

COMPLIANCE OVERVIEW

Provided by Synergy Solutions Group of Virginia

Health Reimbursement Arrangements (HRAs)

Health reimbursement arrangements (HRAs) are employer-funded health care accounts that reimburse employees for their eligible out-of-pocket medical expenses on a tax-favored basis.

Beginning in 2014, the Affordable Care Act's (ACA) market reforms substantially limited the types of HRAs that employers could offer. Due to these reforms, most stand-alone HRAs are currently prohibited, although HRAs that are "integrated" with other group health coverage are still permissible. Also, effective for 2014 plan years, employers cannot use HRAs to reimburse employees for individual health insurance premiums without violating the ACA.

Due to a new federal law, small employers can adopt stand-alone HRAs without violating the ACA, effective for plan years beginning on or after Jan. 1, 2017. This new type of HRA, called a qualified small employer HRA (QSEHRA), can be used to help employees pay for their own health insurance policies and reimburse other out-of-pocket medical expenses.

HIGHLIGHTS

ACA IMPACT

- The ACA limits the types of HRAs that employers may offer.
- Most stand-alone HRAs are prohibited due to the ACA's market reforms.
- If the ACA is repealed, employers may have more flexibility when it comes to designing their HRAs.

QSEHRAs

- QSEHRAs were created to provide small employers with additional design options for their HRAs.
- QSEHRAs are a type of stand-alone HRA that can reimburse employees for their individual health insurance premiums without violating the ACA.

LINKS AND RESOURCES

- [IRS Notice 2013-54](#) and [DOL Technical Release 2013-03](#) (guidance on integrated HRAs under the ACA)
- [The 21st Century Cures Act](#), which created QSEHRAs, effective for plan years beginning on or after Jan. 1, 2017

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HRA PLAN DESIGN

HRAs are employer-funded health care reimbursement plans that receive favorable tax treatment under the federal Internal Revenue Code (Code). Typically, employers that sponsor HRAs establish unfunded “bookkeeping” accounts to reimburse eligible employees for substantiated medical expenses that are not covered by health insurance, such as deductibles and copayments. HRAs are often paired with group health plans that have high deductibles in order to help employees pay for the out-of-pocket medical expenses that they incur before meeting the group health plan’s out-of-pocket limits.

Although employers have some HRA plan design options available to them, there are specific rules regarding eligibility, contributions and reimbursements. Also, the ACA’s market reforms have substantially narrowed the types of HRAs that are permitted under federal law.

Types of HRAs

Before 2014, employers could offer an HRA in conjunction with a group health plan, or they could offer an HRA without a group health plan (that is, a stand-alone HRA). Also, HRAs could be designed to reimburse premiums for individual health insurance policies. This changed, however, when the ACA’s market reforms became effective in 2014.

Effective for plan years beginning on or after Jan. 1, 2014, most stand-alone HRAs are prohibited. HRAs that are integrated with other group health coverage do not violate the ACA and continue to be permissible. Also, as explained in more detail below, QSEHRAs are a new type of stand-alone HRA that are not subject to the ACA’s market reforms and can be offered by small employers beginning in 2017.

Favorable Tax Treatment:

HRAs are an attractive option for employers and employees due to their tax-favored status.

Employers may take a federal income tax deduction for HRA contributions. The value of the HRA coverage is not taxable to covered employees. Any reimbursements that employees receive from their HRAs for medical care are excludable from the employees’ income.

TYPE OF HRA	CURRENT STATUS
Integrated HRA	Permitted if the HRA satisfies one of the integration methods described below
Stand-alone HRA	Not allowed
QSEHRA	Permitted (exempt from the ACA’s reforms)
Stand-alone, retiree-only HRA	Permitted (exempt from the ACA’s reforms)
Stand-alone, limited-scope vision or dental benefit HRA	Permitted (exempt from the ACA’s reforms)

Also, effective for 2014 plan years, employers cannot use HRAs to reimburse employees for individual health insurance premiums without violating the ACA and risking exposure to **excise taxes of \$100 per day** for each applicable employee under Code Section 4980D. This restriction does not apply to HRAs that are exempt from the ACA's reforms, such as QSEHRAs.

What if the ACA is repealed? The legal rules that currently limit the types of HRAs that employers may sponsor and generally prohibit HRAs from reimbursing individual health insurance premiums are part of the ACA's reforms. If the ACA is repealed, employers may no longer be subject to these HRA restrictions, and would have more flexibility when it comes to designing their HRAs. However, the ultimate impact of repealing the ACA will depend on the specific details of the repeal, and any replacement, that is enacted.

ACA Integration Methods

There are two ways for an HRA to be considered "integrated" with another group health plan. One method imposes a minimum value requirement on the non-HRA group health plan coverage. The other method limits the types of expenses that can be reimbursed under the HRA.

Under both methods, integration does not require the HRA and the coverage with which it is integrated to share the same plan sponsor, the same plan document or governing instruments, or file a single Form 5500, if applicable. Under both integration methods, the following four requirements must be met:

- 1** The employer sponsoring the HRA must **sponsor a group health plan** (other than the HRA) that does not only provide excepted benefits.
- 2** Employees (and their spouses and dependent children) who are covered under the HRA must be **enrolled in another group health plan** that does not only provide excepted benefits, regardless of whether the employer sponsors the plan (non-HRA group coverage).
- 3** The HRA must be **available only to employees (and their spouses and dependent children) who are enrolled in the non-HRA group coverage**, regardless of whether the employer sponsors the plan.
- 4** Employees (and former employees) must be offered the opportunity to **permanently opt out and waive future reimbursements from the HRA at least annually**. On termination of employment, the remaining amounts in the HRA must be forfeited or the employee must be permitted to permanently opt out of and waive future reimbursements.

If the non-HRA group health plan coverage described in the first three requirements above meets the ACA's minimum value requirement, the HRA may reimburse any type of permitted medical care expense. However, if the minimum value standard is not met by the non-HRA group health plan coverage, the HRA can only reimburse copayments, coinsurance, deductibles and premiums under

integrated non-HRA group coverage, as well as medical care that does not constitute essential health benefits.

Eligibility Rules

As a general rule, an employer may allow any common law employee (or former employee) to participate in its HRA. While individuals who are not considered employees, such as self-employed individuals, partners in a partnership and more than 2 percent shareholders in a Subchapter S corporation, can sponsor an HRA for their employees, these self-employed individuals cannot participate in an HRA on a tax-favored basis.

Employers may decide that they only want certain groups of employees to be eligible for the HRA (for example, employees who work in a specific geographical location). While an HRA can be designed to only cover a portion of the employer’s workforce, there are two main legal restrictions to consider when designing an HRA’s eligibility rules—the Code Section 105(h) nondiscrimination rules and the ACA’s integration rules.

<p>Code Section 105(h) Rules</p>	<p>HRAs are subject to the Section 105(h) nondiscrimination rules for self-funded health plans. These rules prohibit self-insured plans from discriminating in favor of highly compensated individuals (HCIs) with respect to eligibility or benefits.</p>
<p>ACA Integration Rules</p>	<p>HRAs that are subject to the ACA’s market reforms must satisfy the integration rules described above. This generally means that the HRA can only reimburse the medical expenses of individuals (including dependents) who are actually enrolled in the non-HRA group health plan coverage.</p>

In addition to covering employees (and former employees, including retirees), HRAs may be designed to reimburse the eligible medical care expenses of an employee’s spouse (opposite sex and same-sex) and tax dependents. Due to the ACA, this also includes children who are under age 27 as of the end of the taxable year. However, unless a domestic partner qualifies as a tax dependent under the federal tax law, an HRA cannot reimburse a domestic partner’s medical care expenses on a tax-favored basis, even if the employer offers domestic partner coverage under its group health plan.

Employers may require new employees to satisfy a waiting period before they are allowed to participate in the HRA. However, for HRAs that are subject to the ACA, this waiting period cannot exceed 90 days.

Contribution Rules

Only employers are allowed to make HRA contributions. Unlike health savings accounts (HSAs) and health flexible spending accounts (FSAs), **employees cannot make contributions to their HRAs**. Also, while an HRA can be offered with a group health plan that is offered under a cafeteria plan (or Section

125 plan), the HRA itself may not be funded with pre-tax salary reductions or otherwise provided under a cafeteria plan.

Federal tax law does not impose a dollar limit on the maximum amount of HRA accruals or reimbursements in a year. Thus, an employer has flexibility in establishing this limit. However, because the Section 105(h) nondiscrimination rules apply to the benefits provided under HRAs, employers must be careful to structure HRA contributions so that they do not discriminate in favor of HCIs.

Also, unlike health FSAs, employees are not required to forfeit unused amounts in an HRA at the end of a plan year. As a design option, **employers may allow unused HRA balances to carry over to the next plan year.** Employers that allow HRA carryovers often place a cap on the carryover amount to help limit their financial exposure from year to year. For terminating employees, an employer may choose to either forfeit the unused amounts or permit the employees to spend down their account balances. In either case, employers that are subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA) must offer continuation coverage when a qualifying event (such as a termination of employment) occurs.

Timing of HRA Accruals:

An employer can choose to credit an employee's HRA account once per year, on a pro rata monthly basis or on each payday.

When making this decision, employers should take into account employees' cash flow needs and their own risk of loss for employees who terminate employment during the year.

Reimbursements

An HRA can only reimburse employees for amounts spent on **medical care, as defined under Code Section 213(d)**, with some specific limitations. Code Section 213(d) broadly defines "medical care" to include amounts paid "for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body." Employers that sponsor HRAs can further limit the expenses that are eligible for reimbursement. For example, some HRAs exclude certain expenses that are difficult to administer, such as expenses that could be for personal as well as medical reasons.

The following are examples of common medical care expenses that may be reimbursed by an HRA:

- ✓ Drugs and medicine (with a prescription)
- ✓ Orthodontia
- ✓ Drug addiction treatment
- ✓ Eye exams, eyeglasses, contact lenses or vision correction surgery
- ✓ Deductibles, copayments and coinsurance (if the underlying expense is for medical care)
- ✓ Dental exams and procedures
- ✓ Hearing exams and hearing aids
- ✓ Fertility treatments
- ✓ Durable medical equipment (for example, crutches)
- ✓ Genetic testing or counseling (to the extent the testing is done to diagnose a medical condition or to determine possible defects)

An HRA can only reimburse medical care expenses that **are not reimbursed from other health plan coverage** and that the employee does not claim as a deduction on his or her tax return.

An HRA may only reimburse eligible medical care expenses that are **incurred while an individual's HRA coverage is in effect**. For example, a medical expense that an individual incurs before enrolling in the HRA is not eligible for reimbursement. However, claims that are incurred during one plan year and are not reimbursed during that year (for example, because the individual exhausted his or her HRA balance) may be reimbursed in a future coverage period, depending on the HRA's design. Employers may establish deadlines for submitting claims to restrict the time period for seeking reimbursement. For example, an HRA sponsor may require all claims for a coverage period to be submitted within 90 days after the coverage period ends.

Substantiation Requirement:

HRA claims must be substantiated with information from a third party, such as a health care provider's receipt or bill.

HRA claims must include a statement from the participant that the medical expense has not been reimbursed from another source and that the participant will not seek reimbursement from another health plan.

Due to the administrative expense involved with substantiating claims and HIPAA privacy concerns, many employers hire third-party administrators (TPAs) to substantiate HRA claims.

Unlike health FSAs, HRAs are not subject to the uniform coverage rule. This means that reimbursements from an HRA may be limited to an individual's current HRA balance, and that the maximum amount of reimbursement under an HRA does not have to be available at all times during the period of coverage. For this reason, employers will often decide to prorate their HRA accruals throughout the year.

The federal tax rules also strictly prohibit HRAs from "cashing out" HRA balances (that is, paying some or all of an individual's HRA balance in cash or other taxable benefits). Thus, when an employee dies or terminates employment, an employer may allow the employee (or his or her surviving spouse and dependents) to spend down an HRA account balance to pay for eligible medical expenses, but the balance cannot be cashed out.

QSEHRAs

The [21st Century Cures Act](#) (Cures Act), which was signed into law in December 2016, allows small employers that do not maintain group health plans to establish QSEHRAs, effective for plan years beginning on or after Jan. 1, 2017. Depending on its plan design, a QSEHRA may be used to pay for individual health insurance policies and other out-of-pocket medical expenses. Specific requirements apply to QSEHRAs, including a maximum benefit limit and a notice requirement, as described below.

Eligible Employers

To be eligible to offer a QSEHRA, an employer must meet the following two requirements:

- ✓ The employer is not an applicable large employer (ALE) that is subject to the ACA's employer shared responsibility rules.

- ✓ The employer does not maintain a group health plan for any of its employees.

ALEs are employers that employ, on average, at least 50 full-time employees, including full-time equivalents, during the preceding calendar year. ALE status is determined on a controlled group basis.

Design Requirements

Like all HRAs, a QSEHRA must be funded solely by the employer. Employees cannot make their own contributions to an HRA, either directly or indirectly through salary reduction contributions. In addition, the following requirements apply to QSEHRAs:

<p>Maximum Benefit</p>	<p>The maximum benefit available under the QSEHRA for any year cannot exceed \$4,950 (or \$10,000 for QSEHRAs that also reimburse medical expenses of the employee’s family members). These dollar amounts are subject to adjustment for inflation for years beginning after 2016. The maximum dollar limits must be prorated for individuals who are not covered by the QSEHRA for the entire year.</p>
<p>Eligibility and Benefit Rules</p>	<p>The QSEHRA must be provided on the same terms to all eligible employees except:</p> <ul style="list-style-type: none"> • The maximum benefit may vary based on age and family-size variations in the price of an individual policy in the relevant individual health insurance market; and • The QSEHRA may exclude certain categories of employees, including collectively bargained employees, employees who are part time or seasonal, employees who have not completed 90 days of service, employees who are younger than age 25 and nonresident aliens without earned income from sources within the United States.
<p>Reimbursements</p>	<p>QSEHRA payments or reimbursements must be limited to Code Section 213(d) medical care expenses incurred by the employee or the employee’s family members, after the employee provides proof of coverage. This would include, for example, premiums for individual health insurance coverage and other out-of-pocket medical expenses.</p>

Employee Notice

An employer funding a QSEHRA for any year must provide a written notice to each eligible employee. This notice must be provided no later than 90 days before the beginning of the year. For employees who become eligible to participate in the QSEHRA during the year, the notice must be provided by the date on which the employee becomes eligible to participate.

If an employer fails to provide this notice for a reason other than reasonable cause, the employer may be subject to a penalty of \$50 per employee for each failure, up to a maximum annual penalty of \$2,500 for all notice failures during the year.

The notice must include the following information:

- The employee’s maximum benefit under the QSEHRA for the year;
- A statement that, if the employee is applying for advance payment of the premium assistance tax credit, the employee should provide the Exchange with information about the QSEHRA’s maximum benefit; and
- A statement that, if the employee is not covered under minimum essential coverage for any month, the employee may be subject to a penalty under the ACA’s individual mandate and reimbursements under the QSEHRA may be includible in gross income.

As transition relief, the Cures Act gave small employers until March 13, 2017, to provide the initial QSEHRA notice. However, on Feb. 27, 2017, the Internal Revenue Service (IRS) issued [Notice 2017-20](#) to delay the initial QSEHRA notice deadline until further guidance is issued. According to the IRS, the new deadline for providing the initial QSEHRA notice will be no earlier than 90 days following the issuance of this guidance. In the meantime, employers that provide the QSEHRA notice to their eligible employees may rely upon a reasonable good faith interpretation of the Cures Act to determine the contents of the notice.

OTHER FEDERAL LAWS

ERISA

An HRA is an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA). Unless an employer is exempt from ERISA because it qualifies as a church or governmental employer, its HRA must comply with ERISA’s standards. This means that the HRA must have a plan document and summary plan description (SPD) and is subject to the Form 5500 annual filing requirement (unless an exception applies). Also, if an HRA is funded, it will be subject to additional rules under ERISA regarding plan assets.

ERISA’s general compliance requirements for employee benefit plans apply to QSEHRAs, although the special rules for group health plans may be inapplicable. More guidance from federal agencies on this topic would be helpful.

COBRA

HRAs are group health plans that are subject to COBRA, unless the employer sponsoring the plan is a small employer (with fewer than 20 employees) or a church. QSEHRAs, however, are not subject to COBRA.

Employers with HRAs that are subject to COBRA should make sure that they are providing required notices and offering COBRA coverage to participants who would lose HRA coverage due to a qualifying event. If an employee elects COBRA coverage for the HRA, the employee must have access to the unused balance and any additional accruals provided to similarly situated employees, less any year-to-date reimbursements.

Also, due to the ACA’s reforms, most employers link employees’ HRA eligibility with participation in the employer’s group health plans. If an employer coordinates HRA eligibility in this way, it can design its COBRA practices so that a qualified beneficiary who

	chooses to elect COBRA coverage may only elect the HRA in connection with the group medical plan.
HIPAA	HRAs are group health plans that are subject to the Health Insurance Portability and Accountability Act's (HIPAA) Privacy and Security Rules, unless they qualify for the exemption for small plans (with fewer than 50 participants) that are self-insured and self-administered. These same rules likely apply to QSEHRAs.
Code Section 105(h)	<p>HRAs must comply with nondiscrimination rules for self-insured health plans under Code Section 105(h). Under these rules, an HRA cannot discriminate in favor of HCIs in regards to eligibility to participate in the plan, and the benefits provided under the HRA must not discriminate in favor of participants who are HCIs.</p> <p>QSEHRAs must be provided on the same terms to all eligible employees, subject to the limited exceptions described above.</p>
W-2 Reporting	<p>The ACA requires employers to report the aggregate cost of employer-sponsored group health plan coverage on their employees' Forms W-2. This Form W-2 reporting requirement is currently optional for small employers (those that had to file less than 250 Forms W-2 for the prior calendar year). HRA coverage is exempt from the W-2 reporting requirement under the ACA.</p> <p>Small employers that sponsor QSEHRAs must report each employee's permitted benefit on his or her Form W-2 for the year.</p>