-based group health plan. HRAs are funded solely by employer contributions and reimburse employees solely for medical care expenses incurred by the employee or the employee's spouse, dependents, or children age 26 or younger. References in the proposal's preamble and this memo to "HRAs" include health reimbursement arrangements and other account-based health plans satisfying that general definition.

- Allow "integration"[2] of HRAs with individual health coverage (not just group coverage) purchased on or off the exchanges;[3]
- Recognize HRAs as limited excepted benefits in some circumstances;
- Provide premium tax credit ("PTC") eligibility for individuals offered, but opting out of and waiving reimbursements from, HRA coverage integrated with individual coverage;
- Provide clarification for HRA and qualified small employer health reimbursement arrangement ("QSEHRA") sponsors regarding conditions for *avoiding* individual coverage purchased with such plans becoming subject to ERISA; and
- Offer a special enrollment period in the individual market for individuals who gain access to an integrated HRA or are provided a QSEHRA.

Below is a more detailed discussion of the proposal's provisions. Comments are due 60 days after the proposal's publication in the Federal Register. We anticipate filing comments on behalf of The Council, particularly on the following issues that likely will be impactful for Council members and their clients:

- Any concerns related to destabilization of the employer-sponsored and/or individual markets, including adverse selection issues, and potential modifications to the proposal to remedy such concerns?
- What clarifications and/or provisions (e.g., safe harbors) should be included in future guidance on how these proposed rules interact with the employer mandate—a subject not covered in this proposal but reserved for later regulatory action?
- Whether HRAs should be allowed to integrate with non-group coverage that is not considered "individual insurance" like STLDI?
- Whether additional clarification is needed regarding applicability of Title I of ERISA to HRAs integrated with non-ERISA individual insurance coverage (e.g., applicability of ERISA reporting and disclosure requirements)?

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[2] "Integration" of HRAs with other health coverage offered by a plan sponsor – historically, group health coverage – allows HRAs to be linked with/reimburse coverage that on its own would satisfy the ACA's annual/lifetime limit and preventive service prohibitions (provisions not satisfied by standalone HRAs because of their limited benefits). Because one requirement for HRA integration is that the individual participant actually be enrolled in the other primary coverage offered by the sponsor, the Departments allow the combined benefits (primary coverage plus HRA coverage) to satisfy these ACA requirements.

[3] Notably, the proposal does not make substantive changes to current regulations regarding integration of HRAs with another group health plan.

We would appreciate hearing from interested Council members on these or any other topics in the proposal **by November 30**.

KEY PROVISIONS OF THE PROPOSED RULE

I. HRA Integration Rules Expanded to Include Individual Insurance Coverage

A. Proposed mechanics of individual coverage-HRA integration

Currently, standalone HRAs (treated as a type of self-insured group health plan) generally violate the Affordable Care Act's ("ACA") prohibitions on lifetime and annual limits for essential health benefits ("EHBs") and cost-sharing for certain preventive care, unless they are "integrated" with group – but not individual – health coverage that on its own satisfies these ACA provisions. Under previous Department guidance, this linking of HRAs with other primary coverage offered by the sponsor – as long as the participant is actually enrolled in the other coverage – allows the combined benefit (HRA coverage plus primary plan coverage) to satisfy the ACA's requirements. The proposed rule would now permit HRAs to be integrated with individual health coverage for purposes of complying with the above-referenced ACA prohibitions.

Moreover, because HRAs are considered eligible employer plans, individuals are ineligible for premium tax credits ("PTCs") if they are covered by an HRA or are eligible for an HRA that is affordable and provides minimum value ("MV") (because the HRA then constitutes an offer of Minimum Essential Coverage ("MEC")). The proposal provides PTC eligibility rules for individuals who are offered HRAs integrated with individual coverage – namely, employees may opt out of and waive future reimbursements under the HRA to avoid any adverse impact on their PTC eligibility and employers must notify employees about, among other things, the impact of the HRA on employees' ability to take advantage of the PTC and the opt out option.[4]

To be integrated with individual coverage, HRAs must satisfy the following conditions:

- Require all participants and dependents covered by the HRA to be enrolled in individual health coverage (other than coverage comprised solely of excepted benefits) and implement and comply with "reasonable procedures" to substantiate compliance with this condition;[5]

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[4] The proposal does not change the rule that if an individual is actually covered by the HRA integrated with individual health coverage s/he is not eligible for the PTC, regardless of whether the HRA constitutes MEC.

[5] "Reasonable procedures" include third-party documentation (e.g., insurance card) showing coverage or an attestation from the plan participant. Such substantiation must be

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- To avoid discrimination based on health status and/or adverse selection issues, employers may not offer a traditional group health plan[6] and an HRA integrated with individual coverage to the same class of employees; and

- Within a class of employees, the integrated HRA must be offered on the same terms to all employees in the class.[7]

Permissible employee classes under the proposal are:

- Full-time employees;
- Part-time employees;
- Seasonal employees;
- Employees in a unit covered by a collective bargaining agreement ("CBA");
- Employees who have not satisfied coverage waiting period requirements;
- Employees under age 25 at the beginning of the plan year;
- Non-resident aliens with no U.S.-based income;
- Employees whose primary site of employment is in the same rating area; and
- Groups of employees described in two or more of the above classes (e.g., part-time employees covered by a CBA and full-time employees covered by a CBA may be treated as separate classes).[8]

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provided/confirmed for the plan year and prior to each reimbursement by the HRA (and may be included as part of the reimbursement request form).

[6] "Traditional group health plans" are group health plans other than account-based group health plans or plans consisting solely of excepted benefits.

[7] The proposal clarifies that offering a more generous HRA to individuals based on adverse health factors violates the "same terms" condition. It is permissible, however, under this prong to increase the maximum HRA dollar amount based on age and family size (so long as everyone of the same age/family size is treated the same). It also is permissible to offer HRAs to some former employees, but not others (e.g., based on duration with the employer) – again, as long as the distinction is applied consistently across former employees.

[8] Former employees are treated as being in the class they were in immediately before leaving the job. The Departments propose to use definitions for these classes that are already in use under Internal Revenue Code sections 105(h) and 4980H. For "full-time," "part-time," and "seasonal" employee classes, employers may choose which set of definitions to apply (105(h) or 4980H), but they must be consistent in their approach across class definitions. For the other classes, the 105(h) definitions would apply.

B. Interaction of proposed integration rules with the employer mandate

HRAs are eligible employer-sponsored plans for purposes of the employer mandate, so applicable large employers ("ALEs") will avoid a penalty under section 4980H(a) if they offer an HRA to 95% of their full-time employees. ALEs that offer an HRA to 95% of full-time employees will be subject to a section 4980H(b) penalty, however, if at least one full-time employee is allowed a PTC. The PTC is allowed if the employer-sponsored coverage (HRA) is not affordable or does not provide MV, or if the employee was not offered the coverage.

Given the opt-out option described above (allowing individuals to get the PTC if they opt out of an affordable MV HRA), the Departments plan to issue further guidance on whether an employer that offers an HRA integrated with individual coverage would be treated as having offered affordable coverage that provides MV, regardless of whether the employee declines the HRA coverage and opts for the PTC. The Departments anticipate that the guidance will include an "affordability safe harbor" for ALEs.

C. ERISA clarification

The Departments propose to clarify that individual health insurance the premiums for which are reimbursed by an HRA does not constitute and "employee welfare benefit plan," a "welfare plan," or a "group health plan" (which would bring the coverage within the purview of ERISA), if certain conditions are satisfied. This clarification also applies to purchases of individual health insurance reimbursed by a qualified small employer health reimbursement arrangement ("QSEHRA") and supplementary salary reduction arrangements.[9]

The conditions for HRA-, QSEHRA- and supplementary arrangement-reimbursed individual coverage to avoid being classified as an employee welfare plan or group coverage subject to ERISA include:

- The purchase of the individual coverage must be completely voluntary for employees;
- The employer/plan sponsor does not select or endorse any particular issuer or coverage and receives no consideration in connection with the employee's coverage selection;

[9] Note that the status under ERISA of an HRA, QSEHRA, or supplemental salary reduction arrangement would remain unaffected. The proposal simply keeps the individual coverage purchased with the help of such arrangements from becoming part of a group health plan.

- Reimbursement for non-group insurance premiums is limited solely to individual health insurance coverage (and therefore would not include short-term limited duration plans ("STLDI")); and
- Annual notification to plan participants that individual coverage is not subject to ERISA.

II. Excepted Benefits HRAs

The Departments propose to exercise their discretion to add HRAs to the list of limited excepted benefits, if certain conditions are met. Recall, because coverage consisting of excepted benefits is not minimum essential coverage ("MEC"), an offer of, or enrollment in, such coverage does not render an individual ineligible for the PTC. The Departments propose to offer this option because some employers may wish to offer HRAs that are not integrated with any other insurance coverage (group or individual).

An "excepted benefit HRA" must satisfy the following conditions:

- Must not be an integral part of a health plan;
- Must provide benefits that are limited in amount to $1800, indexed for inflation, per plan year (disregarding carryover amounts from previous HRA plan years);
- Cannot provide reimbursement for premiums for certain health insurance coverage (individual insurance, group health plan, Medicare Parts B or D), but may reimburse premiums for coverage (group or individual) that consists solely of excepted benefits, STLDI, and COBRA; and
- Must be made available under the same terms to all similarly situated individuals (as defined in HIPAA nondiscrimination rules), regardless of health factor.

With respect to the first condition, other group health plan coverage (not consisting solely of excepted benefits) must be made available by the same plan sponsor for the plan year to the participants offered the HRA.[10] Only individuals eligible for the other group health plan may be eligible to participate in the excepted benefit HRAs. Moreover, due to the restrictions outlined above for offering HRAs integrated with individual coverage, employers would not be allowed to offer both an HRA integrated with individual coverage and an excepted benefits HRA to the same employee.

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[10] While other group coverage must be offered by the sponsor, HRA participants would not have to actually enroll to be eligible for the HRA.

III. Individual Market Special Enrollment Periods

Because one requirement for integrated HRAs is enrollment in individual insurance coverage and because QSEHRAs generally require enrollment in MEC, the Departments propose to allow HRA and QSEHRA participants to enroll in individual coverage or change their individual coverage (on or off exchange) outside of annual open enrollment periods if an individual gains access to an HRA integrated with individual insurance or is provided a QSEHRA.

IV. Applicability Dates

The Departments propose that the individual coverage integration rules, excepted benefit HRA rules, and ERISA clarifications described above will be applicable to group health plans, issuers, and taxpayers for plan years beginning on or after January 1, 2020.