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Publications

Proposed Rules Allow the Use of HRAs to Pay For Individual Market Coverage

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PUBLISHED
10/29/2018

SERVICES
Employers & Sponsors
Health & Welfare Programs

On Tuesday, October 23, the Departments of Treasury, Labor, and Health and Human Services (the "Departments") released long-awaited proposed regulations regarding health reimbursement arrangements ("HRA") and other account-based group health plans (the "Proposed Regulations"). Notably, the Proposed Regulations effectively reverse Obama-era guidance to now allow employees to use HRAs to pay for premiums for individual health insurance purchased either on and off the Exchanges.

I. Background

The Proposed Regulations are the last outstanding item from President Trump's Executive Order No. 13813 entitled "Promoting Healthcare Choice and Competition Across the United States" (the "Executive Order"). The Executive Order directed the Departments to consider issuing sweeping new healthcare guidance in a stated effort to lower premium costs and increase choice in the individual health insurance market. The Executive Order focused on policy changes addressing three types of coverage: (1) broadening the ability of small employers to purchase association health plans ("AHPs"); (2) lengthening the duration of, and allowing consumers to renew, short-term, limited-duration insurance ("STLDI"); and (3) expanding the use and availability of HRAs. The AHP and STLDI rules were finalized earlier this year.

By allowing employees to pay for individual health insurance premiums with HRA funds, the Proposed Regulations depart significantly from Obama-era guidance, which expressly prohibits the use of an HRA or other employer funds to pay or reimburse premiums for insurance purchased in the individual insurance market. Under that guidance,[1] the Departments provided that an HRA (or other employer-sponsored arrangement designed to pay for health coverage purchased in the individual market) for active employees must be "integrated" with another *group* health plan to satisfy the Affordable Care Act's ("ACA") market reform requirements. The stated legal rationale for this earlier guidance was that a stand-alone HRA or other similar arrangement for active employees would fail to satisfy two of the ACA's "market reform" provisions: the prohibition against annual dollar limits on essential health benefits ("EHBs") and the requirement to provide certain preventive services without cost-sharing.

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II. HRA Integration and Excepted Benefits

The Proposed Regulations remove the current prohibition on using HRA funds to purchase individual health insurance coverage, *provided certain conditions are met* (thereby creating opportunities for "Individual Coverage HRAs" or "ICHRAs"). In addition, the Proposed Regulations create a new version of stand-alone HRAs that employees can use to pay for out-of-pocket medical expenses ("excepted benefit HRAs" or "EBHRAs").

As discussed in detail below, both approaches include nondiscrimination rules that limit their use. According to the Departments, the imposition of the proposed nondiscrimination rules is designed to "prevent negative consequences" – *i.e.*, discrimination against older and sicker individuals and significant destabilization of the individual insurance market.

A. The New HRA Integrated with Individual Health Insurance Coverage

As noted above, prior guidance from the Departments generally provides that a stand-alone HRA (or other employer-funded arrangement) cannot satisfy all of the ACA's market reform provisions and requires an HRA to be integrated with qualifying *group* health plan coverage. The Proposed Regulations would permit an HRA to be integrated with certain qualifying *individual* health plan coverage in order to satisfy the market reforms. In order to be "integrated" with individual market coverage, the Proposed Regulations provide that the ICHRA must meet several conditions:

- Any individual covered by the ICHRA must be enrolled in health insurance coverage purchased in the individual market and must substantiate and verify that they have such coverage;
- The employer may not offer the same class of individuals both an ICHRA and a "traditional group health plan";
- The employer must offer the ICHRA on the same terms to all employees in a "class";
- Employees must have the ability to opt-out of receiving the ICHRA; and,
- Employers must provide a detailed notice to employees.

Each of these requirements is discussed in more detail below.

1. Requirement that All Individuals Covered by the ICHRA Are Enrolled in Individual Health Insurance Coverage

In order to be integrated with individual market health insurance coverage, any participant (regardless of whether a current and former employee) and dependent who can receive reimbursements from the ICHRA *must* be enrolled in individual market health insurance coverage for each month that they are covered by the ICHRA. Substantiation of enrollment in such health insurance coverage plan is required.

For this purpose, the Proposed Regulations treat all individual market health insurance as subject to, and compliant with, the ACA's market reforms. Thus, the ICHRA can be integrated with any individual market health insurance policy **except** excepted benefits (within the meaning of Internal Revenue Code ("Code") section 9832, ERISA section 733, PHSA section 2791) and STLDI.