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DOL, IRS, and HHS Put the Brakes on Stand-Alone HRAs Used to Access Health Insurance Coverage in the Individual Market

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In a set of Frequently Asked Questions[1] (FAQs) posted to the Department of Labor's website on January 24, the Departments of Health and Human Services, Labor, and Treasury (the "Departments") put a stop to an approach to health plan design under which employers furnish employees with a pre-determined dollar amount (a "defined contribution") that employees can apply toward the purchase of health insurance coverage in the individual health insurance market.

An arrangement under which an employer provides an amount of money to employees to pay for unreimbursed medical expenses or for individual market premiums is itself a "group health plan." Such an arrangement is referred to and regulated under the Internal Revenue Code as a "health reimbursement arrangement" or "HRA."[2] The HRA approach described above is referred to as a "stand-alone HRA" to distinguish it from arrangements in which the HRA is paired with an employer's group health plan. This latter HRA design is referred to as an "integrated HRA."

The rules governing HRAs stand in contrast to cafeteria plans and medical flexible spending arrangements, which pave the way for employee contributions to be paid with pre-tax dollars. Where employee contributions are limited to premiums, the cafeteria plan is referred to colloquially as a "premium-only" plan. Where employees can set aside their own money to pay for certain medical expenses including co-pays and co-insurance with pre-tax dollars, the arrangement is referred to as a "medical flexible spending arrangement" or "medical FSA." Medical FSAs can include employer money (typically in the form of "flex credits"), but they *cannot* be used to pay health insurance premiums.

While some vendors have begun to market stand-alone HRAs, it was never clear that HRAs used to access individual market coverage could pass muster under the Patient Protection and Affordable Care Act (the "Act") or other applicable laws. The regulatory hurdles, both before and after 2014, include the following:

1. Before 2014, carriers issuing coverage in the individual market are free to impose all manner of underwriting conditions, which raise the specter of discrimination based on health status in violation of Title I of the Health Insurance Portability and Accountability Act (HIPAA). These concerns disappear commencing in 2014 as a consequence of the Act's comprehensive overhaul of health insurance underwriting practices.
2. The Act generally prohibits group health plans and health insurance carriers from imposing lifetime or annual limits on the dollar value of essential health benefits. In prior guidance, the regulators gave a "pass" to integrated HRAs, but not to stand-alone HRAs.
3. Because individual market products are age rated, the same coverage will cost more in the hands of an older employee than in the hands of a similarly-situated younger employee. Before 2014, the variations in premium costs are a matter of state law; from and after 2014,

> the Act establishes a federal floor under "modified community rating" rules that permit a disparity of no more than 3:1. Under either regulatory regime, a flat dollar amount is thought to raise questions under the Age Discrimination in Employment Act (ADEA). Under the ADEA, variations in premiums are permitted *only* where the added cost charged to an older employee is justified by the actuarially-adjusted cost of providing the benefits to the older employee.

The FAQs cite the Act's ban on lifetime and annual limits as the basis for their objection to stand-alone HRAs used to access individual market coverage. Specifically, the FAQs note that—

> "[A]n HRA is not considered integrated with primary health coverage offered by the employer unless, under the terms of the HRA, the HRA is available only to employees who are covered by primary group health plan coverage provided by the employer. …"

The Departments state their objections unequivocally: an HRA used to purchase coverage in the individual market cannot be considered integrated with that individual market coverage. Therefore, such an arrangement does not satisfy the requirements Act prohibiting group health plans and health insurance carriers from imposing lifetime or annual limits on essential health benefits. The Departments also made clear that an employer-sponsored HRA may be treated as integrated with other coverage *only* if the employee receiving the HRA is actually enrolled in that coverage. Thus, if an HRA credits additional amounts to an individual only when he or she does not enroll in the employer's group health plan, the HRA will not comply with the Act.

Recognizing the potential hardship to existing stand-alone HRAs, the FAQs include a special rule for amounts credited or made available under HRAs in effect prior to January 1, 2014. Whether or not an HRA is integrated with other group health plan coverage, unused amounts credited before January 1, 2014 may be used after December 31, 2013 to reimburse medical expenses without running afoul of the Act. If the HRA did not prescribe a set amount or amounts to be credited during 2013, then the amounts credited cannot exceed the amount credited for 2012.

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Endnotes

1 http://www.dol.gov/ebsa/faqs/faq-aca11.html.

2 *See* IRS Notice 2002-45, 2002-2 C.B. 93 (Jun. 26, 2002) (defining an HRA as an arrangement that (i) is paid for solely by the employer and not provided pursuant to salary reduction election or otherwise, (ii) reimburses the employee for medical care expenses, and (iii) 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).

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