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Proposed HRA Regulations Would Give Employers a Choice Between the Individual and Group Markets

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INTRODUCTION

On October 29, 2018, the Departments of Health and Human Service (HHS), Labor, and Treasury (the Departments) published proposed regulations that, when finalized, would allow employers to offer health coverage to their employees in the individual insurance market while obtaining tax advantages currently only available for coverage provided through the group market. Thus, employers would have a choice between the group market and the individual market in designing their health coverage for employees.

The proposed regulations will not become effective until finalized and are proposed to apply for plan years beginning on or after January 1, 2020.

The choice between the group and individual markets would be most beneficial to employers currently in the large group market whose workforces are much less healthy than average. The cost of coverage paid by an employer in the large group market is ordinarily based on the experience of that employer. Employers with unhealthy workforces must pay higher rates than other employers. By providing a choice between the group and individual markets, the new regulations would allow these employers to cover their employees through the individual market, which is community rated, and thus could lower the cost of providing coverage.

Other employers – those in the small group market and the large group market with healthy or near average workforces – will have the same choice but much less incentive to move their employees' coverage to the individual market. Employers in the large group market with healthy workforces currently enjoy lower rates resulting from their favorable experience and would pay more if they switched the coverage to the community-rated individual market. Employers in the large group market with workforces whose health is near average generally would also increase their costs by switching to the individual market. The group market covers primarily active employees, while the individual market covers a mix of working and non-working individuals. Because the population that is actively working is, on average, healthier than the population that is not, average rates in the group market tend to be lower than the average in the individual market and so employers with workforces of average health would still have an incentive to stay in the group market.

Employers in the small group market would also have the option to switch to the individual market but may face increased costs if they did so. The small group market, like the individual insurance market, is community-rated but the population covered in the small group market, which is primarily active employees, is generally healthier than that in the individual market and so the cost of coverage will often be lower in the small group market. Under current law, an employer in the small group market can offer group coverage at a community-rated premium and can integrate that coverage with an HRA if it so chooses. It has been argued, however, that small employers may benefit by being able to provide their employees access to a greater variety of coverage options

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through the individual market or that they may be able to lower their administrative costs.[1]

The proposed regulations would permit employers to provide coverage in the individual market on a tax-advantaged basis through a variety of arrangements, but the arrangement highlighted in the proposed regulations (as in the current final regulations) is a health reimbursement arrangement (HRA). The term HRA was coined in Notice 2002-45. At that time, health flexible spending arrangements (FSAs) were required to forfeit all amounts not used by the employee for expenses during the year.[2] Many employers wished to offer their employees, on a tax-favored basis, nominal accounts that would be available for reimbursement of medical expenses and under which amounts not used in one year would carry over to the next. Notice 2002-45 explained the conditions under which this would be permitted.

Under Notice 2002-45 and subsequent guidance, an HRA is an arrangement that meets three requirements. First, the funds available to pay reimbursements must be from the employer and not from salary reduction contributions by employees or other amounts under a cafeteria plan. Second, the amounts available under the HRA must be available solely to reimburse the employee for medical care expenses incurred by the employee or the employee's spouse, dependents, or children under the age of 27. Third, the arrangement provides reimbursements up to a maximum dollar amount for a coverage period and any unused portion of the maximum dollar amount at the end of a coverage period is carried forward to increase the maximum reimbursement amount in subsequent coverage periods.

In colloquial usage, the term HRA is also often used to refer to nominal accounts that meet the conditions for an HRA but which provide that amounts not used in a year are forfeited at the end of the year. The proposed regulations use the term HRA in this looser sense – covering both accounts under which amounts may be carried over from year to year and those requiring forfeiture at the end of the year.

There is an alphabet soup of accounts used in connection with group health plans – health savings accounts (HSAs), medical savings accounts (MSAs), and flexible spending arrangements (FSAs) – and HRAs are often lumped in with them. It is worth noting, however, that unlike some other accounts, HRAs get no special tax treatment. Notice 2002-45 simply applied general tax principles to develop the conditions for an HRA, and similar arrangements existed before Notice 2002-45 (although they were not called HRAs).

The proposed regulations, although they specifically reference HRAs in many places, also do not accord HRAs special treatment. Instead, HRAs are used as an example of what the proposed regulations refer to as an ''account-based group health plan.'' Account-based group health plan is defined in the proposed regulations as ''an employer-provided group health plan that provides reimbursements of medical care expenses with the reimbursement subject to a maximum fixed dollar amount for a period.''[3] HRAs are specifically included in the definition and QSEHRAs[4] are specifically excluded. The preamble provides that arrangements under which an employer reimburses premiums for individual coverage would also be considered account-based group health plans.[5] For ease of exposition, this article will primarily refer to HRAs, but it should be kept in mind that other account-based group health plans will generally get the same treatment.

The first section below discusses the current law treatment of HRAs for purposes of the market reform provisions of the Affordable Care Act (ACA). The following section summarizes the conditions under which the new proposed regulations would allow employers to provide coverage through the individual market by means of integrated HRAs and other account-based group health plans. The next section discusses the effect on different types of employers and collateral effects on the individual market and taxpayers. The final section briefly mentions some additional issues addressed in the proposed regulations and in Notice 2018-88, a follow-up to the proposed regulations that were released on November 18, 2018.

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[1] Note, however, that an employer would still need to administer the HRA and the requirements described below to integrate an HRA with an individual market plan. Switching to an arrangement in which employees must find their own individual market policy also puts a greater burden on the employees, which the employer may view as a positive or negative consideration. On the one hand, this extra burden may lead to employee dissatisfaction. On the other hand, the employer may hope to lower its costs of providing coverage because some employees will not go through the trouble of finding their own individual market policy and therefore will not get the HRA either, which will reduce the employer's cost.

[2] Health FSAs are now permitted to carry over up to $500 from year to year but HRAs still provide a significant advantage over FSAs in that there is no limit on the amount that can be carried over.

[3] Prop. Treas. Reg. §54.9815-2711(d)(6)(i). As has been the practice in HIPAA and the ACA, the Departments each issued a set of proposed regulations. The three sets of proposed regulations are substantially parallel except where the underlying statutory language differs. When this article cites to the regulations, it will cite to the proposed Treasury Regulations, rather than all three sets.

[4] A qualified small employer health reimbursement arrangement (QSEHRA) is defined in I.R.C. §9831(d).

[5] 83 Fed. Reg. 54,421 (Oct. 29, 2018). HSAs and MSAs are generally not considered group health plans and so are not subject to the market reform requirements. 83 Fed. Reg. at 54,422.

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ACA MARKET REFORM PROVISIONS: CURRENT LAW TREATMENT OF HRAs

The ACA contains various market reform provisions that apply to the group and individual insurance markets. An HRA is a group health plan and is subject to the market reform provisions.

By itself, an HRA generally cannot satisfy two of these ACA market reform provisions. First, Public Health Service Act (PHSA) §2711 prohibits annual or lifetime limits on essential health benefits (EHBs).[6] Because the reimbursement for medical expenses from an HRA is limited to the amount in the employee's nominal account, HRAs cannot provide coverage for EHBs without limits. Second, PHSA §2713 requires that group health plans provide preventive services without cost to the participant. Again, because an HRA only provides limited reimbursement of medical expenses, it cannot provide preventive services without cost if the amount the HRA would be obligated to pay to the providers of the services exceeded the amount in the employee's nominal account.

The current regulations allow HRAs to be **integrated** with certain other group health plans. For this purpose, **integration** means that the HRA and another group health plan are, in effect, treated as one plan for purposes of determining compliance with the market reform provisions.

There are five requirements under current law for an HRA or other account-based plan to be integrated with another group health plan. In the discussion that follows, this article generally uses ''HRA'' as a shorthand for ''HRA or other account-based plan''[7] and ''non-HRA'' for a group health plan that is not an HRA or other account-based plan.

Specifically, under current law, for an HRA to be integrated with another group health plan with respect to an employee of an employer:

1) The employer must offer a non-HRA group health plan to the employee that does not consist solely of excepted benefits.[8]

2) The employee receiving the HRA must be actually enrolled in a non-HRA group health plan that does not consist solely of excepted benefits.

3) The HRA must be available only to employees who are enrolled in non-HRA group coverage.

4) If the employer offers the employee a non-HRA group health plan that provides minimum value (MV), the employee is actually enrolled in a non-HRA group health plan that provides MV, and the HRA is available only to employees who are enrolled in non-HRA coverage that provides MV, the HRA can reimburse any medical expenses incurred by the employee or the employee's spouse, dependents, or children under the age of 27. Otherwise, the benefits under the HRA must be limited to reimbursement of one or more of the following: copayments, co-insurance, deductibles, and premiums under the non-HRA group coverage, and medical care that does not constitute EHBs.

5) Under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA.[9]

Although the current final regulations require, as a condition of integration, that the employer offer the employee a non-HRA group health plan that does not consist solely of excepted benefits, and that the employee be enrolled in such a non-HRA group health plan, the plan in which the employee is enrolled is not required to be one offered by his employer. For example, suppose Employee E is employed by Employer A, and S (Employee E's spouse), is employed by Employer B. If Employee E turns down the non-HRA group health plan offered by Employer A, and instead enrolls in the non-HRA group health plan of S's employer B, B's non-HRA group health plan could be integrated with an HRA offered by A (if the remaining requirements were met).

Although the current final regulations allow integration of an HRA offered by one employer with the non-HRA group health plan offered by another employer, the regulations do not allow integration of an HRA with an individual insurance policy. The reason

[6] PHSA §2711. The market reform provisions appear only in the PHSA but are incorporated into the Internal Revenue Code (Code) by I.R.C. §9815 and into the Employee Retirement Income Security Act by ERISA §715. Essential health benefits are defined in ACA §1302(b).

[7] The current final regulations refer to ''account-based plans,'' which are defined as employer-provided group health plans that provide reimbursements of medical expenses other than individual market policy premiums, with the reimbursement subject to a maximum fixed dollar amount for a period. Treas. Reg. §54.9815-2711(d)(6). The proposed regulations would change ''account-based plans'' to ''account-based group health plans'' and would substantively modify the definition.

[8] Excepted benefits are defined in §9831(c) and are discussed further below.

[9] Treas. Reg. §54.9815–2711(d)(2).

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integration with an individual policy is not allowed is concern that it would drive up premiums in the individual market. As explained above, if employers are offered a choice between covering their employees through the group market or the individual market, there will be an incentive for employers in the large group market with unhealthy workforces to cover their employees through the individual market, thereby driving up premiums in that market.

INTEGRATION OF HRAs WITH INDIVIDUAL POLICIES UNDER THE NEW PROPOSED REGULATIONS

Requirements for Integration

The new proposed regulations, when finalized, would allow employers to integrate an HRA or other account-based group health plan with **individual health insurance coverage** if certain conditions were satisfied. Individual health insurance coverage is defined as ''health insurance coverage offered to individuals in the individual market'' and can include dependent coverage but does not include short-term limited duration coverage (STLDI).[10] For purposes of the proposed regulations, individual health insurance coverage also does not include coverage that consists solely of excepted benefits.[11]

The new proposed regulations would also give guidance on the effect of such arrangements on an individual's ability to obtain a premium tax credit and a means for applicable large employers (ALEs) to avoid additional payments under the employer mandate of §4980H[12] if they provide an HRA integrated with individual health insurance coverage. Employers would also continue to be permitted to integrate an HRA with a non-HRA group health insurance plan, as under current law.

An HRA or other account-based group health plan that is intended to be integrated with an individual health insurance coverage is referred to in Notice 2018-88 as an ''individual coverage HRA,'' and this terminology is used below. Some of the requirements that would be imposed by the proposed regulations for an HRA to be integrated with an individual market policy are analogous to those that apply to integration of an HRA with a non-HRA group health plan, while others are intended to limit the potential impact on the individual market. The drafters of the proposed regulations put a great deal of thought and effort into providing rules that would mitigate the adverse effect on the individual market of allowing HRAs to be integrated with individual insurance policies, and may well have done as much as they could given the constraints under which they were operating. Nevertheless, the potential remains for significant increases in individual market premiums if the regulations are finalized as proposed.

Under the proposed regulations, the following requirements would be required to be satisfied in order to integrate an individual coverage HRA with individual health insurance coverage:

Must be enrolled in individual health insurance coverage. Each employee and dependent whose medical care expenses are reimbursable under the individual coverage HRA would be required to be enrolled in individual health insurance coverage that satisfies the requirements of PHSA §2711 (no annual or lifetime limits on EHBs) and PHSA §2713 (free preventive services). The individual coverage HRA would be required to implement reasonable procedures to ensure that individuals whose medical care expenses are reimbursable by the HRA are, or will be, enrolled in individual health insurance coverage for the plan year.[13]

In addition to the initial verification, the HRA would not be permitted to reimburse participants for any medical care expenses unless, prior to each reimbursement, the participant provided substantiation that the participant or dependent whose medical care expenses are requested to be reimbursed continued to be enrolled in individual health insurance coverage for the month during which the medical care expenses were incurred. The verification could take the form of a written attestation by the participant.[14]

Must be offered to all members of class on same terms and conditions. An employer that offers an individual coverage HRA to a current employee generally would be required to offer the individual coverage HRA in the same amount and on the same terms and conditions to all participants in the ''class'' that includes the employee. Amounts that are carried over from a prior year under the HRA would not be taken into account in determining whether all employees in

[10] Both individual health insurance coverage and STLDI are defined in Treas. Reg. §54.9801-2.

[11] Prop. Treas. Reg. §54.9802-4(c)(1).

[12] All section references are to the Internal Revenue Code of 1986, as amended (Code), and the regulations thereunder, unless otherwise indicated.

[13] Prop. Treas. Reg. §54.9802-4(c)(5)(i). Under the proposed regulations, requiring the participant to provide documents from third parties that show the individual market coverage, or requiring the participant to attest to such coverage, including the provider and dates of coverage, are examples of reasonable procedures.

[14] Prop. Treas. Reg. §54.9802-4(c)(5)(ii). The HRA could rely on the attestation unless it had actual knowledge that it was not accurate. Prop. Treas. Reg. §54.9802-4(c)(5)(iii).

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the class are offered the same amount.[15] Under the proposed regulations, larger amounts could be offered to employees in the class who are older or have a larger number of dependents, however, as long as all employees in the class who are the same age or have the same number of dependents are offered the same amount.[16]

Some of the permitted variations under the proposed regulations may raise issues under the nondiscrimination rules for self-insured group health plans in §105(h). Notice 2018-88 requested comments on various issues relating to the proposed regulations, including the application of §105(h) to individual coverage HRAs.

Only the following distinctions would be permitted to be used to divide employees into classes:

1) full-time employees, within the meaning of the regulations under either §105(h) (nondiscrimination rules for self-insured plans) or §4980H (employer mandate),
2) part-time employees, within the meaning of the regulations under either §105(h) or §4980H,
3) seasonal employees, within the meaning of the regulations under either §105(h) or §4980H,
4) employees in a collective bargaining unit, as defined in the regulations under §105(h),
5) employees who have not satisfied the waiting period under the HRA, which must not exceed 90 days,
6) employees who have not attained age 25 prior to the beginning of plan year,
7) non-resident aliens with no U.S.-based income (generally, foreign employees who work abroad),
8) employees whose primary site of employment is in same rating area, as defined in 45 C.F.R. §147.102(b).[17]

So, for example, an employer could offer an individual coverage HRA on the same terms to all full-time employees but not offer an individual coverage HRA to part-time employees, or offer an individual coverage HRA to part-time employees that is different in amount or in terms and conditions from that offered to full-time employees.

Other classifications, such as salaried vs. hourly, or job title, could not be used to distinguish among employees. For example, if a company had both salaried and hourly employees, it would be impermissible to offer an HRA to the salaried employees but not the hourly employees, unless one of the classes above permitted such a distinction (such as if the hourly employees were members of a collective bargaining unit and the salaried employees were not).

Employers would also be permitted to combine two or more of the factors above to determine a class. For example, an individual coverage HRA could be offered only to full-time workers who are part of a collective bargaining unit. Although, under the general rules prohibiting discrimination based on a health factor under HIPAA and the ACA, an employer is permitted to provide more favorable treatment to employees with a health factor, this would not be permitted under the proposed regulations for an individual coverage HRA.

For the first three classes above – full-time, part-time, and seasonal employees – an employer would be permitted to choose either the definitions that apply under §105(h) or those that apply under §4980H. The employer, however, would be required to use either the §4980H definitions or the §105(h) definitions for all three classes and would not be permitted to mix and match.[18]

Must not offer employee choice between individual coverage HRA and traditional group health plan. A plan sponsor that offers any class of employees an individual coverage HRA would not be permitted to offer a ''traditional group health plan'' to that class of employees. A traditional group health plan is any group health plan other than an account-based group health plan or a group health plan that consists solely of excepted benefits.[19]

Former employees would be treated somewhat differently than current employees. Former employees are considered to be in the same class they were in immediately before separation from service. Employers would be permitted to offer an individual coverage HRA to some, but not all, former employees within a class of employees. However, if a plan sponsor offers the individual coverage HRA to one or more former employees within a class of employees, the

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[15] *Id.*

[16] Prop. Treas. Reg. §54.9802-4(c)(3). Employers (other than certain small employers) are not permitted to offer coverage on an Exchange as a benefit under a cafeteria plan that can be paid for with salary reduction contributions. I.R.C. §125(f)(3). An employer can, however, permit premiums for individual health insurance coverage offered off of the Exchange to be paid for with salary reduction contributions through a cafeteria plan. If the employer offers any employees the choice to pay for non-Exchange individual health insurance coverage with salary reduction contributions, it must offer that choice to all employees in the class.

[17] Rates for coverage in the individual and small group markets are permitted to vary between different rating areas in a state. 45 C.F.R. §147.102(a)(1)(ii). Rating areas are established by a state or the Centers for Medicare and Medicaid Services based on significant differences in the cost of health coverage in different areas of the state and other factors. 45 C.F.R. §147.102(b).

[18] Prop. Treas. Reg. §54.9802-4(d)(2).

[19] Prop. Treas. Reg. §54.9802(c)(2).

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HRA must be offered to the former employees on the same terms as to all other employees (current and former) within the class.[20]

Opt-out available annually and upon termination. The employer would be required to permit participants to opt out of and waive future reimbursements from the individual coverage HRA at least annually. In addition, when a participant terminates employment, either the remaining amounts in the individual coverage HRA would be required to be forfeited or the employer would be required to permit the participants to permanently opt out of and waive future reimbursements.

Annual Notice. Employers maintaining individual coverage HRAs generally would be required to provide a written notice to each participant at least 90 days before the beginning of each plan year.[21] The notice would be required to contain an explanation of the consequence of accepting the individual coverage HRA for eligibility for a premium tax credit (PTC) and to provide information that the plan sponsor has and that the participant will need to determine the effect of being offered the individual coverage HRA on PTC eligibility.

Coordination with Premium Tax Credit

Under the ACA, an employee is not eligible for a PTC for a month if either: (1) the employee is eligible for coverage under an eligible employer-sponsored plan and the coverage is **affordable** and provides minimum value (MV), or (2) the employee actually enrolls in an eligible employer-sponsored plan, even if the coverage is not affordable and does not provide MV. Coverage under an eligible employer-sponsored plan is **affordable** if the cost of self-only coverage under the plan is no greater than a specified percentage of the individual's household income – the required contribution percentage.[22] The required contribution percentage is adjusted each year and is 9.86% for 2019.[23]

The proposed regulations would provide rules for coordinating individual coverage HRAs with eligibility for a PTC. Under the proposed regulations, if an employee is actually covered by an individual coverage HRA for a month, the employee is not eligible for a PTC for that month, regardless of whether the individual coverage HRA is affordable or provides MV.[24]

If an employer offers an employee an individual coverage HRA that is affordable and provides MV, then the employee is not eligible for a PTC even if the employee turns down the individual coverage HRA.[25] Under the proposed regulations, an individual coverage HRA is affordable for a month if the excess of: 1) the monthly premium for self-only coverage under the lowest-cost silver plan available to employee over 2) the **monthly amount** available under the HRA for self-only coverage, does not exceed the required contribution percentage. The monthly amount under the HRA is generally the amount newly made available under the HRA for the plan year divided by 12.[26] Amounts available under the HRA that are carried over from a prior year are not taken into account in determining affordability.[27]

The proposed regulations further provide that, if an individual coverage HRA is affordable, it also provides MV (because employees can use the amount available to purchase a silver plan, which provides MV). Accordingly, if an employee is offered an individual coverage HRA that is affordable, the employee is generally not eligible for a PTC even if the employee turns down the HRA.

Coordination with Employer Mandate

Section 4980H, the employer mandate provision of the ACA, provides that applicable large employers (ALEs) may be liable for a payment under either §4980H(a) or §4980H(b) if they fail to offer coverage to their employees or if the coverage is not affordable or does not provide MV. The proposed regulations do not include proposed regulations under §4980H but the rules provided for purposes of the PTC would determine whether a §4980H(a) or §4980H(b) payment would apply.

If an ALE offers an eligible employer-sponsored plan to at least 95% of the employer's full-time employees and their dependents, the employer is not subject to a §4980H(a) penalty. An individual coverage HRA is an eligible employer-sponsored plan and thus an offer of an individual coverage HRA would count towards meeting the 95% threshold to avoid a §4980H(a) penalty.

An employer is potentially subject to a §4980H(b) penalty only with respect to full-time employees of

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[20] Prop. Treas. Reg. §54.9802-4(c)(3).

[21] Prop. Treas. Reg. §54.9802(c)(6)(i). If a participant is not eligible to participate at the beginning of the plan year (or at the time the notice for that plan year was provided), the employer would be required to provide the notice no later than the date on which the participant is first eligible to participate in the HRA.

[22] Treas. Reg. §1.36B-2(c)(3)(v)(A).

[23] Rev. Proc. 2018-34, §2.02.

[24] Prop. Treas. Reg. §1.36B-2(c)(3)(i)(B).

[25] *Id.*

[26] Prop. Treas. Reg. §1.36B-2(c)(5). The proposed regulations would provide adjustments to this calculation if the employee is not eligible for the HRA for the full plan year or if portions of the plan year fall in different taxable years.

[27] Prop. Treas. Reg. §1.36B-2(c)(5)(v).

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the employer that actually obtain a PTC on an Exchange. Consistently with the rules for coordination of the individual coverage HRA and the PTC described above, an employee would not be eligible for a PTC if the employee either was actually covered by an individual coverage HRA (whether or not it was affordable or provided MV) or if the employee was offered an individual coverage HRA that was affordable (which in turn would automatically satisfy MV).

Effect on Individual Market if the Regulations are Finalized as Proposed

Although the proposed regulations contain provisions that attempt to mitigate the effect on rates in the individual market of employers sending their less healthy employees to the individual market, those provisions are likely to be only partly effective. Employers in the large group market would have an incentive to send the less healthy portion of their workforces to the individual market, where the employers would pay a community-rated amount for coverage, while covering the healthier portion of their workforces in the large group market, where they can get the benefit of the favorable experience of the healthier group. The extent to which an employer can accomplish this under the proposed regulations depends on the particular facts.

For example, suppose a coal mining company employs coal miners whose health costs are considerably higher than average and office workers who are relatively healthy. Under the proposed regulations, the employer would not be able to separate the coal miners and office workers into separate classes merely because the miners are hourly and the office staff is salaried. If, however, the miners and office staff were in different rating areas, the employer could treat the miners and office workers as separate classes, which would allow it to offer an individual coverage HRA to the miners while keeping the office workers in a traditional group health plan (and providing them an HRA integrated with the traditional group health plan, if the employer so chose). Similarly, if the miners were members of a collective bargaining unit, while the office staff was not, the employer could treat them as separate classes. In this case, however, the employer would have to bargain with the union over transferring the miners to the individual market.

More fundamentally, the proposed regulations contain nothing that prevents an employer in the large group market whose workforce is very unhealthy on average from moving all of its employees to the individual market. For example, if the average cost of coverage for a coal mining company were significantly higher overall than average, it could provide an individual coverage HRA to all of its employees, thereby obtaining coverage for them on the community-rated individual market.

To the extent that this adverse selection in the employees who move from the group market to the individual market results in higher rates in the individual market, much of the increased cost would be borne by taxpayers, in the form of higher PTCs for individuals who are eligible for the PTC. Another part of the cost would be borne by individuals covered in the individual market who are not eligible for a PTC, who will have to pay higher rates for coverage or forego coverage. A third part of the cost would circle back to employers who provide individual coverage HRAs, in that higher rates in the individual market will require them to provide a higher subsidy to employees in order for the coverage to remain affordable.

The economic analysis accompanying the proposed regulations estimates the increase in the individual market will be very small – less than 1% overall.[28] This may be overly optimistic.

EXCEPTED BENEFITS HRA

Excepted benefits are not subject to the requirements of Chapter 100 of the Code, including the ACA market reform provisions. Section 9831(c), and corresponding provisions of ERISA and the PHSA, contain a list of benefits that are considered excepted benefits and authorize the Departments to designate additional benefits as excepted benefits. Coverage that consists of excepted benefits is not minimum essential coverage and therefore an employee who is otherwise eligible for a PTC is not ineligible for the PTC merely because the employee is covered by excepted benefit.

The proposed regulations would provide that an HRA or other account-based group health plan that meets certain requirements would be an excepted benefit, and thus exempt from the market reform requirements, if the following requirements were satisfied:[29]

- Other group health plan coverage that is not limited to excepted benefits, and that is not an HRA or other account-based group health plan, is made available by the employer for the plan year to the participant. A participant could enroll in the excepted benefit HRA, however, even if the participant declines coverage in the other group health plan coverage.
- The amounts newly made available for each plan year under the HRA or other account-based group health plan do not exceed $1,800 (adjusted for in-

[28] 83 Fed. Reg. 54,445 (Oct. 29, 2018).

[29] Prop. Treas. Reg. §54.9831-1(c)(3)(viii).

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flation for years after 2020). Amounts carried over from prior years are disregarded for this purpose. If the plan sponsor provides more than one HRA or other account-based group health plan to the participant for the same time period, the amounts made available under all such plans are aggregated toward the $1,800 limit.

- The HRA or other account-based group health plan does not reimburse premiums for individual health insurance coverage, group health plan coverage (other than COBRA continuation coverage or other continuation coverage), or Medicare parts B or D (except coverage that consists solely of excepted benefits). The HRA would be permitted to reimburse STLDI premiums.

- The HRA or other account-based group health plan is made available under the same terms to all **similarly situated** individuals, regardless of any health factor. **Similarly situated** is defined in the regulations governing nondiscrimination[30] and is more flexible than the definition of classes that applies to integrated individual coverage HRAs.

[30] *See* Treas. Reg. §54.9802-1(d) for the definition of ''similarly situated.''

ADDITIONAL MATTERS, NOTICE 2018-88, AND REQUESTS FOR COMMENTS

In addition to the items described above, the package of proposed regulations contains: 1) HHS proposed regulations that would provide a special enrollment period in the individual market for individuals who gain access to and enroll in an individual coverage HRA or who are provided a QSEHRA; and 2) a proposed clarification from the DOL to provide plan sponsors with assurance that the individual health insurance coverage, the premiums of which are reimbursed by an HRA or a QSEHRA, does not become part of an ERISA plan if certain conditions are met (and the Departments provided a related clarification of the definition of the term ''group health insurance coverage'').

On November 18, 2018, the IRS and Treasury released Notice 2018-88, which requested comments on various issues relating to the proposed regulations. Among these issues are potential safe harbors for purposes of the employer mandate and the application of the nondiscrimination rules for self-insured group health plans in §105(h) to individual coverage HRAs.

Comments on the proposed regulations and on Notice 2018-88 were due by December 28, 2018. The proposed regulations cannot be relied on until finalized.

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