Scott A. Sinder
202 429 6289
ssinder@steptoe.com

1330 Connecticut Avenue, NW
Washington, DC 20036-1795
202 429 3000 main
www.steptoe.com

Steptoe
STEPTOE & JOHNSON LLP

October 1, 2019

TO: The Council

FROM: Scott Sinder
Kate Jensen
Chelsea Gold

RE: Expansion of Access to Health Reimbursement Arrangements – ***UPDATED Oct. 1 to incorporate the proposed rule on employer mandate and Section 105(h) safe harbors***

On June 13, the Departments of Treasury, Labor, and Health and Human Services (the "Departments") released a final rule to expand the use of, and access to, Health Reimbursement Arrangements and "other account-based group health plans" (collectively referred to in this memo as "HRAs").[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

[1] "Account-based group health plans" are generally defined 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). Plan sponsors may limit the medical care expenses that are reimbursable to, for example, only premiums. 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 up to a maximum dollar amount for the coverage period (with leftover amounts often carried over to subsequent years).

References in the preamble to the rule and this memo to "HRAs" include health reimbursement arrangements and other account-based health plans satisfying that general definition (e.g., employer payment plans and health FSAs). QSEHRAs, MSAs, HSAs, and cafeteria plans are not considered account-based health plans covered by this rule.

heels of rules to expand association health plans and short-term limited duration ("STLDI") plans).

Subject to certain conditions, the rule:

- Allows "integration"[2] of HRAs with individual health insurance coverage purchased on or off the exchanges (referred to in the rule and this memo as "individual coverage HRAs") to satisfy ACA coverage requirements;[3]
- Requires "opt out" rights for participants offered individual coverage HRAs (with those opting out of unaffordable individual coverage HRAs remaining eligible for premium tax credits ("PTC") on the exchanges);
- Recognizes HRAs as limited excepted benefits in some circumstances ("excepted benefit HRAs");
- Provides clarification for HRA and qualified small employer health reimbursement arrangement ("QSEHRA") sponsors on how to *avoid* individual coverage purchased with such plans from becoming group plans subject to ERISA; and
- Offers a special enrollment period in the individual market for individuals who newly gain access to or enroll in an individual coverage HRA or a QSEHRA.

Following issuance of the final HRA rule, the Department of Treasury and the Internal Revenue Service released proposed rules governing how this new structure interacts with the employer mandate and certain Section 105(h) nondiscrimination provisions (hereinafter, the "interim safe harbors").[4] Comments are due on the proposed/interim safe harbors by December 30, 2019.

The final HRA rule is generally applicable as of **January 1, 2020** and taxpayers may rely on the interim employer mandate and 105(h) safe harbors until **6 months** after those final rules are published. Below is a more detailed discussion of these provisions.

---

[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] The rule also allows HRA integration with Medicare Part A and B or Part C, which likely is of less interest to Council members and is not a focus of this memo.

[4] Proposed Rule, *Application of the Employer-Shared Responsibility Provisions and Certain Nondiscrimination Rules to Health Reimbursement Arrangements and Other Account-Based Group Health Plans Integrated with Individual Health Insurance Coverage or Medicare*, 84 Fed. Reg. 51471 (Sept. 30, 2019), https://www.govinfo.gov/content/pkg/FR-2019-09-30/pdf/2019-20034.pdf.

KEY PROVISIONS OF THE FINAL AND PROPOSED RULES

I. HRAs Integrated with Individual Insurance Coverage

A. Individual Coverage HRAs under the ACA – Integration and PTC Eligibility

1. *Integration with Individual Coverage*

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 prohibitions for certain preventive care. But when integrated with or linked to other coverage that independently satisfies these ACA provisions, HRAs have been considered ACA-compliant group coverage—as long as the participant is actually enrolled in the other coverage linked with the HRA.

Notably, prior guidance restricted such HRA integration to other group health coverage. The rule now permits HRAs to be integrated with individual health coverage for purposes of complying with the above-referenced ACA provisions.[5]

The final rule clarifies that individual coverage with which an HRA may be integrated includes:

- catastrophic coverage,
- grandmothered individual health insurance coverage, and
- student health insurance that satisfies the requirements in 45 C.F.R § 147.145 (does not include self-insured student health insurance),

but does not include:

- coverage consisting solely of excepted benefits,
- STLDI,
- other non-HRA group coverage such as spousal coverage,
- healthcare sharing ministries, or
- TRICARE.

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 and the HRA must implement and comply with "reasonable procedures" to substantiate compliance with this condition;[6]

[5] The rule does not make substantive changes to current regulations regarding integration of HRAs with another group health plan. Moreover, for individual coverage eligible to be integrated with HRAs, the Departments clarify that it is reasonable to assume—without independent verification by the beneficiary or HRA—that such coverage sold in the individual market (including grandfathered coverage) satisfies the ACA's requirements with respect to annual/lifetime limits for EHBs and free preventive care.

- To avoid discrimination based on health status and/or adverse selection issues, employers/plan sponsors may not offer a traditional group health plan[7] and an individual coverage HRA to the same class of employees;[8] and
- Within a class of employees, the individual coverage HRA must be offered on the same terms to all employees in the class.[9]

---

[6] "Reasonable procedures" include third-party documentation (e.g., insurance card, carrier lists, etc.) showing coverage or an attestation from the plan participant. Such substantiation must be 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). The Departments are providing model attestation language that would fulfill the substantiation requirement—HRAs may, but are not required to, use the model language. HRAs may rely on documentation and attestations provided, unless they have actual knowledge that the participant is not enrolled in eligible health coverage.

Failure to maintain enrollment in the integrated individual coverage causes prospective forfeiture of the individual coverage HRA.

[7] "Traditional group health plans" are group health plans other than account-based group health plans or plans consisting solely of excepted benefits. Under this definition, employers may offer individual coverage HRAs and a separate HRA that only reimburses premiums for excepted benefits. They also may, for individuals with individual coverage HRAs that purchase individual coverage outside of an exchange, allow employees to pay the balance of their premium through a cafeteria plan (the rule's preamble notes that any requested changes to existing cafeteria plan guidance or regulations are outside the scope of this rulemaking).

[8] There is a special rule for new hires. If an employer currently offers a traditional group health plan and wants to allow current employees to continue that coverage, but also wants to phase in individual coverage HRAs for new hires, the employer may prospectively—as of a specified hire date post-January 1, 2020—offer employees coming into a certain class individual coverage HRA without having to transition current employees in that same class over to the HRA (effectively creating a "new hire" subclass). Again, however, employers may not offer current employees or new hires a *choice* between the traditional plan and the HRA. The special rule for new hires may be discontinued by the plan sponsor at any time and may be used again in the future under the same rules/terms as its initial application.

[9] The rule 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 the maximum dollar amount made available to the oldest participants is not more than three times the amount made available to the youngest participants (i.e., satisfies the 3:1 age rating limit) and so long as everyone of the same age/family size is treated the same.

It also is permissible to offer individual coverage HRAs to some former employees based on the class in which the former employee was included prior to leaving the job. Employers do not have to offer to former employees, but if they do, they must offer to all former employees from that same class on the same terms (so, for example, it would violate these rules to offer larger or smaller HRA amounts to former employees from the same class based on years of service).

For new employees and/or dependents joining mid-year, under the same terms requirement, the individual coverage HRA may make the full amount available or adopt a reasonable proration methodology (which must apply equally to the same class and be established before the plan year).

The permissible employee classes under the final rule are:

- Full-time employees;
- Part-time employees;
- Salaried employees;
- Non-salaried employees;
- Employees of an entity that hired the employees for temporary placement to an unrelated entity (e.g., temp/staffing agency placements);
- Seasonal employees;
- Employees in a unit covered by a collective bargaining agreement ("CBA") or a related participation agreement;
- Employees who have not satisfied coverage waiting period requirements;
- 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).[10]

The Departments did make some notable changes, vis-à-vis the proposal, with respect to employee classes. They removed the "under 25" class in the final rule, but added salaried and non-salaried employees as permitted classes, along with employees hired for temporary placement from a placement agency (this does not extend to independent contractors or self-employed individuals who may not be provided tax-favored HRAs).

Also, to better address adverse selection concerns raised in comments, the Departments have added a minimum class size requirement in some circumstances. The minimum class size requirement varies based on employer size and only applies to certain class types (and does not apply to classes offered traditional group health plans). The following provisions apply:

- Class size only applies if the plan sponsor offers a traditional group health plan to at least one class and an individual coverage HRA to at least one other class.

It also does not violate the "same terms" requirement to offer the same class of employees a choice between an individual coverage HRA that is HSA-compatible and one that is not HSA-compatible.

Finally, classes of employees are determined at the common law employer level, not at the controlled group level.

[10] Again, former employees are treated as being in the class they were in immediately before leaving the job. The Departments will use definitions for these classes that are already used under the 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.

- It applies to the following class types (referred to as "applicable classes") and to any "combined" class consisting of one of these classes (except no combination with the waiting period class is subject to the class size requirement):

  - Salaried employees;
  - Non-salaried employees;
  - Full-time employees (only if part-time employees are offered traditional plans);
  - Part-time employees (only if full-time employees are offered traditional plans); and
  - Employees whose primary site of employment is in the same rating area.

- The class size minimums are as follows:

  - For employers with fewer than 100 employees, class size must be at least 10;
  - For employers with 100 to 200 employees, class size must be 10% of the total number of employees (rounded down to a whole number); and
  - For employers with more than 200 employees, class size must be at least 20.[11]

2. *PTC Eligibility & Affordability Calculation for Individual Coverage HRAs*

Additionally, 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 rule allows individuals who are offered individual coverage HRAs to opt out and waive future reimbursements under the HRA (the opt out will be deemed to apply to dependents as well). The opt out option must be available once for each plan year—in advance of the plan year—but there may not be multiple opt in/out opportunities during the course of the plan year (except an opportunity upon termination).

Ultimately, with respect to claiming the PTC (which remains available only through the exchanges):

- An individual may not claim the PTC for any month s/he is covered by the HRA;
- An individual who receives an offer but opts out of an affordable HRA may not claim the PTC; but
- An individual who opts out of an unaffordable HRA may claim the PTC.

[11] Class sizes are based on the number of employees in the class who are *offered* (not enrolled in) the individual coverage HRA as of the first day of the plan year. Again, former employees are considered to be members of the same class in which they were members before they left service, and classes are determined at the common law employer level, not the controlled group level. New hire subclasses are not covered by the minimum size rules, unless the new hire subclass is subsequently divided by a permissible class distinction.

The rule details how individual coverage HRAs' affordability should be calculated. Generally, an individual coverage HRA is affordable for an employee for a month if the employee's required HRA contribution does not exceed 1/12 of the product of the employee's household income and the required contribution percentage (as defined under current affordability regulations). The "required HRA contribution" is the excess of: (1) the monthly premium for the lowest cost silver plan[12] for the employee for self-only coverage offered by the exchange for the rating area in which the employee resides (the HRA "affordability plan"); over (2) in general, the self-only reimbursement amount the employer makes available to the employee under the individual coverage HRA for the month.

Only amounts made newly available for the plan year of the HRA (e.g., not carryover amounts) are considered in the affordability calculation. Individual coverage HRAs that are affordable under this calculation are treated as providing minimum value for the month.

3. *Notice Requirement Regarding Consequences of Coverage Under Individual Coverage HRAs*

Employers must notify employees in writing about, among other things, the impact of the HRA on employees' ability to take advantage of the PTC and the opt out option. Notices generally must be delivered to eligible participants at least 90 days before the start of the plan year; and for newly eligible participants, no later than the date on which they become eligible.

The notice, which need not be individualized, must include:

- Description of the terms of the individual coverage HRA (including amounts available for reimbursements);
- Statement of the right to opt out of future reimbursements under the HRA;
- Description of the potential availability of the PTC if the participant opts out and the HRA is not affordable, and how the participant can get assistance in determining the coverage's affordability;
- Description of the PTC consequences if a participant is covered by the HRA;
- Statement that the participant must provide certain information to exchanges about the HRA;
- Statement that there are many types of HRAs and the type being offered is an individual coverage HRA (not, for example, a QSEHRA or other type);
- Contact information for persons who can answer questions about the HRA;

[12] The Centers for Medicare and Medicaid Services released an Individual Coverage HRA Employer Lowest Cost Silver Plan Premium Look-Up Table to allow employers to access individual market lowest cost silver plan data by geographic location. For more information, *see* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Employer-Initiatives/Employer-Initiatives.html.

- Statement of availability of a special enrollment period for newly eligible employees/dependents;
- Dates as of which the HRA coverage may become effective and dates the plan year begins and ends;
- Statement that individual coverage HRA may be integrated with Medicare, but that Medicare beneficiaries are ineligible for the PTC; and
- Any additional information that does not conflict with the required content.

The Departments are providing model language to help ease the burden of this new notice requirement on employer sponsors.

B. Interim Safe Harbors for the Employer Mandate and Section 105(h) Nondiscrimination Rules

1. *Employer Mandate Affordability Safe Harbors*

Because an individual coverage HRA constitutes an offer of an eligible employer-sponsored plan, for ALEs, the employer mandate's affordability determination—as well as the penalty exposure—comes into play. Specifically, because multiple components of the affordability calculation will vary between individual employees (and thus create significant administrative hurdles for ALEs trying to make affordability determinations), the interim safe harbors build on prior proposed guidance[13] and sets forth optional affordability safe harbors regarding:

- The location that may be used to identify the employee's affordability plan;
- Use of a "look-back month safe harbor" for premium information; and
- Application of existing safe harbors—W-2 wages, rate of pay, and federal poverty line—to the individual coverage HRA context.

i. ***Location Safe Harbor***

Because the affordability determination for individual coverage HRAs will be based on the lowest cost silver plan for each employee in the rating area in which the employee resides—a factor that will vary by employee—the interim safe harbors allow ALEs to use the cost of the affordability plan at an employee's "primary site of employment" (rather than their place of residence) to determine whether an offer of an individual coverage HRA is affordable.[14]

[13] IRS Notice 2018-88 (Oct. 2018), https://www.irs.gov/pub/irs-drop/n-18-88.pdf.

[14] Although affordability plan premiums will vary based on employees' age, an age-specific safe harbor is not included among the interim safe harbors. The proposal does, however, clarify *when* an employee's age would be determined for a plan year for the purposes of determining affordability under the other safe harbors—for an employee who is eligible for an individual coverage HRA on the first day of the plan year, age would be determined on the first day of the plan year; for an employee who becomes

The "primary site of employment" would generally be the location at which the employer "reasonably expects the employee to perform services on the first day of the plan year" (or on the first day the HRA may take effect). The interim safe harbors also address how to determine the primary site of employment for:

- Employees whose primary site of employment would be "treated as changing"[15] (i.e., the location as of the first day of the second calendar month after the employee has begun performing services in the new location);
- Teleworkers with assigned office space/a particular location to which they may be required to report (i.e., the location to which the employee would report to provide services if requested); and
- Employees who work from home/another location that is not the premises of the ALE or an assigned office space (i.e., the location of the employee's residence).

In instances when employees' "primary site of employment" falls within a rating area with multiple lowest cost silver plans (i.e., if different insurers only offer coverage in parts of rating areas by, for example, zip code or county), the interim safe harbors use the lowest cost silver plan in the part of the rating area that includes the employee's primary site of employment. This may result in an administrative burden for employers with multiple worksites within a rating area, as the amount that an employer would need to make available under an individual coverage HRA may vary by zip code or county, rather than by rating area.

ii. *Look-Back Month Safe Harbor*

The affordability of an individual coverage HRA for a month is determined, in part, based on the cost of the affordability plan for that month. This can be problematic for employers that set benefits for a plan year well in advance of the start of the plan year. To address this issue, one of the interim safe harbors allows employers to use prior premium information to determine affordability. Specifically, this interim safe harbor allows, for all calendar months of the plan year:

- Employers with calendar-year plans to use the monthly premium for the applicable affordability plan[16] for January of the prior calendar year;

---

eligible during the plan year, age would be determined as of the date the HRA can first become effective for the employee.

[15] This determination would apply if the location at which the employee performs services changes and the employer expects the change to be permanent or indefinite.

[16] Note that you still use the employee's *current* age and applicable location for this safe harbor. So, if the employee's applicable location changes during the plan year, the look-back month safe harbor still applies, but the employer must update the applicable affordability plan for that employee.

- Employers with non-calendar year plans to use the monthly premium for the applicable affordability plan for January of the current calendar year; and
- Employers to use the look-back month safe harbor in conjunction with the other interim safe harbors or on its own (i.e., an ALE may apply the look-back month safe harbor even if the ALE chooses not to use the location safe harbor and instead bases the affordability plan on employee residence).

iii. ***Application of Current Safe Harbors to Individual Coverage HRAs***

As described above, whether an offer of coverage is "affordable" will depend on a calculation tied to an employee's household income. Because an employee's household income is often not available to the employer, existing regulations set forth three safe harbors that allow employers to instead use the following information that is readily available to them: (1) an amount based on the employee's W-2, (2) the employee's rate of pay, or (3) the federal poverty line (the "household income safe harbors").

Under the proposal, ALEs offering individual coverage HRAs would retain the ability to use the household income safe harbors in determining whether the offer of the HRA is affordable for purposes of the employer mandate.

2. *Nondiscrimination Safe Harbors*

Under Section 105(h) of the Code, excess reimbursements paid to "highly compensated individuals" ("HCIs") under a self-insured medical reimbursement plan (including an individual coverage HRA) are includible in the gross income of the HCI if either the plan or benefits provided under the plan discriminate in favor of HCIs.[17]

Under section 105(h) regulations pertaining to nondiscriminatory benefits, to avoid violating this nondiscrimination rule:

- All benefits made available under an individual coverage HRA to an HCI must also be made available to all other participants; and
- "Any maximum limit attributable to employer contributions must be uniform for all participants and for all dependents of employees who are participants and may not be modified by reason of a participant's age or years of service."

These provisions conflict with the final rule, under which (and as described above) employers are allowed to:

[17] Note, however, that individual coverage HRAs that make available reimbursements to employees only for premiums paid to purchase health insurance policies—but not other expenses—are not subject to Section 105(h) or its associated regulations.

- Limit individual coverage HRAs to certain classes of employees;
- Vary the maximum amounts, terms, and conditions of individual coverage HRAs between the different classes of employees and increase the maximum amounts made available under an individual coverage HRA within any class of employees as the employee's age increases.[18]

For example, absent regulatory clarification, certain amounts paid to an HCI under an individual coverage HRA that implements an age-based increase—as permitted under the final rule—could be includible in the HCI's income because the HRA would fail to satisfy the Section 105(h) nondiscrimination rule that prohibits maximum employer contributions from being modified by reason of a participant's age.

To address these conflicts, at least partially, one of the interim safe harbors facilitates the offering of individual coverage HRAs that would satisfy Section 105(h)'s nondiscriminatory *benefits* requirements—but not, notably, the discriminatory *operation* restrictions.[19]

Specifically, with respect to the age variance provision, the interim safe harbors allow an individual coverage HRA to increase the maximum amount made available to participants within a class of employees as the age of the employee increases without failing to satisfy the nondiscriminatory benefits rule under Section 105(h) and its associated regulations, provided the variation is based solely on age.

More generally, the interim safe harbors allow the maximum amount made available to vary for employees within a class—or between classes—without violating Section 105(h) **if**:

- Within each class of employees, the maximum dollar amount only varies in accordance with permitted variation provisions under the final rule (i.e., due to number of dependents or age); and
- With respect to the differences in the maximum amount made available for different classes of employees, the classes are those permitted by the final rule (e.g., full-time employees, part-time employees, salaried employees, etc.).

Nonetheless, there may be situations in which these interim safe harbors do not offer complete protection against violation of the 105(h) nondiscrimination requirements. For example, if a disproportionate number of HCIs qualify for and utilize a higher maximum HRA amount

[18] This is an exception to the broader requirement that—within any class of employees offered an individual coverage HRA—the employer must offer the HRA on the same terms and conditions to all employees in the class (i.e., the "same terms" condition).

[19] As noted below, these safe harbors may not provide complete protection under the 105(h) regulations in all circumstances. Section 105(h) regulations prohibit discrimination in benefits (26 CFR 1.105-11(c)(3)(**i**)) and discrimination in operation (26 CFR 1.105-11(c)(3)(**ii**)). The interim safe harbors only address the former category of discrimination under (c)(3)(i).

allowed based on age in comparison to the number of non-HCIs who qualify and use lower HRA amounts based on age, the HRA could satisfy the safe harbor requirements and offer nondiscriminatory benefits, but it may still be found to be discriminatory *in operation*—a prohibition not addressed by the interim safe harbors—and the excess reimbursements would be included in the HCIs' income.

II. ERISA Status of Individual Coverage When Premiums are Reimbursed by HRAs, QSEHRAs, Etc.

The Departments clarify that individual health insurance does not become an "employee welfare benefit plan" or "group health plan" covered under ERISA because the premiums for such coverage are reimbursed by an HRA, a QSEHRA, or a supplementary salary reduction arrangement[20] if certain conditions are satisfied, including:

- 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[21] and receives no consideration in connection with the employee's coverage selection;
- Reimbursement for non-group insurance premiums is limited solely to individual health insurance coverage (and therefore would not include STLDI); and
- Annual notification is provided to plan participants that individual coverage is not subject to ERISA.

III. Excepted Benefits HRAs

The rule adds "excepted benefit HRAs" to the current list of limited excepted benefits, if certain conditions are met. These excepted benefit HRAs may be used to reimburse medical care expenses, other than prohibited premium reimbursements (discussed below), incurred with respect to coverage that are not limited to other types of excepted benefits (e.g., cost sharing for individual or group plan coverage).

Recall, because coverage consisting of excepted benefits is not MEC, an offer of, or enrollment in, such coverage does not render an individual ineligible for the PTC. The Departments are providing 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:

---

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

[21] The final rule confirms that private exchanges offering individual coverage HRAs and other coverage options that work with all individual market issuers in a neutral and unbiased fashion would not violate this requirement.

- Must not be an integral part of a health plan (other group health plan coverage, not consisting solely of excepted benefits, must be made available by the same plan sponsor to the participants offered the HRA);[22]
- Eligibility for the HRA must be limited to individuals eligible to participate in the sponsor's other group coverage;
- Must provide benefits that are limited in amount to $1800, indexed for inflation, per plan year (disregarding carryover amounts from previous HRA plan years, but aggregating amounts made available under multiple HRAs for the same period (except HRAs that reimburse only for excepted benefits));
- Cannot provide reimbursement for premiums for certain health insurance coverage (individual insurance, group health plan, Medicare), but may reimburse premiums for coverage (group or individual) that consists solely of excepted benefits, STLDI, and COBRA;[23] and
- Must be made available under the same terms to all similarly situated individuals (as defined in HIPAA nondiscrimination rules), regardless of health factor.[24]

Due to the restrictions outlined above for offering HRAs integrated with individual coverage, employers would not be allowed to offer both an individual coverage HRA and an excepted benefits HRA to the same employee.

IV. 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 will 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 when an individual:

---

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

[23] There is a special rule for the small group market for excepted benefit HRAs that reimburse STLDI premiums. Namely, the Departments may restrict excepted benefit HRAs from reimbursing such premiums if:

- The HRA is offered by a small employer;
- The other coverage offered by the small employer is fully- or partially-insured coverage;
- HHS makes a finding, in consultation with Labor and Treasury, that such reimbursements in a state have caused significant harm to the small group market in that state and the small employer's principal place of business in in that state;
- The finding above is made after submission of a written recommendation, with supporting evidence, by the applicable state regulatory authority; and
- The restriction must be made prospectively and give plan sponsor reasonable time to comply.

[24] Under this prong, the rule clarifies that employers may not condition enrollment in the excepted benefit HRA on declining traditional group health plan coverage.

- Newly gains access to an individual coverage HRA or is provided a QSEHRA; or
- Had access to the HRA/QSEHRA during prior plan years or earlier in the current plan year, but is not currently covered by the HRA/QSEHRA.

The special enrollment triggering event is the first day on which coverage for the individual under the HRA or QSEHRA can take effect (generally, the first day of the plan year ore new hire eligibility dates). Individuals generally have 60 days before the triggering event to select their individual insurance coverage (and in some instances, depending on the notice required from the employer regarding eligibility for the HRA/QSEHRA, 60 days after the triggering event).

* * * *