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Additional Guidance on Health Reimbursement Arrangements ("HRAs")

Since the implementation of the Affordable Care Act (ACA), the Internal Revenue Service (IRS), the Department of Labor (DOL) and the Department of Health and Human Services (HHS) have issued guidance on how the ACA affects health reimbursement arrangements, referred to as HRAs. With the latest guidance coming from the IRS under Notice 2015-87, employers and plan sponsors should review all HRA plan designs to be sure that plan documents and operations follow all applicable rules, including newer requirements set out in the guidance. The highlights of this new guidance are outlined below.

Background on HRAs

HRAs, often referred to as medical reimbursement accounts, are a popular group health plan design feature. HRAs provide employees (or former employees) with a spending account up to a specified limit to reimburse or pay for qualified medical expenses. An HRA can be designed to cover both active employees and retirees (or just one group or the other) along with their dependents. HRA contributions must be made exclusively by the employer or other plan sponsor; no participant pre-tax or after-tax contributions are allowed. Balances remaining in the HRA at the end of a coverage period may be carried forward if the plan document permits or can be forfeited back to the employer/plan sponsor.

Impact of the ACA on HRAs

Prior to the ACA, HRAs were considered very flexible plans and could be provided on a stand-alone basis, meaning the HRA could reimburse qualified medical expenses regardless of whether the employee was enrolled in other non-HRA major medical group health coverage. The ACA has changed how employers/plan sponsors may structure and offer HRAs.

HRAs are considered group health plans and when covering two or more active employees, are subject to the ACA's market reform provisions including the requirement to cover preventive services and the prohibition on annual limits for essential health benefits. Subsequently, most stand-alone HRAs will not satisfy these market reforms and must be "integrated" with another group health plan to comply with ACA requirements. For a full account of the approved HRA integration methods, please see the DOL's Technical Release 2013-03.

As a result, plan sponsors can generally no longer offer an HRA on a stand-alone basis unless the plan is a separate retiree-only plan, or provides reimbursement for HIPAA "excepted" benefits only, such as a limited scope dental or vision benefits. (Note that health FSAs that meet certain

requirements are not considered HRAs and are still compliant under ACA.) HRAs may only be offered to individuals who also enroll in other non-HRA major medical group health coverage that complies with all applicable ACA market reform requirements. Plan sponsors must also offer employees (or former employees) the ability to permanently opt out of and waive future reimbursements from the HRA at least once per year and upon termination of employment.

HRAs Covering Actives (or Actives and Retirees in a Single Plan)

Agency issued guidance provides several important clarifications to the rules governing HRAs that cover actives or actives and retirees in a single plan (i.e., not a retiree-only HRA):

- The HRA cannot reimburse individuals for premiums paid for health insurance in the individual market, the federal marketplace, or a state exchange. This is true even if the individual has money left in the HRA after ceasing to be covered under the group health plan that is integrated with the HRA. In other words, the prohibition on reimbursing individual market premiums continues throughout the “spend-down” phase of the HRA.
- The HRA may reimburse individuals for premiums for individual market coverage if that coverage consists only of “excepted benefits,” such as insured dental, vision or specific illness coverage. (Special rules also apply for HRAs that satisfy certain Medicare or TRICARE integration rules.)
- If a spouse and/or dependent are not enrolled in a group health plan, the HRA cannot reimburse their expenses. For example, if an employee is enrolled in self-only major medical health coverage with an HRA, the HRA cannot pay medical expenses for a spouse or dependents. HRAs can contain language that automatically expands HRA eligibility to a spouse or dependent when he or she is enrolled in a group health plan, and prohibits it when not enrolled. While not explicit in the latest guidance issued under Notice 2015-87, it may be possible that an HRA could reimburse the expenses of a dependent or spouse covered under the spouse’s major medical group health plan, since guidance under Notice 2013-15 is clear that an HRA may be integrated with a group health plan sponsored by a participant’s spouse’s employer. The agencies will not enforce this standard for plan years commencing prior to January 1, 2016. HRAs in place as of December 16, 2015 are not required to be amended until the first day of the 2017 plan year to comply with this requirement.
- Amounts credited to an HRA before January 1, 2014, including amounts credited before January 1, 2013 and any amounts that were credited during 2013 under the terms of an HRA in effect on January 1, 2013, may be used after December 31, 2013 to reimburse medical expenses under the terms of the plan in effect before December 31, 2013 without violating ACA market reform provisions. Plan sponsors that increased their contributions in 2013 (compared to 2012) will want to review those contributions if the amount or timing of the 2013 contributions was not set out in plan terms in effect as of January 1, 2013.
- An employer cannot offer a Section 125 cafeteria plan that reimburses individuals for coverage on the individual health insurance market, whether the plan is funded by the employer or through salary reduction.
- The terms of the HRA must comply with the ACA in operation and in documentation, meaning that the written plan document should comply with the operational terms of the HRA. For example, the HRA document should be clear that the HRA may not be used to reimburse or pay individual insurance premiums, as it is not enough that the HRA not just actually reimburse individual insurance premiums when applicable.
- Allowing HRAs to reimburse health insurance premiums raises tax, HIPAA, and other

concerns, so reimbursements for such coverage will generally need to be limited to retiree-only plans and plans providing only excepted benefits.

Retiree-Only Plans That Offer HRAs

Retiree-only plans that offer HRAs are not subject to the rules described above. Notice 2015-87 makes the following points with respect to retiree-only HRAs.

- An HRA that covers only retirees or other former employees (referred to as a "retiree-only HRA") may reimburse retirees for premiums paid for health insurance in the individual market, the federal marketplace, or a state exchange. However, the retiree or former employee would not be eligible for a federal premium assistance tax credit in the federal marketplace or a state exchange because the HRA is considered group health plan coverage.
- A retiree-only HRA includes one where the available amounts were credited in whole or in part when the individual was a current employee. In other words, a retiree-only HRA does not lose its status as a retiree-only plan merely because the dollars were credited during active employment.

Implications

Employers and plan sponsors should review all HRA plan designs and at a minimum, must ensure that HRA documents are amended to exclude coverage for spouses and/or dependents not enrolled in a group health plan as well as document any other applicable changes. Plans should also be reviewed for operational compliance as well in other related areas. It is also important for employers to be mindful of arrangements that promote individual account based plans that purport to be ACA compliant. In particular, employers could be subject to significant excise taxes if they generally offer to reimburse employees' individual health insurance premiums either on a pre- or post-tax basis or if they offer employees with high claims risk a choice between the employer's health plan and cash.

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