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Introduction to Consumer Directed Healthcare and Account-Based Plans (HSAs, FSAs and HRAs)

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Agenda

- Health Savings Accounts
  - Background
  - Eligibility Rules
  - Contributions
  - Employer Contributions
  - Distributions
  - Coordination with FSAs & HRAs
- Health Reimbursement Arrangements under the ACA
- QSEHRAs (Qualified Small Employer HRAs)
- Health Flexible Spending Accounts under the ACA

Definitions

- FSA – Health Care Flexible Spending Account
- HDHP – Qualified High Deductible Health Plan
- HRA – Health Reimbursement Arrangement
- HSA – Health Savings Account
- QSEHRA – Qualified Small Employer HRA
- ICHRA – Individual Coverage HRA
- EBHRA – Excepted Benefits HRA

Health Savings Accounts (HSAs)

HSA Background

- HSAs became available in 2004 as part of Congress' attempt to expand coverage and control costs through consumer-directed programs
- HSAs are tax-favored investment accounts that may be used to pay for an individual's current or future medical, dental and vision expenses
- To set up an HSA, an individual must be covered by an HDHP and satisfy certain other eligibility rules
- Within the statutory limits, employer contributions to an HSA are not taxable and individuals may make tax-deductible HSA contributions

HSA Eligibility

- There are four basic HSA eligibility rules
- Individuals must be:
  1. Covered by a qualified High Deductible Health Plan;
  2. Not covered by any non-HDHP plan;
  3. Not entitled to (*i.e.*, enrolled in) Medicare; and
  4. Not eligible to be claimed as a dependent on another individual's federal tax return

HSA Eligibility

1. In order to qualify, the HDHP must have an annual deductible at or above the statutory minimum, and contributions and out-of-pocket limits at or below the statutory maximum

	2020 (single/family)	2019 (single/family)
Minimum Annual HDHP Deductible	$1,400 / $2,800	$1,350 / $2,700
Annual HSA Contribution Limit	$3,550 / $7,100	$3,500 / $7,000
Maximum Out-of-Pocket for HDHP (applies to all in-network benefits)	$6,900 / $13,800	$6,750 / $13,500

HSA Eligibility

1. (cont'd.) An HDHP may provide preventive care before the minimum annual deductible is satisfied, which include:
   - Periodic health evaluations, including diagnostic procedures ordered in connection with routine examinations, such as annual physicals
   - Routine prenatal and well-child care
   - Child and adult immunizations
   - Tobacco cessation programs
   - Obesity weight-loss programs
   - Screening services for: cancer; heart disease; mental health/substance abuse; metabolic, nutritional, and endocrine conditions; musculoskeletal disorders; obstetric and gynecological conditions; pediatric conditions; and vision and hearing disorders
   - ACA-recommended preventive care services
   - New expanded list of *specific* preventive care services for *certain* chronic conditions

Expanded List of Preventive Care Services

For Individuals Diagnosed with	Preventive Care for Specified Condition
Asthma	Inhaled corticosteroids, peak flow meter
Congestive heart failure and/or coronary artery disease	Beta-blockers
Congestive heart failure, diabetes, and/or coronary artery disease	Angiotensin Converting Enzyme (ACE) inhibitors
Depression	Selective Serotonin Reuptake Inhibitors (SSRIs)
Diabetes	Insulin and other glucose lowering agents
Diabetes	Retinopathy screening
Diabetes	Glucometer, Hemoglobin A1c testing
Heart disease	Low-density Lipoprotein (LDL) testing
Heart disease and/or diabetes	Statins
Hypertension	Blood pressure monitor
Liver disease and/or bleeding disorders	International Normalized Ratio (INR) testing
Osteoporosis and/or osteopenia	Anti-resorptive therapy

HSA Eligibility

2. In order to be eligible to contribute to an HSA, an individual must not be covered under any non-qualified health care plan, with two exceptions: permitted insurance and permitted coverage
   - Permitted insurance: Worker's compensation, tort liability, ownership liability, specified disease coverage, per-diem indemnity insurance
   - Permitted coverage: Accident coverage, disability, dental, vision, long-term care

HSA Eligibility

3. Individuals who are entitled to Medicare are not eligible to establish or contribute towards an HSA
   - Entitled means actually covered under any part of Medicare: Part A, Part B, a Medicare Advantage Plan, or Part D
   - Individuals who are eligible for Medicare, but have not enrolled, may establish and contribute to an HSA
   - Medicare entitlement is not automatic at age 65!
     - Employees can maintain HSA eligibility by delaying enrollment in Medicare
     - *Caution*: Medicare entitlement can be retroactive when an individual waits to enroll
     - If an individual starts receiving Social Security retirement benefits *more than six months* past their "normal" retirement age (between 66-67 for most people), they receive six months "back pay," which also triggers retroactive Medicare enrollment by six months

HSA Eligibility

4. Any individual who is eligible to be claimed as a dependent on another person's federal tax return is not eligible to establish or contribute to an HSA

Example: A student who is eligible for an HDHP, but whose parents claim her as a dependent because she meets the IRS definition of "qualifying relative," is not HSA eligible

Veteran Eligibility for HSAs

- Surface Transportation and Veterans Health Care Choice Improvement Act changed how veterans' health coverage affects HSA eligibility
- The "3-month" rule no longer applies to care received through the VA for a "service-connected disability"
  - In the past, an individual was not HSA-eligible for a month if he or she had received VA medical benefits during the previous three months
- This new rule only applies to VA coverage
  - For these purposes, any hospital care or medical services received from the VA by a veteran who has a disability rating is considered service-connected
- TRICARE coverage still disrupts HSA eligibility

HSA Eligibility

- 2 ½ month FSA grace period may not prevent HSA eligibility
- Generally, an individual may not participate in both an HSA and an FSA because FSA coverage is not an HDHP
- According to the IRS, this restriction includes any FSA "grace period," even if there is no money left in the FSA
- However, individuals with a zero balance in their FSA at year end may contribute to an HSA at the start of the new year

HSA Contributions

- Full-year contribution allowed for mid-year enrollees
- Under this rule, individuals who first enroll in a high deductible plan after the start of the year may make a full HSA contribution for the year
- However, the individual must remain HSA-eligible for the next full calendar year, otherwise the ineligible amount is included in income, plus a 10% penalty applies
  - Ineligible amount is based on the amount contributed in excess of the applicable limit based on tier (single/family) and months of HDHP coverage

Employer Contributions to HSAs

- Employers may, but are not required to, contribute to their employees' HSAs
- If an employer contributes to an employee's HSA, the contributions are excludable from federal taxable income and are not taxable to the individual
- Employers can structure their contributions under one of two rule sets:
  - Comparable Contributions
  - Contributions through a Cafeteria Plan

Comparable Employer Contributions

- Comparable employees are employees in the same category (full-time, part-time, former) who have the same tier of coverage
- Employers may use up to 4 tiers:
  - Single (self only)
  - Employee & 1 Dependent
  - Employee & 2 Dependents
  - Employee & 3 or more Dependents
- **Restriction:** contributions to each family tier must be equal to or greater than the tier below

Comparable Employer Contributions

- Employees may be placed in the following categories only:
  - Full-time (30 hours)
  - Part-time (<30 hours)
  - Former Employees (does not include COBRA)
  - Union (collectively bargained health benefits)
- **Note:** the 30-hour threshold must be used
- Differences not permitted for: management, salaried, specific locations or subgroups (e.g., division or subsidiary)

Comparable Employer Contributions

- Contributions will be comparable only if they are calculated using one of two methods:
  - Same dollar amount by tier (single or family); or
  - Same percentage of the HDHP deductible (single or family level)
- When HSA contributions are not comparable, the penalty on the employer is a **35% excise tax**

Employer Contributions Through a Cafeteria Plan

- Employer contributions toward an employee's HSA offered under a cafeteria plan will generally be in one of 3 forms:
  1. Salary reductions;
  2. Employer credits (cashable or non-cashable); and/or
  3. Employer non-credit contributions such as:
     - Flat dollar amount
     - Specified percentage of deductible(s)
     - Matching contributions

Employer Contributions Through a Cafeteria Plan

- An employer's HSA contribution may not be considered to be "through" a cafeteria plan if the contribution is non-elective and non-cashable
- Example of a contribution not "through" a cafeteria plan:
  - Employees contribute to HDHP via salary reduction,
  - Employer contributes to HSA for all enrollees, and
  - Employer contribution is only for the HSA:
    - It can't be taken as cash,
    - It can't be used for other benefits, and
    - Employees cannot contribute pre-tax to HSAs
- Employer's HSA contribution is *not* through a cafeteria plan!

HSA Distributions

- Distributions from an HSA are tax-free if used to pay or reimburse "qualified medical expenses" incurred after establishment of the HSA
- Distributions for non-qualified expenses are subject to income tax and an additional 20% tax
  - The additional 20% tax does not apply if the HSA holder is age 65 or older

HSA Distributions

- "Qualified medical expenses" are those expenses that would generally qualify for a tax deduction as medical and dental expenses (see IRS Pub. 502) AND which are incurred by:
  - You or your spouse (as determined under federal law)
  - All dependents you claim on your tax return
  - Anyone you could have claimed as a dependent except that:
    - The person filed a joint return; or
    - The person had gross income of $4,200 or more (2019)

HSA Distributions

- "Qualified medical expenses" do not include insurance premiums, unless they are for:
  - Long-term care insurance (amounts are limited)
  - COBRA continuation coverage
  - Health care coverage while receiving unemployment compensation under federal or state law
  - Medicare and other health care coverage if the HSA holder is age 65 or older (other than premiums for a Medicare supplemental policy, such as Medigap)

HDHPs and Embedded Deductibles

- How do embedded individual deductibles work?
  - A family HDHP cannot pay claims (other than preventive care) until the minimum annual deductible is satisfied ($2,700 in 2019)
  - Many HDHPs have deductibles for family coverage that exceed $2,700 in aggregate; however, they allow individuals to satisfy a lower deductible
  - As long as the embedded individual deductible is not lower than the minimum deductible for family coverage, HSA eligibility is not disrupted
    - For example, a $3,000 / $6,000 plan with an embedded individual deductible would not jeopardize HSA eligibility, as the embedded $3,000 deductible equals or exceeds $2,700

2019 HSA and ACA OOP Limits

	2019 (single/family)	2018 (single/family)
Minimum Annual HDHP Deductible	$1,350 / $2,700	$1,350 / $2,700
Annual HSA Contribution Limit	$3,500 / $7,000	$3,450 / $6,900
Maximum Out-of-Pocket for HDHP (applies to all in-network benefits)	$6,750 / $13,500	$6,650 / $13,300
ACA Maximum Out-of-Pocket Limits (applies to all in-network essential heath benefits)	$7,900 / $15,800	$7,350 / $14,700

- ACA requires family plans to have an embedded individual OOP limit
- Embedded OOP limit rule applies to all non-grandfathered group health plans, including HDHPs

Interaction between HSA Rules and ACA OOP Limits

- Recap:
  - **HSA Rule**: OOP limit for family HDHP coverage cannot exceed $13,500 in 2019
  - **ACA Rule**: Family coverage (whether HDHP or non-HDHP) must have an embedded individual OOP limit that does not exceed $7,900 in 2019
- This means that for the 2019 plan year, an HDHP subject to the ACA out-of-pocket limit rules may have a $6,750/$13,500 out-of-pocket limit (and be HSA-compliant) so long as there is an embedded individual out-of-pocket limit in the family tier no greater than $7,900 (so that it is also ACA-compliant)

Coordination of HSAs with FSAs and HRAs

- Employers implementing HSA-qualified HDHPs should consider the following five plan design examples and their effect on an employee's eligibility to contribute to an HSA
- For the purpose of the following five examples, the HDHP has the following features for calendar year 2019:
  - 80%/20% coinsurance
  - $1,350 deductible for individual, $2,700 for family
  - Maximum out-of-pocket cost of $6,750 for individual, $13,500 for family
  - HDHP covers standard medical and Rx expenses, and does not cover dental or vision expenses

1. HSA with "Traditional" FSA or HRA

- Both the FSA and HRA cover all qualified medical expenses not covered by the HDHP (co-payments, co-insurance, expenses not covered due to the deductible, any other medical expenses not covered by the HDHP)
- This individual is **not** eligible to contribute to an HSA
  - The FSA and HRA pay or reimburse medical expenses incurred before the annual deductible has been satisfied
  - The FSA and HRA are not limited to the exceptions for permitted insurance, permitted coverage, or preventive care
- **Note:** In this example, both the FSA and HRA are considered health plans that are NOT qualified HDHPs

2. HSA with "Limited Purpose" FSA or HRA

- Both the FSA and HRA are "limited purpose" arrangements that cover only vision or dental expenses, as well as preventive care (without regard as to whether the HDHP deductible has been satisfied)
- This individual **is** eligible to contribute to an HSA
  - The FSA and HRA pay or reimburse medical expenses incurred before the annual deductible has been satisfied
  - However, the medical expenses paid by the FSA or HRA include only vision and dental benefits (which are permitted or disregarded coverage) and preventive care

3. HSA with "Suspended" HRA

- The individual elects, before the beginning of the HRA coverage period, to suspend the payment of medical expenses during the upcoming HRA coverage period (permitted or disregarded coverage and preventive care is allowed)
- This individual is eligible to contribute to an HSA
  - The individual **is** eligible to contribute to an HSA until the individual is again entitled to receive, from the HRA, payments for medical expenses incurred after the suspension
  - **Note:** This allows an HRA and HSA to co-exist by permitting an individual to maintain an HRA (and to continue receiving accruals) and still be eligible to contribute to an HSA

4. HSA with "Post Deductible" FSA or HRA

- Both the FSA and the HRA are "post deductible" arrangements that only pay or reimburse medical expenses after the HDHP deductible has been satisfied (permitted or disregarded coverage and preventive care is allowed)
- This individual **is** eligible to contribute to an HSA
  - The FSA and HRA do not reimburse medical expenses incurred before the annual deductible has been satisfied
  - **Note:** The post deductible HRA or FSA will not qualify as a HDHP; the individual will need to be covered by a qualified HDHP in order to contribute to an HSA

5. HSA with "Retirement" HRA

- The HRA is a "retirement" HRA and only reimburses expenses incurred after the individual retires
- This individual is eligible to contribute to an HSA
  - The individual **is** eligible to contribute to an HSA before retirement because the HRA will only pay or reimburse medical expenses incurred after retirement
  - **Note:** This individual will not be eligible to make contributions to an HSA after retirement

HRAs under the ACA

HRAs under the ACA

- HRAs and FSAs must comply with the ACA's annual limit and preventive care requirements, unless they are ***integrated*** with a compliant group health plan (or are "excepted benefits" under HIPAA)
  - Most FSAs are excepted benefits
  - Most HRAs are not excepted benefits, unless they reimburse only dental or vision benefit or are offered only to retirees
  - **Trump administration's final rules provide a new pathway for HRAs**
    - Oct. 2017 Executive Order instructed DOL, HHS and IRS to consider expanding association health plans, short-term limited duration insurance, and HRAs

HRAs under the ACA

- HRAs must be "*integrated*" with a group health plan, which occurs if:
  1. The employer offers a minimum value plan to the employee;
  2. The employee is enrolled in a group plan that provides minimum value;
  3. The HRA is available only to employees with group coverage; and
  4. The employee must be able to opt out of the HRA at least annually
- These HRAs may reimburse any qualified medical expense
- If the plan is not minimum value, the HRA can only reimburse copays, co-insurance, deductibles or premiums under the GHP, or non-essential benefits

HRAs & Individual Market Coverage (Pre-2020)

- IRS guidance provides that a group health plan, including an HRA, will not be considered "integrated" with an individual market policy for purposes of satisfying the ACA's annual limit or preventive care rules
  - This means that employers cannot reimburse employees for the cost of individual insurance premiums on a non-taxable basis
  - **Note**: Exception for Qualified Small Employer HRAs
  - **New exception** starting in 2020 under Final HRA regulations

HRAs & Individual Market Coverage (Pre-2020)

- Employer Payment Plans
  - Employers may offer employees the choice of taxable compensation (cash) or an after-tax payment to be applied to health coverage
  - IRS guidance also permits employers to establish a payroll practice of forwarding employee contributions to an insurance carrier without the arrangement being considered a group health plan; however, the arrangement generally must comply with the rules for "voluntary" plans under ERISA, with one such requirement being that the employees pay 100% of the cost of the coverage

HRAs & Individual Market Coverage (Pre-2020)

- Premium Reimbursement Arrangements
  - IRS generally considers premium reimbursement arrangements to be group health plans (i.e., HRAs)
  - Arrangements that reimburse only health insurance premiums are not subject to Section 105(h)
    - Treas. Reg. 1.105-11(b)(2): "a plan which reimburses employees for premiums paid under an insured plan is not subject to this section"

Qualified Small Employer HRAs (QSEHRAs)

Qualified Small Employer HRAs

- 21st Century Cures Act – allows establishment of QSEHRAs
- Enables small employers (non-Applicable Large Employers) to use an HRA to reimburse medical expenses and individual market health insurance premiums, up to a specified annual limit
- Limit for 2019 is $5,150 (individual) / $10,450 (family)
  - Must be prorated for partial years of coverage
  - Employer contribution generally must be the same for all eligible employees; however, certain variations are permitted based on age and number of covered family members

Qualified Small Employer HRAs

Conditions of offering a QSEHRA

- Employer cannot be an Applicable Large Employer (ALE)
- Employer cannot offer a group health plan to any employee
  - Cannot offer dental/vision coverage either
  - Employers may allow pre-tax HSA contributions for eligible employees (if the QSEHRA only reimburses premiums)
- QSEHRA must be funded solely by employer contributions
- Must be offered to all "eligible employees"
  - Generally, all full-time, non-union employees who have worked at least 90 days

Qualified Small Employer HRAs

Notice Requirements

- Employers must notify employees at least 90 days prior to the beginning of the plan year (or upon eligibility for employees who become eligible during the year)
- Notice must state:
  - The amount available under the HRA for the year;
  - That employees receiving federally subsidized coverage must disclose the HRA contribution to the Marketplace; and
  - That if the employee does not have MEC, an individual mandate penalty may apply and any reimbursement from the HRA may be included in gross income that month
- Notice failures may result in penalty of $50 per employee, not to exceed $2,500 per year

Qualified Small Employer HRAs

Federal Premium Subsidy Reduction

- Employees participating in a QSEHRA will have their monthly federal premium subsidy for Marketplace coverage reduced by 1/12th of the employer's annual QSEHRA contribution
  - For example, if an employee's subsidy is $250 per month and 1/12th of the employer's annual contribution is $200, the employee's subsidy will be reduced to $50 per month

Qualified Small Employer HRAs

Federal Premium Subsidy Reduction

- If the QSEHRA provides "affordable" coverage, the employee's subsidy will be reduced to zero that month
  - A QSEHRA provides affordable coverage in any month where the difference between the cost of coverage under the second-lowest-cost silver plan in the Marketplace and the employer's HRA contribution does not exceed 9.5% (9.86%, as indexed for 2019) of the employee's household income

Qualified Small Employer HRAs

Effect on Other Laws

- QSEHRAs are not group health plans under ERISA and, with the exception of the Cadillac tax and PCORI, are not subject to the ACA's mandates, including Section 6055 reporting for self-insured plans
  - No plan document, SPD, or Form 5500 requirement
  - QSEHRAs are also exempt from COBRA continuation requirements

Qualified Small Employer HRAs

- **Notice 2017-67 –** Includes guidance on the following topics:
  - Eligible employer and eligible employee
  - Same terms requirement
  - Statutory dollar limits
  - Written notice requirement
  - MEC requirement
  - Substantiation requirement
  - Reimbursement of medical expenses
  - Reporting requirement
  - Coordination with PTC
  - Failure to satisfy the requirements to be a QSEHRA
  - Interaction with HSA requirements

Final Regulations Expanding HRAs

Final Rule for Individual Coverage HRAs

- Final rule effective January 1, 2020 would allow employers of all sizes to offer an HRA that is integrated with individual health insurance coverage or Medicare (an "ICHRA")
  - May be used for Marketplace or non-Marketplace coverage
    - Remainder of non-Marketplace premiums may be paid under Section 125 plan
- DOL estimates that once employers fully adjust to the new rules, roughly 800,000 employers will adopt ICHRAs to pay for insurance for approximately 11 million employees and their family members
- Employers cannot offer employees a *choice* between group coverage and an ICHRA, although ICHRAs may be offered on a class basis or to employees hired after a certain date (after 1/1/2020)

Final Rule for Individual Coverage HRAs

- ICHRAs must be offered on same terms for all employees in a class ("same terms" requirement)
  - ICHRA contributions are unlimited, unlike QSEHRAs
  - ICHRA amounts may be increased for older workers and based on number of dependents
  - Employers can maintain their traditional group health plan for existing enrollees, with new hires offered only an ICHRA
    - Date-of-hire rules may be applied on a class-by-class basis
- Employee and dependents must be enrolled in individual market coverage or Medicare

Permitted Classes for Individual Coverage HRAs

- Employers may offer an ICHRA on a class basis to:
  - Full-time vs. Part-time employees
  - Employees in the same geographic area (e.g., same rating area, state, or multi-state region)
  - Seasonal employees
  - Collectively bargained (union) employees
  - Employees who have not satisfied a waiting period
  - Non-resident aliens with no U.S.-based income
  - Salaried workers vs hourly
  - Temporary employees of staffing firms, or
  - A combination of two or more classes
    - FT, PT and Seasonal can be defined under Section 105(h) or 4980H

Minimum Class Size (MCS) Requirement

- MCS requirement applies if an employer offers a group health plan to one or more classes of employees and offers an ICHRA to one or more other classes
- MCS requirement does not apply to a class of employees offered a traditional group health plan or a class of employees offered no coverage

Minimum Class Size (MCS) Requirement

- MCS requirement applies to a class comprised of full-time employees, part-time employees, salaried employees, non-salaried employees, or employees whose primary site of employment is in the same rating area ("applicable classes"), unless:
  - the geographic area defining the class is a State or a combination of two or more entire States; or
  - if the class is FT vs. PT, the MCS requirement applies only to the class offered an ICHRA
- MCS requirement also applies if the class comprises at least one of the applicable classes with any other class, unless the class is the result of a combination of one of the applicable classes and a class of employees who have not satisfied a waiting period

Minimum Class Size (MCS) Requirement

- Minimum number of employees in a class subject to the MCS requirement is determined before the start of the plan year and is:
  - **10**, for an employer with fewer than 100 employees;
  - **10%** of the total number of employees, for employers with 100 to 200 employees;
  - **20**, for an employer with more than 200 employees
- Employer size is determined in advance of the plan year based on the number of employees that the employer reasonably expects to employ on the first day of the plan year
- MCS requirement is satisfied based on the number of employees in the class offered the ICHRA as of the first day of the plan year
- MCS requirement does not apply to the "new hire" subclass

ICHRAs – General Rules

- Employees must be able to opt-out of an ICHRA at least once per year
- Procedures must be in place to verify individual market coverage
- HRA must provide written notices to each participant upon initial eligibility and at least 90 days before the beginning of each plan year
- ICHRAs that reimburse only premiums do not disrupt HSA eligibility
- Marketplace special enrollment available for those who gain access to an ICHRA (or a QSEHRA)
- ICHRAs eliminate premium tax credit eligibility; QSEHRAs reduce premium tax credit eligibility (possibly to $0)

ICHRAs – General Rules

- ICHRAs are eligible employer-sponsored plans for purposes of the ACA's employer mandate
  - ICHRAs are "minimum essential coverage"
  - ICHRAs can offer "affordable" minimum value coverage
  - IRS to issue additional guidance on affordability safe harbors
  - Based on Notice 2018-88, anticipated safe harbors include:
    - **Location-Based** – employer may use the lowest cost silver plan for the employee for self-only coverage offered by the Exchange in the rating area in employee's primary worksite
    - **Calendar and Non-Calendar Year Safe Harbor** – affordability determined based on cost of the applicable plan for the prior calendar year (the calendar year safe harbor), or the cost of the plan at the start of the ICHRA plan year (non-calendar year safe harbor)
    - **Affordability** – employer may estimate affordability using the W-2, Rate of Pay, or Federal Poverty Level safe harbor

ICHRAs – General Rules

- Employees may pay for the remainder of their individual (non-Marketplace) coverage pre-tax through a cafeteria plan without the individual plan being considered a group health plan for ERISA and ACA purposes
  - Ability to pay pre-tax must be offered on the same terms and conditions by class
- ICHRAs may reimburse Medicare premiums (e.g., Parts B and D) and Medicare Supplement premiums without violating the Medicare Secondary Payer rules

ICHRAs – General Rules

- Participants and any dependent(s) must be enrolled in individual coverage for each month that they're covered by the ICHRA
- If any covered individual ceases to be covered by individual coverage, the ICHRA can no longer reimburse that individual's medical expenses
  - If the participant and all covered dependents cease to be covered by individual health insurance coverage, the participant must forfeit the HRA
  - Participants must notify the ICHRA that individual coverage has been cancelled or terminated and the date on which the cancellation or termination is effective
  - If a participant or dependent loses coverage under the HRA for a reason other than cessation of individual health insurance coverage, COBRA may apply

ICHRAs – General Rules

- ICHRAs must consider individuals enrolled in individual coverage if they are in a grace period to pay premiums
- Carryover of unused amounts permitted
  - Must be available on the same terms and conditions for all participants in a class
  - When an employee changes classes, amounts under an ICHRA may transfer without violating the "same terms" requirement
- Variations in employer contributions permitted by age and number of dependents
  - Increases based on age may not exceed 3X the amount available to the youngest participants

ICHRAs – General Rules

- ICHRAs may provide benefits to some, but not all, former employees within a class of employees
- Amounts may be prorated for mid-year entry, changes in family size
- All benefits must be available on the “same terms” within a classification
- Choice of HSA-compatible ICHRA may be offered

ICHRAs- Affordability Safe Harbors for ALEs

- IRS has established safe harbors for ALEs to set their ICHRA contributions
- ***Location Based Safe Harbor***
  - Employers may use the lowest cost silver plan offered through the Exchange where the employee's primary site of employment is located
  - An employer may, but is not required to, use an employee's actual residence, unless the employee's worksite is his or her home
  - Primary site of employment is the location the employer expects the employee to perform services on the first day of the plan year or the effective date of coverage
- ***Age-Related Issues under the Location Based Safe Harbor***
  - While affordability is determined on an individual basis, an employer may, as a general matter, use the age of the oldest employee as an affordability measure
  - Age is determined as of the first day of the plan year or date of eligibility

ICHRAs- Affordability Safe Harbors for ALEs

- ***Look-Back Month Safe Harbor***
  - For CY plans: Employer may use the premium for the lowest-cost self-only silver plan from January of the *prior* calendar year
  - For non-CY plans: Employer may use the monthly premium amount from January of the *current* calendar year
  - An employer using the look-back month safe harbor must use the employee's *current* applicable location and *current* age, regardless of what month and year is being used to determine affordability
- HHS will provide a platform to view the lowest-cost silver plans
- For plans offered through a state Exchange, HHS will work with the states to implement a similar platform

Final Rule for Excepted Benefits HRAs

- Effective January 1, 2020, Final Rule treats certain types of HRAs as "excepted benefits" that are not subject to ACA requirements
- Employees offered an Excepted HRA must also be offered Non-Excepted group health plan coverage by the employer
- Employer may offer up to $1,800 per year to reimburse employees for out-of-pocket medical expenses, including premiums for:
  - Limited scope dental or vision benefits;
  - Short-term, limited-duration insurance plans; and
  - COBRA coverage

FSAs under the ACA

FSAs under the ACA

- Under the ACA, health FSAs must be "excepted benefits"
- FSAs will be "excepted" if the employer also offers non-excepted group health plan coverage and the FSA is structured so that the maximum benefit payable cannot exceed the **greater** of:
  a. 2x the participant's salary reduction election to the FSA for the year; or
  b. $500 plus the participant's salary reduction election
- If an employer provides a non-excepted FSA, it is subject to the market reforms, including the preventive services requirements
  – Because a non-excepted FSA is not integrated with a group health plan, it will fail to meet the preventive services requirements

FSA Carryovers

- Modification to the Use-It-Or-Lose-It Rule for FSAs
  - Can carryover up to $500 to following plan year
  - Plan cannot have both a grace period and a carryover feature
  - Employers may design FSAs to automatically carry over funds from a general purpose FSA to a limited purpose FSA for employees enrolling in HDHP coverage
- Employee contribution limit is $2,500 per year (as indexed, plus the $500 carryover)
  - 2019 indexed limit is $2,700
  - 2020 projected limit is $2,750
- What is more valuable—Grace Period or Rollover?

FSA Carryovers and COBRA

- Application of COBRA to FSAs with $500 Carryover Feature
- General rule: Employers that allow carryovers must also allow them for COBRA participants
  - This could extend COBRA past the end of the plan year
- **However**, an employer may limit the carryover to employees who elect to contribute to the FSA in the following year, in which case COBRA ends at the end of the plan year
- Employers may limit carryovers to a maximum period (e.g., one or more years)

Questions?

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