ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES:

PRACTICAL Q&A

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

Attorneys John R. Hickman, Ashley Gillihan, Carolyn Smith, and Dan Taylor provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte, Dallas and Washington, D.C. law firm. Ashley Gillihan, Carolyn Smith and Dan Taylor are members of the Health Benefits Practice. Answers are provided as *general guidance* on the subjects covered in the question and are *not provided as legal advice* to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to Mr. Hickman at john.hickman@alston.com.

A NEW ERA OF HRAS BEGINS IN 2020

After a little more than 18 months after the President's Executive Order, the Departments of Labor, Treasury, and Health and Human Services (the "tri-agencies") have issued their long-awaited final regulations on health reimbursement arrangements (HRAs). The final regulations come a mere eight months after the tri-agencies issued proposed HRA regulations in response to the Executive Order. Like the proposed regulations, these final regulations expand HRAs in ways that could significantly change the health benefits landscape (especially for small employers) by establishing two new HRAs:

- An HRA that is integrated with certain individual market coverage (IMC) and Medicare (individual coverage HRA (ICHRA)).
- A nonintegrated general purpose HRA that is considered an excepted benefit (excepted benefit HRA (EBHRA)).

The final regulations are effective for plan years beginning on or after January 1, 2020. These new designs should, subject to the availability of traditional individual health insurance coverage, significantly expand the possibilities for defined contribution health coverage—igniting a new HRA-Era beginning in 2020. We address this new guidance in a two-part series. This article addresses the ICHRA. Next month's article will address the EBHRA.

INTRODUCTION

What prompted the regulations?

Before the Affordable Care Act (ACA), it was not uncommon for employers to offer HRAs as the sole group health coverage offered by employers to employees, and such HRAs frequently reimbursed an employee's premiums for major medical coverage purchased in the individual market. The ACA changed that. After the ACA became effective, HRAs offered to active employees generally had to be integrated with group health coverage and meet certain other requirements (such as allowing the employee to waive coverage each year). Why?

The integration requirements are driven largely by a health reform requirement added by the ACA—Public Health Service Act (PHSA) Section 2711. PHSA Section 2711 prohibits group health plans that provide other than excepted benefits from imposing annual or lifetime dollar limits on essential health benefits. HRAs that reimbursed general medical expenses (i.e., other than dental or vision) provide essential health benefits.

Since an HRA limits the reimbursement each year to a specified amount, a general purpose HRA would, by its nature, run afoul of the Section 2711 prohibition. Tri-agency guidance made it clear that HRAs could only be integrated with a group health plan other than an HRA and plans providing only excepted benefits. The tri-agency guidance also impacted HRAs that reimbursed an employee's individual market coverage (IMC) premiums. IMC, by law, had to provide essential health benefits. Since a premium reimbursement HRA paid or reimbursed the premiums for IMC coverage, the tri-agency guidance deemed the HRA to run afoul of the prohibition in Section 2711.

Practice Pointer:
Nonintegrated HRAs would also run afoul of PHSA Section 2713—the requirement to provide coverage for recommended preventive treatment services, as defined by the ACA.

Congress expands access to HRAs with QSEHRAs–sort of!

In 2016, Congress took an initial step to expand the scope of HRAs by creating a new type of HRA, the QSEHRA. QSEHRAs allow small employers to integrate an HRA with IMC under certain circumstances. QSEHRAs only go so far.

First and foremost, they are limited to employers that average fewer than 50 full-time equivalents in the prior calendar year. In other words, QSEHRAs are only available to employers that are not applicable large employers as defined for purposes of the ACA employer shared responsibility rules.

Second, the reimbursement is limited each year (adjusted annually by the IRS based on inflation). Third, an employer cannot not offer any other health coverage (even vision, dental, or excepted benefits) for any other employees and also offer a QSEHRA. Finally, the requirements for establishing and maintaining a QSEHRA are very complex.

How do the final regulations expand access to HRAs?

Effective for plan years beginning on or after January 1, 2020, the final regulations allow HRAs sponsored by employers of all sizes to be integrated with IMC (ICHRAs) and to offer excepted benefit HRAs (EBHRAs) to employees who are eligible for traditional major medical coverage.

ICHRA

What is an ICHRA?

HRAs sponsored by employers of any size may be integrated with IMC for purposes of PHSA Section 2711 if the following requirements are satisfied:

- The HRA is limited to employees and their spouse or tax dependents who are enrolled in IMC that qualifies as ACA-compliant coverage—i.e., coverage that satisfies PHSA 2711 (relating to the prohibition on annual and lifetime caps for EHBs) and 2713 (relating to mandatory preventive care benefits)—or Medicare ("qualifying IMC") for each month that they are covered by the HRA.

  For example, ACA-compliant catastrophic coverage and coverage subject to an ACA 1332 state waiver, as well as so-called grandmothered and grandfathered plan coverage, would constitute qualifying IMC. Certain insured individual coverage student plans may also constitute qualifying IMC. Group health coverage of any type (including a spouse's plan) and excepted-benefit-only coverage would not constitute qualifying IMC.

  Also, short-term limited-duration insurance (STLDI) coverage and health care sharing ministry coverages do not constitute qualifying IMC.

- The employer must obtain substantiation from the employee that the employee and any covered family members have qualifying IMC both initially and thereafter each time expenses are submitted for reimbursement. The regulations indicate that employee attestation of qualifying IMC is sufficient unless the employer has knowledge to the contrary. The regulations include a model form for participant attestation.

- An employee or dependent who ceases to be covered by qualifying IMC would forfeit any remaining balance in the HRA subject to any applicable continuation rules. COBRA eligibility could arise in the case of traditional COBRA events such as termination of employment or reduction in hours (and presumably death, divorce, or loss of dependent status under the IMC).

- The employer must offer the ICHRA on the same terms and conditions to all eligible employees within a "designated" class. Variations to benefits offered to employees within the designated class can only be based on family size and age. Age-based variations in ICHRA benefits cannot exceed the 3:1 ratio allowed for individual market premium differences based on age.

  If coverage is provided to one or more former employees, it must be provided on the same terms

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and conditions as provided to the class of employees the employee formerly belonged to and cannot vary based on compensation or years of service. Finally, ICHRA coverage can be pro-rated based on period of participation in the plan year.

Practice Pointer Wellness Programs: The final regulations clarify that an employer must offer the ICHRA on the same terms and conditions to all eligible employees within a "designated" class. It is unclear whether this would prohibit ICHRAs funded in part by disparate wellness program contributions. Read literally, this could be a problem.

Practice Pointer HSAs: The final regulations clarify that an employer might offer employees within a class an option of ICHRA coverage that is limited to IMC premium expenses (and thus is HSA compatible) or IMC expenses and other nonexcepted Section 213(d) expenses (which would disqualify an electing employee from HSA eligibility) without violating the "same terms and conditions" requirement.

- The designated classes are determined on a common-law employer basis and not on a controlled-group basis. This means that different employers within a controlled group may (subject to the class size rules) have different class rules. In addition, the final rules allow the class determination to apply to employees hired after a specified date (e.g., allowing the new ICHRA benefit to be extended prospectively while current employees retain eligibility under a traditional group health plan). The classes identified in the regulations are:
    - Salaried.
    - Non-salaried (e.g., hourly).
    - Full-time (as defined by Section 105 or 4980H).
    - Part-time (as defined by Section 105 or 4980H).
    - Seasonal (as defined by Section 105 or 4980H).
    - Employees in a unit covered by a particular collective bargaining agreement.
    - Employees who have not satisfied a waiting period for coverage.
    - Nonresident aliens with no U.S.-based income.
    - Employees of an entity that hired the employees for temporary placement at another entity (temporary-worker rule).
    - Employees whose primary site of employment is in the same rating area. The rating area is defined as the rating area used for ACA premium rating requirements in the individual market. This will essentially allow employers to offer or vary the benefits based on worksite location.
    - Any combination of two or more of the above classes. For example, full-time union employees could be a designated class separate and apart from any other designated class.

Certain class types that are offered an ICHRA are subject to a minimum size requirement if the employer also offers a traditional plan to one or more classes of employees. The minimum class size is determined before the plan year based on the number of employees the employer reasonably expects to employ on the first day of the plan year: 10 for an employer with fewer than 100 employees, or 10% of the total number of employees for an employer with 100 to 200 employees, and 20 thereafter. The class categories subject to this minimum size requirement are salaried, non-salaried, full-time, part-time, and employees in the same rating area.

Practice Pointer: An ICHRA is a self-funded medical reimbursement plan subject to Section 105, including the Section 105(h) nondiscrimination requirements. Offering different benefits to different classes of employees could run afoul of the Section 105(h) nondiscrimination rules. Likewise, offering different benefits based on age could run afoul of the nondiscrimination rules. Since the regulations allow variations between the designated classes and within a class based on age, the IRS has indicated that future guidance is likely to exempt these differences from the Section 105(h) rules so long as the ICHRA satisfies the ICHRA requirements..

- If employees are offered the ICHRA, the employer cannot also offer those employees traditional group health plan coverage that provides other than excepted benefits. An employer plan sponsor may offer the same employees both an ICHRA and excepted benefits such as vision, dental, health FSA, or fixed indemnity coverage.

Practice Pointer FSA/ICHRA Combo Cleared: A health FSA will not qualify as an excepted benefit unless, among other things, the FSA-eligible employee is also offered the opportunity to enroll in group health plan coverage that provides other than excepted benefits. Since an ICHRA is a group health plan that provides other than excepted benefits, a health FSA offered alongside an ICHRA may still qualify as an excepted benefit.

- Employees must be allowed to opt out and waive benefits at least annually and upon termination (subject to COBRA requirements). The final regulations clarify that an opt-out by an employee would be considered a waiver for eligible dependents as well.

- The employer must provide an annual notice to employees at least 90 days before the start of each plan year or before the effective date of coverage (if the employee becomes eligible after the start of the plan year). An extended notice period is allowed for the first plan year, and the agencies have provided a model notice for these purposes.

How do the final regulations align the ICHRA rules with Medicare's rules?

The preamble describes a struggle between the application of Medicare's anti-duplication and secondary payer rules and the proposed regulations regarding ICHRAs, which did not specifically address an HRA's integration with Medicare—even though the tri-agencies had addressed integration with Medicare in the HRA provisions of the prior final regulations and IRS Notice 2015-17.

Medicare's anti-duplication rules prohibit the sale of IMC to an individual enrolled in Medicare. This meant that Medicare-eligible employees in a class of employees offered the ICHRA could not participate since they could not purchase

IMC—making the ICHRA unavailable to all employees in the class on the same terms and conditions. Also, Medicare's secondary payer (MSP) rules prohibit employers subject to the MSP rules from offering incentives. The final regulations make the following very important clarifications:

- An employer subject to MSP rules may offer an ICHRA to a class of employees without running afoul of those rules, even though some employees in the class are eligible for or enrolled in Medicare. At first glance, this seems counterintuitive since no member of that class may also be offered traditional health coverage—an apparent MSP violation—but the tri-agencies noted that the HRA itself is a group health plan. Consequently, such employees are, in fact, offered group health plan coverage on the same terms as other non-Medicare-eligible employees in the same class—consistent with the MSP rules. Likewise, reimbursement of Medicare premiums and/or Medicare supplemental premiums by the ICHRA is not considered an impermissible financial incentive to forgo enrollment in the employer's group health plan since such employees are, in fact, enrolled in the employer's group health plan.

- For employers subject to the MSP rules, the ICHRA may not limit reimbursement of medical expenses to expenses not otherwise covered by Medicare; however, the ICHRA may be limited to premiums or medical expenses generally.

- To align the rules that the ICHRA be offered on the same terms and conditions to all members of the eligible class and Medicare's anti-duplication rules, which prohibit the sale of IMC to a Medicare beneficiary, the final regulations treat Medicare as qualifying IMC. Thus, employees must be allowed to qualify for the ICHRA by enrolling in either ACA-compliant IMC or Medicare. This applies without regard to whether the employer is subject to the MSP rules, since the anti-duplication rules apply irrespective of the MSP rules.

What is the maximum reimbursement for an ICHRA?

There is no regulatory prescribed maximum reimbursement for an ICHRA. Also, unused amounts may carry over from year to year without limitation.

What expenses are reimbursable from an ICHRA?

Except as may otherwise be limited by plan design, ICHRAs may reimburse any expense that qualifies as "medical care" under Section 213(d).

Does ERISA apply to the ICHRA?

The DOL issued separate regulations indicating that ERISA applies to the HRA part of the ICHRA and that ERISA will also apply to the policies the ICHRA is integrated with unless the employer otherwise satisfies ERISA's voluntary plan safe harbor (except, of course, the prohibition against employer contributions). This means that employers must not receive any consideration in connection with the ICHRA (such as free or subsidized FSA or HRA administration).

However, as with HSAs, we would anticipate that any employer FICA tax savings from an ICHRA supplemental cafeteria plan (see below) would not be considered to be impermissible remuneration. The DOL further notes that sponsors of an ICHRA should be careful not to endorse any particular carrier or coverage, including by offering a limited subset of IMC through a "private exchange." It would seem that employers must accept all forms of IMC selected by employees to limit exposure under the non-endorsement rule.

Can ICHRA participants pay the excess IMC premiums with pre-tax salary reductions?

In a surprising twist, the regulations indicate that employees may pay the portion of the IMC premiums not paid for by the ICHRA with pre-tax salary reductions through a "supplemental" cafeteria plan maintained by the employer. Presumably this supplemental plan provision need not be part of a separate plan and could be part of an existing cafeteria plan.

The supplemental cafeteria plan must be extended to all employees within a class and would only be available for qualifying IMC purchased outside the Exchange. This would apparently include Exchange-eligible coverage that is purchased off the Exchange. Such an arrangement would not be considered traditional group health coverage disqualifying the individual from participating in an ICHRA.

Can "applicable large employers" use an ICHRA to avoid employer shared responsibility excise taxes?

Yes, they possibly can. The proposed regulations and subsequent guidance issued by the IRS (see Notice 2018-88) address the application of the employer shared responsibility rules to an ICHRA. The final regulations note that additional proposed rules will be issued to incorporate IRS Notice 2018-88 and the comments received relating to it. In the interim:

- The ICHRA qualifies as minimum essential coverage (MEC); therefore, an employer that offers an ICHRA (or a combination of group major medical coverage and ICHRA coverage) to at least 95% of its full-time employees in a month will avoid the excise tax under Section 4980H(a) (aka the "sledgehammer" tax) for that month.

- An applicable large employer can also avoid the Section 4980H(b) tax (aka the "tackhammer" tax) if the ICHRA coverage is affordable. If the coverage is affordable, it will also be considered to provide minimum value. The IRS has prescribed the following special rules to facilitate the employer's affordability calculation:
    - The rating area used by the employer may be the rating area for the employee's primary situs of employment.
    - Employers may determine affordability for a year using the silver plan premiums from the prior calendar year or, if the plan year spans two calendar years, the premiums for the first month of the plan year, even if the silver plan premiums change during the plan year.
    - The IRS has indicated that employers may continue to use the Section 4980H affordability safe harbors to determine whether the ICHRA is "affordable" and provides minimum value for purposes of Section 4980H. ■