

**DEPARTMENT OF THE TREASURY****Internal Revenue Service****26 CFR Parts 1 and 54**

[TD 9867]

RIN 1545–BO46

**DEPARTMENT OF LABOR****Employee Benefits Security Administration****29 CFR Parts 2510 and 2590**

RIN 1210–AB87

**DEPARTMENT OF HEALTH AND HUMAN SERVICES****45 CFR Parts 144, 146, 147, and 155**

[CMS–9918–F]

RIN 0938–AT90

**Health Reimbursement Arrangements and Other Account-Based Group Health Plans**

**AGENCY:** Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

**ACTION:** Final rule.

**SUMMARY:** This document sets forth final rules to expand opportunities for working men and women and their families to access affordable, quality healthcare through changes to rules under various provisions of the Public Health Service Act (PHS Act), the Employee Retirement Income Security Act (ERISA), and the Internal Revenue Code (Code) regarding health reimbursement arrangements (HRAs) and other account-based group health plans. Specifically, the final rules allow integrating HRAs and other account-based group health plans with individual health insurance coverage or Medicare, if certain conditions are satisfied (an individual coverage HRA). The final rules also set forth conditions under which certain HRAs and other account-based group health plans will be recognized as limited excepted benefits. Also, the Department of the Treasury (Treasury Department) and the Internal Revenue Service (IRS) are finalizing rules regarding premium tax credit (PTC) eligibility for individuals offered an individual coverage HRA. In addition, the Department of Labor (DOL) is finalizing a clarification to provide assurance that the individual health

insurance coverage for which premiums are reimbursed by an individual coverage HRA or a qualified small employer health reimbursement arrangement (QSEHRA) does not become part of an ERISA plan, provided certain safe harbor conditions are satisfied. Finally, the Department of Health and Human Services (HHS) is finalizing provisions to provide a special enrollment period (SEP) in the individual market for individuals who newly gain access to an individual coverage HRA or who are newly provided a QSEHRA. The goal of the final rules is to expand the flexibility and use of HRAs and other account-based group health plans to provide more Americans with additional options to obtain quality, affordable healthcare. The final rules affect employees and their family members; employers, employee organizations, and other plan sponsors; group health plans; health insurance issuers; and purchasers of individual health insurance coverage.

**DATES:**

*Effective date:* These final rules are effective on August 19, 2019.

*Applicability dates:* The final rules generally apply for plan years beginning on or after January 1, 2020. However, the final rules under Code section 36B apply for taxable years beginning on or after January 1, 2020, and the final rules providing a new special enrollment period in the individual market apply January 1, 2020. See Section VI of the **SUPPLEMENTARY INFORMATION** section for more information on the applicability dates.

**FOR FURTHER INFORMATION CONTACT:**

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*Customer Service Information:* Individuals interested in obtaining information from the DOL concerning employment-based health coverage laws may call the EBSA Toll-Free Hotline at 1–866–444–EBSA (3272) or visit the DOL’s website ([www.dol.gov/ebsa](http://www.dol.gov/ebsa)). In addition, information from HHS on private health insurance coverage and coverage provided by non-federal governmental group health plans can be found on the Centers for Medicare & Medicaid Services (CMS) website ([www.cms.gov/ccio](http://www.cms.gov/ccio)), and information on healthcare reform can be found at [www.HealthCare.gov](http://www.HealthCare.gov).

**SUPPLEMENTARY INFORMATION:****I. Background***A. Executive Order*

On October 12, 2017, President Trump issued Executive Order 13813,<sup>1</sup> “Promoting Healthcare Choice and Competition Across the United States,” stating, in part, that the “Administration will prioritize three areas for improvement in the near term: association health plans (AHPs), short-term, limited-duration insurance (STLDI), and health reimbursement arrangements (HRAs).” With regard to HRAs, the Executive Order directs the Secretaries of the Treasury, Labor, and HHS to “consider proposing regulations or revising guidance, to the extent permitted by law and supported by sound policy, to increase the usability of HRAs, to expand employers’ ability to offer HRAs to their employees, and to allow HRAs to be used in conjunction with nongroup coverage.” The Executive Order further provides that expanding “the flexibility and use of HRAs would provide many Americans, including employees who work at small businesses, with more options for financing their healthcare.”

*B. HRAs and Other Account-Based Group Health Plans***1. In General**

An account-based group health plan is an employer-provided group health plan that provides for reimbursement of expenses for medical care (as defined under Code section 213(d)) (medical care expenses), subject to a maximum fixed-dollar amount of reimbursements for a period (for example, a calendar year). An HRA is a type of account-based group health plan funded solely by employer contributions (with no salary reduction contributions or other contributions by employees) that reimburses an employee solely for medical care expenses incurred by the employee, or the employee’s spouse, dependents, and children who, as of the end of the taxable year, have not attained age 27, up to a maximum dollar amount for a coverage period.<sup>2</sup> The reimbursements under these types of arrangements are excludable from the employee’s income and wages for federal income tax and employment tax purposes. Amounts that remain in the HRA at the end of the year often may

<sup>1</sup> 82 FR 48385 (Oct. 17, 2017). The executive order was issued on October 12, 2017 and was published in the **Federal Register** on October 17, 2017.

<sup>2</sup> See IRS Notice 2002–45, 2002–2 CB 93; Revenue Ruling 2002–41, 2002–2 CB 75; and IRS Notice 2013–54, 2013–40 IRB 287.

be used to reimburse medical care expenses incurred in later years, depending on the terms of the HRA.

HRAs are not the only type of account-based group health plan. For example, an employer payment plan is also an account-based group health plan. An employer payment plan is an arrangement under which an employer reimburses an employee for some or all of the premium expenses incurred for individual health insurance coverage, or other non-employer sponsored hospital or medical insurance. This includes a reimbursement arrangement described in Revenue Ruling 61-146, 1961-2 CB 25, or an arrangement under which the employer uses its funds directly to pay the premium for individual health insurance coverage or other non-employer sponsored hospital or medical insurance covering the employee.<sup>3</sup> Other examples of account-based group health plans include health flexible spending arrangements (health FSAs) and certain other employer-provided medical reimbursement plans that are not HRAs.<sup>4</sup>

## 2. Application of the Patient Protection and Affordable Care Act to HRAs and Other Account-Based Group Health Plans

The Patient Protection and Affordable Care Act, Public Law 111-148, was enacted on March 23, 2010 and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, was enacted on March 30, 2010 (collectively, PPACA). PPACA

<sup>3</sup> For more information about employer payment plans, see IRS Notice 2013-54, Q&A-1 and Q&A-3, and IRS Notice 2015-17, Q&A-4 and Q&A-5, 2015-14 IRB 845.

<sup>4</sup> For simplicity, the preamble generally refers only to HRAs, but references to HRAs should also be considered to include other account-based group health plans as defined in the final rules, unless otherwise specified. This term does not include QSEHRAs, under Code section 9831(d); medical savings accounts (MSAs), under Code section 220; or health savings accounts (HSAs), under Code section 223. In addition, for purposes of the final rules, the term "HRA or other account-based group health plan" does not include an employer arrangement that reimburses the cost of individual health insurance coverage through a cafeteria plan under Code section 125 (cafeteria plan premium arrangements); however see later in this preamble for a clarification that plan sponsors may offer such an arrangement in addition to an individual coverage HRA. A QSEHRA is not a group health plan for purposes of the market requirements of the Code (except as provided in Code section 4980I(f)(4)), parts 6 and 7 of ERISA, and titles XXII and XXVII of the PHS Act, and is not included in the definition of HRAs and other account-based group health plans for purposes of the final rules or this preamble. A QSEHRA is, however, considered a group health plan under the PHS Act for purposes of part C of title XI of the Social Security Act (42 U.S.C. 1320d *et seq.*). See PHS Act section 2791(a)(1), as amended by the 21st Century Cures Act (Cures Act), Public Law 114-255, section 18001(c).

reorganized, amended, and added to the provisions of part A of title XXVII of the PHS Act relating to health coverage requirements for group health plans and health insurance issuers in the group and individual markets. The term "group health plan" includes both insured and self-insured group health plans.

PPACA also added section 715 to ERISA and section 9815 to the Code to incorporate the provisions of part A of title XXVII of the PHS Act, PHS Act sections 2701 through 2728 (the market requirements), into ERISA and the Code, making them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. In accordance with Code section 9831(b) and (c), ERISA section 732(b) and (c), and PHS Act sections 2722(b) and (c) and 2763, the market requirements do not apply to a group health plan or a health insurance issuer in the group or individual market in relation to the provision of excepted benefits described in Code section 9832(c), ERISA section 733(c), and PHS Act section 2791(c).<sup>5</sup> See the discussion later in this preamble for additional background on excepted benefits. In addition, in accordance with Code section 9831(a)(2) and ERISA section 732(a), the market requirements do not apply to a group health plan that has fewer than two participants who are current employees on the first day of the plan year.<sup>6</sup>

PHS Act section 2711, as added by PPACA, generally prohibits group health plans and health insurance issuers offering group or individual health insurance coverage<sup>7</sup> from

<sup>5</sup> While the PPACA amendments to PHS Act section 2722(b) and (c) (formerly PHS Act section 2721(c) and (d)) could be read as restricting the exemption for excepted benefits so it applies only with respect to subpart 2 of part A of title XXVII of the PHS Act, HHS does not intend to use its resources to enforce the market requirements with respect to excepted benefits offered by non-federal governmental plan sponsors and encourages states to adopt a similar approach with respect to issuers of excepted benefits. See 75 FR 34537, 34539-34540 (June 17, 2010).

<sup>6</sup> While the PPACA amendments to title XXVII of the PHS Act removed the parallel provision at section 2722(a) (formerly PHS Act section 2721(a)), HHS follows a similar approach for retiree-only non-federal governmental plans and encourages states to adopt a similar approach with respect to health insurance issuers of retiree-only plans. See 75 FR 34537, 34539-34540 (June 17, 2010).

<sup>7</sup> PHS Act section 2711 applies to grandfathered health plans, except that the annual dollar limit prohibition does not apply to grandfathered individual health insurance coverage. Grandfathered health plans are health plans that were in existence as of March 23, 2010, and that are only subject to certain provisions of PPACA, as long as they maintain status as grandfathered health plans under the applicable rules. See 26 CFR 54.9815-1251, 29 CFR 2590.715-1251, and 45 CFR 147.140.

establishing for any individual any lifetime or annual limits on the dollar value of essential health benefits (EHBs), as defined in PPACA section 1302(b). PHS Act section 2711, however, does not prevent a group health plan, or a health insurance issuer offering group or individual health insurance coverage, from placing an annual or lifetime dollar limit for any individual on specific covered benefits that are not EHBs, to the extent these limits are otherwise permitted under applicable law.<sup>8</sup>

HRAs are subject to PHS Act section 2711. An HRA generally will fail to comply with PHS Act section 2711 because the arrangement is a group health plan that imposes an annual dollar limit on EHBs that the HRA will reimburse for an individual.<sup>9</sup>

<sup>8</sup> For information regarding EHBs, see HHS's February 25, 2013 final rules addressing EHBs under PPACA section 1302 (78 FR 12834 (Feb. 25, 2013)); see also HHS Notice of Benefit and Payment Parameters for 2016 (80 FR 10871 (Feb. 27, 2015)). In addition, HHS issued final rules providing states with additional flexibility to define EHBs, starting with plan years beginning on or after January 1, 2020. See 45 CFR 156.111 (83 FR 16930 (April 17, 2018)). The current rules under PHS Act section 2711 include a definition of EHBs that applies for plans that are not required to cover EHBs. See 26 CFR 54.9815-2711(c), 29 CFR 2590.715-2711(c), and 45 CFR 147.126(c). As explained later in this preamble, the rules set forth in this document include amendments to the definition of EHBs under the PHS Act section 2711 rules to reflect the updated final EHB rules.

<sup>9</sup> As explained in prior guidance, the Departments of Labor, the Treasury and HHS (the Departments) have determined that the annual dollar limit prohibition is not applicable to certain account-based group health plans that are subject to other statutory provisions limiting the benefits available under those plans. See 80 FR 72192, 72201 (Nov. 18, 2015). Specifically, the Departments have explained that the annual dollar limit prohibition does not apply to health FSAs that are offered through a cafeteria plan under Code section 125 (cafeteria plan) because PPACA section 9005 specifically limits salary reduction contributions to health FSAs to \$2,500 (indexed for inflation) per year. Notwithstanding this exclusion for certain health FSAs from the application of the annual dollar limit prohibition, rules under Code section 125 provide that health FSAs are not permitted to reimburse employees for premiums for health insurance coverage. See Code section 125(d)(2)(A) and proposed 26 CFR 1.125-5(k)(4) (72 FR 43938, 43959 (Aug. 6, 2007)). Similarly, although MSAs and HSAs generally are not treated as group health plans subject to the market requirements, the Departments have concluded that the annual dollar limit prohibition would not apply to an MSA or HSA even if a particular arrangement did satisfy the criteria to be a group health plan because both types of arrangements are subject to specific statutory provisions that limit the contributions. See 75 FR 37188, 37190 (June 28, 2010); see also IRS Notice 2004-2, Q&A-1 and Q&A-3, 2004-2 IRB 269, which defines an HSA as a tax-exempt trust or custodial account and a high-deductible health plan as a health plan; see also DOL Field Assistance Bulletin No. 2004-01, available at <https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2004-01> and DOL Field Assistance Bulletin No. 2006-02, Continued

PHS Act section 2713, as added by PPACA, generally requires non-grandfathered group health plans, and health insurance issuers offering non-grandfathered group or individual health insurance coverage, to provide coverage for certain preventive services without imposing any cost-sharing requirements for these services.<sup>10</sup> Non-grandfathered HRAs are subject to and fail to comply with PHS Act section 2713 because, while HRAs may be used to reimburse the costs of preventive services, HRAs do not reimburse such costs after the HRAs have reimbursed the maximum dollar amount for a coverage period, and therefore HRAs fail to provide the required coverage, and violate the prohibition on imposing cost sharing for preventive services.<sup>11</sup>

### 3. Prior Rules and Guidance on Integration of HRAs and Other Account-Based Group Health Plans

The Departments previously issued rules and subregulatory guidance regarding the application of PHS Act sections 2711 and 2713 to HRAs.<sup>12</sup> The

available at <https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2006-02>, which provide guidance regarding HSAs not constituting “employee welfare benefit plans” covered by ERISA Title I where employer involvement with the HSA is limited. Therefore, the final rules do not apply to MSAs, HSAs, or, in certain circumstances, health FSAs.

<sup>10</sup> See also 26 CFR 54.9815–2713, 29 CFR 2590.715–2713, and 45 CFR 147.130.

<sup>11</sup> Because MSAs and HSAs generally are not treated as group health plans, these arrangements are not subject to PHS Act section 2713. Health FSAs are group health plans and, unless they are excepted benefits, will fail to satisfy the requirements of PHS Act section 2713 unless they are integrated with other coverage that satisfies these requirements. For more information about the application of PHS Act section 2713 to health FSAs, see IRS Notice 2013–54, Q&A–7; DOL Technical Release No. 2013–03, Q&A–7, issued on September 13, 2013, available at <https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/13-03>; and CMS Insurance Standards Bulletin, Application of Affordable Care Act Provisions to Certain Healthcare Arrangements, September 16, 2013, available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cms-hra-notice-9-16-2013.pdf>.

<sup>12</sup> Rules and subregulatory guidance issued on this topic include: (1) 75 FR 37188 (June 28, 2010); (2) FAQs about Affordable Care Act Implementation (Part XI), available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xi.pdf> or [http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca\\_implementation\\_faqs11.html](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html); (3) IRS Notice 2013–54 and DOL Technical Release No. 2013–03 and CMS Insurance Standards Bulletin, Application of Affordable Care Act Provisions to Certain Healthcare Arrangements; (4) IRS FAQ on Employer Healthcare Arrangements, available at <https://www.irs.gov/affordable-care-act/employer-health-care-arrangements>; (5) FAQs about Affordable Care Act Implementation (Part XXII), available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xxii.pdf> or <https://www.cms.gov/CCIIO/>

rules and guidance generally provide that, if an HRA is “integrated” with other group health plan coverage that complies with PHS Act sections 2711 and 2713, the HRA is considered to be in compliance with those sections because the combined arrangement complies with them. The rules and guidance also provide that HRAs may be integrated with Medicare and TRICARE coverage if certain conditions are satisfied, but may not be integrated with individual health insurance coverage for purposes of complying with PHS Act sections 2711 and 2713.<sup>13</sup>

More specifically, in the preamble to the 2010 interim final rules under PHS Act section 2711, the Departments provided that HRAs may be integrated with “other coverage as part of a group health plan” that complies with PHS Act section 2711 in order for the HRAs to be considered to satisfy PHS Act section 2711.<sup>14</sup> The interim final rules did not, however, set forth rules for implementing integration; the integration methods were set forth in later subregulatory guidance and subsequently included in the final rules under PHS Act section 2711 issued in 2015.

On September 13, 2013, the Treasury Department and the IRS issued Notice 2013–54, the DOL issued Technical Release 2013–03, and HHS issued contemporaneous guidance explaining that HHS concurred with the DOL and Treasury Department guidance.<sup>15</sup> This guidance stated that an HRA may not be

*Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-XXII-FINAL.pdf*; (6) IRS Notice 2015–17, issued on February 18, 2015; (7) 80 FR 72192 (Nov. 18, 2015); (8) IRS Notice 2015–87, 2015–52 IRB 889, issued on December 16, 2015; (9) IRS Notice 2016–17, 2016–9 IRB 358, issued on February 5, 2015; DOL Technical Release No. 2016–01, issued on February 5, 2016, available at <https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/16-01>; and CMS Insurance Standards Bulletin, Application of the Market Reforms and Other Provisions of the Affordable Care Act to Student Health Coverage, issued on February 5, 2016, available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/student-health-bulletin.pdf>; (10) FAQs about Affordable Care Act Implementation Part 33, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-33.pdf> or <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ACA-FAQ-Set-33-Final.pdf>; (11) FAQs about Affordable Care Act Implementation Part 37, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-37.pdf> or <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-37.pdf>; (12) 83 FR 54420 (Oct. 29, 2018); and (13) IRS Notice 2018–88, 2018–49 IRB 817, issued on November 19, 2018.

<sup>13</sup> 26 CFR 54.9815–2711(d)(4), 29 CFR 2590.715–2711(d)(4), and 45 CFR 147.126(d)(4).

<sup>14</sup> See 75 FR 37187, 37190–37191 (June 28, 2010).

<sup>15</sup> See CMS Insurance Standards Bulletin, Application of Affordable Care Act Provisions to Certain Healthcare Arrangements.

integrated with individual health insurance coverage for purposes of PHS Act sections 2711 and 2713, but described methods for integrating an HRA with another group health plan.<sup>16</sup> The Departments later incorporated the provisions of this guidance into the final rules issued in 2015 under PHS Act section 2711<sup>17</sup>, which are summarized later in this section of the preamble.

On November 6, 2014, the Departments issued FAQs about Affordable Care Act Implementation (Part XXII).<sup>18</sup> Q&A–1 reiterated and clarified prior subregulatory guidance by explaining that if an employer offers its employees cash to reimburse the purchase of individual health insurance coverage, the payment arrangement is a group health plan, without regard to whether the employer treats the money as a pre-tax or post-tax benefit to the employee, and it may not be integrated with individual health insurance coverage, and, therefore, will fail to comply with PHS Act sections 2711 and 2713.<sup>19</sup>

On February 18, 2015, the Treasury Department and the IRS issued Notice 2015–17. Q&A–3 provided that an arrangement under which an employer reimburses (or pays directly) some or all of the medical care expenses for employees covered by TRICARE constitutes an HRA and may not be integrated with TRICARE to comply with PHS Act sections 2711 and 2713 because TRICARE is not a group health

<sup>16</sup> In addition to describing the integration methods, IRS Notice 2013–54 and DOL Technical Release No. 2013–03, in Q&A–5, provided that, whether or not an HRA is integrated with other group health plan coverage, unused amounts that are credited to the HRA while the HRA is integrated with other group health plan coverage may be used to reimburse medical care expenses in accordance with the terms of the HRA after an employee ceases to be covered by the integrated group health plan coverage without causing the HRA to fail to comply with PHS Act sections 2711 and 2713. In IRS Notice 2015–87, Q&A–2, however, the Departments clarified that an HRA that includes terms permitting the purchase of individual health insurance coverage, even if reimbursement is only allowed after the employee ceases to be covered by other integrated group health plan coverage, fails to be integrated with other group health plan coverage and therefore fails to comply with PHS Act sections 2711 and 2713.

<sup>17</sup> See 80 FR 72192 (Nov. 18, 2015).

<sup>18</sup> See FAQs about Affordable Care Act Implementation (Part XXII), available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xxii.pdf> or <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-XXII-FINAL.pdf>.

<sup>19</sup> The Treasury Department and the IRS note that the information included in this preamble is not intended to be guidance regarding the proper federal tax treatment or consequences of any particular arrangement, except to the extent the preamble addresses the application of Code sections 36B, 9801, 9802, 9815, 9831, and 9832 and PHS Act sections 2711 and 2713.

plan for integration purposes. However, Q&A–3 stated that an HRA that pays for or reimburses medical care expenses for employees covered by TRICARE may be integrated with another group health plan offered by the employer for purposes of PHS Act sections 2711 and 2713 if: (1) The employer offers a group health plan (other than the HRA) to the employee that does not consist solely of excepted benefits and that provides minimum value (MV); (2) the employee participating in the HRA is enrolled in TRICARE; (3) the HRA is available only to employees who are enrolled in TRICARE; and (4) the HRA is limited to reimbursement of cost sharing and excepted benefits, including TRICARE supplemental premiums.

Q&A–3 of Notice 2015–17 also provided that an employer payment plan through which an employer reimburses (or pays directly) all or a portion of Medicare Part B or D premiums for employees may not be integrated with Medicare coverage to comply with PHS Act sections 2711 and 2713 because Medicare coverage is not a group health plan. However, under the notice, this type of employer payment plan may be integrated with another group health plan offered by the employer for purposes of PHS Act sections 2711 and 2713 if: (1) The employer offers a group health plan (other than the employer payment plan) to the employee that does not consist solely of excepted benefits and that provides MV; (2) the employee participating in the employer payment plan is actually enrolled in Medicare Part A and B; (3) the employer payment plan is available only to employees who are enrolled in Medicare Part A and Part B or D; and (4) the employer payment plan is limited to reimbursement of Medicare Part B or D premiums and excepted benefits, including Medigap premiums. Notice 2015–17 also includes a general reminder that, to the extent such an arrangement is available to active employees, it may be subject to restrictions under other laws, such as the Medicare secondary payer (MSP) provisions.<sup>20</sup> See later in this preamble for a discussion of the rules provided in the 2015 rules under PHS Act section 2711 allowing Medicare Part B and D reimbursement arrangements to be integrated with Medicare in certain limited circumstances (that is, generally, for HRAs sponsored by employers with fewer than 20 employees).

On November 18, 2015, the Departments finalized the proposed and

interim final rules under PHS Act section 2711, incorporating certain subregulatory guidance regarding HRA integration, and making various additional clarifications (the 2015 rules).<sup>21</sup> The 2015 rules incorporate prior subregulatory guidance that HRAs may not be integrated with individual health insurance coverage for purposes of complying with PHS Act sections 2711 and 2713. Consistent with the initial subregulatory guidance, the 2015 rules provide two methods for integration of HRAs with other group health plan coverage.<sup>22</sup> The first method applies to HRAs integrated with other group health plan coverage that provides MV (the MV Integration Method).<sup>23</sup> The second method applies to HRAs integrated with other group health plan coverage that does not provide MV (the Non-MV Integration Method).<sup>24</sup>

Both the MV Integration Method and the Non-MV Integration Method require that: (1) The HRA plan sponsor offer the employee a group health plan other than the HRA (non-HRA group coverage); (2) the employee receiving the HRA be enrolled in non-HRA group coverage, even if the non-HRA group coverage is not offered by the HRA plan sponsor, such as a group health plan maintained by an employer of the employee's spouse;<sup>25</sup> and (3) the HRA be made available only to employees who are enrolled in non-HRA group coverage, regardless of whether such coverage is provided by the HRA plan sponsor. For both integration methods, the non-HRA group coverage may not consist solely of excepted benefits and, for the MV

<sup>21</sup> See 80 FR 72192 (Nov. 18, 2015). To the extent the 2015 rules did not incorporate or modify the prior subregulatory guidance, that guidance remains in effect.

<sup>22</sup> These two methods of integration were originally discussed in IRS Notice 2013–54, Q&A–4, and DOL Technical Release No. 2013–03.

<sup>23</sup> See 26 CFR 54.9815–2711(d)(2)(ii), 29 CFR 2590.715–2711(d)(2)(ii), and 45 CFR 147.126(d)(2)(ii).

<sup>24</sup> See 26 CFR 54.9815–2711(d)(2)(i), 29 CFR 2590.715–2711(d)(2)(i), and 45 CFR 147.126(d)(2)(i).

<sup>25</sup> In IRS Notice 2015–87, Q&A–4, the Departments clarified that an HRA that may be used to reimburse the medical care expenses of an employee's spouse or dependents (a family HRA) may not be integrated with self-only coverage of the employee under the employer's non-HRA group health plan. On January 12, 2017, the Departments issued guidance to clarify that a family HRA is permitted to be integrated with a combination of coverage under qualifying non-HRA group health plan coverage for purposes of complying with PHS Act sections 2711 and 2713, provided that all of the individuals who are covered under the family HRA are also covered under qualifying non-HRA group coverage. See FAQs about Affordable Care Act Implementation Part 37, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-37.pdf> or <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-37.pdf>.

Integration Method, the non-HRA group coverage offered by the employer and in which the employee enrolls must provide MV.

In addition, both the MV Integration Method and the Non-MV Integration Method require that, under the terms of the HRA, an employee (or former employee) be permitted to permanently opt out of and waive future reimbursements at least annually from the HRA. Both integration methods also require that, upon termination of employment, either the funds remaining in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements under the HRA. For this purpose, forfeiture of the funds remaining in the HRA, or waiver of future reimbursements under the HRA, occurs even if the forfeited or waived amounts may be reinstated upon a fixed date, the participant's death, or the earlier of the two events.

The two methods differ with respect to the expenses that the HRA may reimburse. Under the MV Integration Method, the HRA may reimburse any medical care expenses, but under the Non-MV Integration Method, the HRA may reimburse only co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care that does not constitute EHBs.<sup>26</sup>

The 2015 rules also include a special integration method for certain arrangements offered by employers that are not required to offer, and do not offer, non-HRA group coverage to employees who are eligible for Medicare coverage (generally, employers with fewer than 20 employees), but that offer non-HRA group coverage that does not consist solely of excepted benefits to employees who are not eligible for Medicare.<sup>27</sup> For these employers, an

<sup>26</sup> Although, in general, an HRA integrated with non-HRA group coverage fails to comply with PHS Act section 2711 if the non-HRA group coverage with which the HRA is integrated does not cover a category of EHB and the HRA is available to cover that category of EHB and limits the coverage to the HRA's maximum benefit, the Departments have provided that if the non-HRA group coverage satisfies the MV Integration Method, an HRA will not be treated as failing to comply with PHS Act section 2711, even if the non-HRA group coverage with which the HRA is integrated does not cover a category of EHB and the HRA is available to cover that category of EHB and limits the coverage to the HRA's maximum benefit. See IRS Notice 2013–54, Q&A–6.

<sup>27</sup> See 26 CFR 54.9815–2711(d)(5), 29 CFR 2590.715–2711(d)(5), and 45 CFR 147.126(d)(5). The 2015 rules did not address the Medicare integration rules that apply to employers who are required to offer non-HRA group coverage to employees who are eligible for Medicare (generally, employers with 20 or more employees). For a discussion of those rules, see IRS Notice 2015–17 and the discussion in this preamble.

<sup>20</sup> See later in this preamble for a clarification of the meaning of this statement included in IRS Notice 2015–17, regarding the MSP provisions.

HRA that may be used to reimburse premiums under Medicare Part B or D may be integrated with Medicare (and deemed to comply with PHS Act sections 2711 and 2713) if the employees who are offered the HRA are enrolled in Medicare Part B or D, the HRA is available only to employees who are enrolled in Medicare Part B or D, and the HRA complies with the opt-out and forfeiture rules under the MV Integration Method and Non-MV Integration Method. These employers may use either of the non-Medicare-specific integration methods, as applicable, for HRAs offered to employees who are ineligible for Medicare.

### C. HIPAA Nondiscrimination Provisions

Prior to the enactment of PPACA, titles I and IV of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104–191, added Code section 9802, ERISA section 702, and PHS Act section 2702 (HIPAA nondiscrimination provisions). The Departments published final rules implementing the HIPAA nondiscrimination provisions on December 13, 2006 (the 2006 rules).<sup>28</sup> PPACA section 1201 reorganized and amended the HIPAA nondiscrimination provisions of the PHS Act. Although Code section 9802 and ERISA section 702 were not amended, the requirements of PHS Act section 2705 were incorporated by reference into Code section 9815 and ERISA section 715.<sup>29</sup> As amended by PPACA, the nondiscrimination provisions of PHS Act section 2705 largely reflect the 2006 rules and extend the HIPAA nondiscrimination protections (but not the wellness program exception) to the individual market. These provisions generally prohibit group health plans and health insurance issuers in the group and individual markets from discriminating against individual participants and beneficiaries in eligibility, benefits, or premiums based on a health factor.<sup>30</sup>

<sup>28</sup> 71 FR 75013 (Feb. 12, 2007).

<sup>29</sup> PPACA section 1201 moved the HIPAA nondiscrimination provisions from PHS Act section 2702 to PHS Act section 2705, with some modifications.

<sup>30</sup> The HIPAA nondiscrimination provisions set forth eight health status related factors. The eight health factors are health status, medical condition (including both physical and mental illnesses), claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, and disability. These terms are largely overlapping and, in combination, include any factor related to an individual's health. 66 FR 1377, 1379 (Jan. 8, 2001).

Q&A–2 of FAQs about Affordable Care Act Implementation (Part XXII)<sup>31</sup> provided that, if an employer offers only employees with high claims risk a choice between enrollment in a traditional group health plan or cash, the arrangement would not comply with the market requirements, citing PHS Act section 2705 (which is incorporated by reference into Code section 9815 and ERISA section 715), as well as the HIPAA nondiscrimination provisions of Code section 9802 and ERISA section 702. The Q&A explained that these arrangements violate the nondiscrimination provisions regardless of whether: (1) The cash payment is treated by the employer as pre-tax or post-tax to the employee, (2) the employer is involved in the selection or purchase of any individual market product, or (3) the employee obtains any individual health insurance coverage. The Departments explained that offering cash as an alternative to health coverage for individuals with adverse health factors is an eligibility rule that discourages participation in the traditional group health plan, in contravention of the HIPAA nondiscrimination provisions.

### D. Excepted Benefits

Code section 9831, ERISA section 732, and PHS Act sections 2722 and 2763 provide that the requirements of chapter 100 of the Code, part 7 of ERISA, and title XXVII of the PHS Act do not apply to excepted benefits. Excepted benefits are described in Code section 9832, ERISA section 733, and PHS Act section 2791.

There are four statutory categories of excepted benefits, including limited excepted benefits. Under the statutory provisions, limited excepted benefits may include limited scope vision or dental benefits, benefits for long-term care, nursing home care, home healthcare, or community-based care, or any combination thereof, and “such other similar, limited benefits as are specified in regulations” by the Departments.<sup>32</sup> To be excepted benefits under this category, the benefits must either: (1) Be insured and provided under a separate policy, certificate, or contract of insurance; or (2) otherwise not be an integral part of the plan.<sup>33</sup> The

<sup>31</sup> See FAQs about Affordable Care Act Implementation (Part XXII), available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xxii.pdf> or <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-XXII-FINAL.pdf>.

<sup>32</sup> See Code section 9832(c)(2), ERISA section 733(c)(2), and PHS Act section 2791(c)(2).

<sup>33</sup> See Code section 9831(c)(1), ERISA section 732(c)(1), and PHS Act section 2722(c)(1) and

Departments previously exercised the authority to specify additional types of limited excepted benefits with respect to certain health FSAs, certain employee assistance programs, and certain limited wraparound coverage.<sup>34</sup>

Coverage that consists of excepted benefits is not minimum essential coverage (MEC).<sup>35</sup> Therefore, an individual offered or covered by an excepted benefit is not deemed ineligible for the PTC by virtue of the excepted benefit offer or coverage.<sup>36</sup> Further, the offer of an excepted benefit by an employer is not considered to be an offer of MEC under an eligible employer-sponsored plan for purposes of Code section 4980H, the employer shared responsibility provisions. Thus, an employer does not avoid a payment under Code section 4980H by virtue of an offer of an excepted benefit.<sup>37</sup>

### E. Premium Tax Credit

#### 1. In General

Code section 36B allows for the PTC to be available to applicable taxpayers to help with the cost of individual health insurance coverage obtained through an Exchange.<sup>38</sup> Under Code section 36B(a) and (b)(1) and 26 CFR 1.36B–3(d), a taxpayer's PTC is the sum of the premium assistance amounts for all coverage months during the taxable year for individuals in the taxpayer's family.

Under Code section 36B(c)(2), a month is not a coverage month for an individual if either: (1) The individual is eligible for coverage under an eligible employer-sponsored plan and the coverage is affordable and provides MV; or (2) the individual is enrolled in an eligible employer-sponsored plan, even if the coverage is not affordable or does not provide MV.<sup>39</sup> An eligible employer-sponsored plan includes coverage under a self-insured (as well as an insured) group health plan<sup>40</sup> and is MEC unless it consists solely of excepted benefits.<sup>41</sup>

2763(b). See also 79 FR 59130, 59131–59134 (Oct. 1, 2014) discussing the application of these requirements to benefits such as limited-scope dental and vision benefits and employee assistance programs.

<sup>34</sup> See 26 CFR 54.9831–1(c)(3)(v), (vi), and (vii); 29 CFR 2590.732(c)(3)(v), (vi), and (vii); and 45 CFR 146.145(b)(3)(v), (vi), and (vii).

<sup>35</sup> See Code section 5000A(f)(3).

<sup>36</sup> See Code section 36B(c)(2)(B).

<sup>37</sup> See Code section 4980H(a)(1) and (b)(1). See also 26 CFR 54.4980H–1(a)(14).

<sup>38</sup> Exchanges are entities established under PPACA section 1311 through which qualified individuals and qualified employers can purchase health insurance coverage.

<sup>39</sup> See Code section 36B(c)(2)(C)(iii) and 26 CFR 1.36B–2(c)(3)(vii)(A) and 1.36B–3(c).

<sup>40</sup> See 26 CFR 1.5000A–2(c).

<sup>41</sup> See Code section 5000A(f)(3) and 26 CFR 1.5000A–2(g).

An HRA is a self-insured group health plan and, therefore, is an eligible employer-sponsored plan. Accordingly, under existing rules, an individual is ineligible for the PTC for the individual's Exchange coverage for a month if the individual is covered by an HRA or is eligible for an HRA that is affordable and provides MV for the month.

## 2. Affordability and Minimum Value

Under Code section 36B(c)(2)(C) and 26 CFR 1.36B-2(c)(3)(v)(A)(1) and (2), an eligible employer-sponsored plan is affordable for an employee, or for an individual who may enroll in the coverage because of a relationship to the employee, if the amount the employee must pay for self-only coverage whether by salary reduction or otherwise (the employee's required contribution) does not exceed a specified percentage of the employee's household income. The percentage is adjusted annually. However, 26 CFR 1.36B-2(c)(3)(v)(A)(3) provides an employee safe harbor under which an eligible employer-sponsored plan is not considered affordable for the entire plan year of the eligible employer-sponsored plan if, at the time an individual enrolls in a qualified health plan (QHP) offered through an Exchange, the Exchange determines that the eligible employer-sponsored plan is not affordable.<sup>42</sup> Thus, the employee safe harbor locks in the Exchange's determination of unaffordability, which is based on estimated household income, even if the eligible employer-sponsored plan ultimately proves to be affordable based on actual household income for the tax year.

Under Code section 36B(c)(2)(C)(ii), an eligible employer-sponsored plan provides MV if the plan's share of the total allowed costs of benefits provided under the plan is at least 60 percent of the costs. PPACA section 1302(d)(2)(C) provides that, in determining the percentage of the total allowed costs of benefits provided under a group health plan, the rules promulgated by HHS under that paragraph of PPACA apply. In general, HHS rules provide that an eligible employer-sponsored plan provides MV only if the percentage of the total allowed costs of benefits provided under the plan is greater than or equal to 60 percent, and the benefits under the plan include substantial

coverage of inpatient hospital services and physician services.<sup>43</sup>

## F. QSEHRAs

### 1. In General

The 21st Century Cures Act (Cures Act) Public Law 114-255 was enacted on December 13, 2016. Cures Act section 18001 amended the Code, ERISA, and the PHS Act to permit an eligible employer to provide a QSEHRA to its eligible employees. The Cures Act provides that a QSEHRA is not a group health plan for purposes of the market requirements, and, as a result, QSEHRAs are not subject to PHS Act sections 2711 and 2713.<sup>44</sup> For purposes of these rules, the term "HRA or other account-based group health plans" does not include QSEHRAs, unless otherwise specified.

Pursuant to Code section 9831(d), a QSEHRA is an arrangement that generally must be provided on the same terms, subject to certain exceptions, and cannot exceed a prescribed maximum amount.<sup>45</sup> For the purpose of identifying who can provide a QSEHRA, the statute provides that an eligible employer is an employer that is not an applicable large employer (ALE), as defined in Code section 4980H(c)(2), and that does not offer a group health plan to any of its employees. The statute also requires that an employer providing a QSEHRA satisfies certain notice requirements including a statement that the employee should provide the information about the permitted benefit to the applicable Exchange if the employee applies for advance payments of the premium tax credit (APTC).

On October 31, 2017, the Treasury Department and the IRS issued Notice 2017-67<sup>46</sup> to provide guidance on the

requirements for providing a QSEHRA. If an eligible employer complies with the guidance provided in Code section 9831(d) and Notice 2017-67, it may provide a QSEHRA to its eligible employees and the QSEHRA is not required to comply with PHS Act sections 2711 and 2713 because it is not subject to those requirements.

### 2. QSEHRAs and the PTC

The Cures Act also added provisions to Code section 36B relating to how participation in a QSEHRA affects a taxpayer's eligibility for the PTC and how participation in a QSEHRA affects a taxpayer's computation of the PTC. Under Code section 36B(c)(4)(A), if an employee is provided a QSEHRA that constitutes affordable coverage for a month, the month is not a coverage month for the employee or the employee's spouse or dependents, meaning that the PTC is not allowed for that month. Code section 36B(c)(4)(C) provides that a QSEHRA constitutes affordable coverage for a month if the excess of the monthly premium for the self-only second lowest cost silver plan in the employee's individual market over  $\frac{1}{2}$  of the employee's permitted benefit, as defined in Code section 9831(d)(3)(C), does not exceed  $\frac{1}{2}$  of a specified percentage of the employee's household income.

Code section 36B(c)(4)(B) provides that if an employee is provided a QSEHRA that does not constitute affordable coverage for a coverage month, the PTC otherwise allowable for the month is reduced by  $\frac{1}{2}$  of the employee's annual permitted benefit under the QSEHRA.

## G. Individual Market Special Enrollment Periods

Generally, individuals may enroll in or change to different individual health insurance coverage only during the annual open enrollment period described in 45 CFR 155.410. An individual may qualify for an SEP to enroll in or change to a different Exchange plan outside of the annual open enrollment period under a variety of circumstances prescribed by PPACA section 1311(c)(6)(C) and (D) and as described in 45 CFR 155.420. These SEPs are under the jurisdiction of HHS, and apply to persons seeking individual health insurance coverage through a State Exchange or Federally-facilitated

employees regarding a QSEHRA, and see FAQs About Affordable Care Act Implementation Part 35, Q&A-3, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-35.pdf> and [https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Part-35\\_12-20-16.pdf](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Part-35_12-20-16.pdf).

<sup>42</sup> This employee safe harbor does not apply if the individual does not respond to a redetermination notice or, with reckless disregard for the facts, provides incorrect information to the Exchange. See 26 CFR 1.36B-2(c)(3)(v)(A)(3).

<sup>43</sup> See 45 CFR 156.145. See also 80 FR 52678 (Sept. 1, 2015).

<sup>44</sup> See Code section 9831(d)(1), ERISA section 733(a)(1), and PHS Act section 2791(a)(1). However, QSEHRAs are group health plans under the PHS Act definition for purposes of part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.). See PHS Act section 2791(a)(1), as amended by Cures Act section 18001(c). In addition, QSEHRAs were not excluded from ERISA's definition of employee welfare benefit plan under ERISA section 3(1) and, therefore, remain subject to the requirements for employee welfare benefit plans under ERISA. See H. Rept. 114-634—Small Business Health Care Relief Act of 2016 (the relevant provisions of this bill were passed into law by the Cures Act). Moreover, because QSEHRAs are employee welfare benefit plans, individual health insurance coverage that is reimbursed by a QSEHRA would not become part of an ERISA plan if the conditions of the DOL safe harbor described later in this preamble are satisfied.

<sup>45</sup> See Code section 9831(d) and IRS Notice 2017-67, 2017-47 IRB 517, for additional detail.

<sup>46</sup> See IRS Notice 2017-20, 2017-11 IRB 1010, which extended the period for an employer to furnish an initial written notice to its eligible

Exchange (FFE) and, in most cases, to individuals seeking individual health insurance coverage outside an Exchange.<sup>47</sup>

Paragraph (d) of 45 CFR 155.420 describes the triggering events that qualify individuals, enrollees, and in some cases, their dependents for SEPs on the Exchanges through which they can enroll in a QHP or change from one QHP to another. Paragraph (b) of 45 CFR 155.420 describes the coverage effective dates available in connection with each SEP. Paragraph (c) describes the availability of each SEP relative to its triggering event—that is, whether applicants may select a plan after the event or also before the event. That paragraph also describes the length of time applicants have to select a plan based on their SEP. Paragraph (a)(4) of 45 CFR 155.420 describes the plan changes that current Exchange enrollees and their dependents may make upon qualifying for an SEP. Generally, current Exchange enrollees who qualify for most SEPs may change to another QHP within the same metal level, or “plan category,” as their current QHP. Current enrollees whose dependent(s) qualify for most SEPs may add their dependent(s) to their current QHP, or enroll them in a separate QHP.<sup>48</sup> In combination, the rules at 45 CFR 155.420(a)(4) are generally referred to as “plan category limitations.”

With regard to individual health insurance coverage sold outside of an Exchange, 45 CFR 147.104(b)(2) provides that health insurance issuers must provide SEPs (referred to in the regulation as limited open enrollment periods) for the triggering events described in 45 CFR 155.420(d), except for certain triggering events listed under 45 CFR 147.104(b)(2). Additionally, 45 CFR 147.104(b)(4)(ii) and (b)(5) apply the SEP availability and coverage effective dates at 45 CFR 155.420 to SEPs available off-Exchange. However, the plan category limitations do not apply outside the Exchanges.

<sup>47</sup> Group health plans and group health insurance issuers must provide SEPs under certain circumstances and the Departments have jurisdiction over those provisions. See Code section 9801(f), ERISA section 701(f), and PHS Act section 2704(f); see also 26 CFR 54.9801–6, 29 CFR 2590.701–6, and 45 CFR 146.117. The final rules do not affect the group health plan and group health insurance issuer SEPs, which continue to apply to group health plans, including HRAs, and group health insurance issuers.

<sup>48</sup> If an enrollee wants to add their dependent(s) to their current QHP, but the plan’s business rules do not allow the dependent(s) to enroll, then the Exchange must allow the enrollee and his or her dependent(s) to change to another QHP within the same level of coverage, or one metal level higher or lower, if no such QHP is available.

#### H. Proposed Rules

In response to Executive Order 13813, the Departments published a notice of proposed rulemaking entitled “Health Reimbursement Arrangements and Other Account-Based Group Health Plans” on October 29, 2018 (83 FR 54420) (the proposed rules), which would expand the flexibility and use of HRAs.

The proposed rules would expand the use of HRAs in several ways. First, the proposed rules included a proposal to remove the current prohibition against integrating an HRA with individual health insurance coverage<sup>49</sup> under the PHS Act section 2711 rules (the proposed integration rules). The proposed integration rules included a proposal to permit an HRA to be integrated with individual health insurance coverage and, therefore, to satisfy PHS Act sections 2711 and 2713, if the provisions of the proposed rules under 26 CFR 54.9802–4, 29 CFR 2590.702–2, and 45 CFR 146.123 were satisfied. These final rules refer to this type of HRA as an individual coverage HRA.

Second, the proposed rules provided an expanded definition of limited excepted benefits, under Code section 9832(c)(2), ERISA section 733(c)(2), and PHS Act section 2791(c)(2)(C), to include certain HRAs that are limited in amount and with regard to the types of coverage for which premiums may be reimbursed, if certain other conditions are satisfied (an excepted benefit HRA) (the proposed excepted benefit HRA rules).

The Treasury Department and the IRS also proposed rules under Code section 36B for PTC eligibility for individuals who are offered an individual coverage

<sup>49</sup> For purposes of this preamble and the final rules, “individual health insurance coverage” means health insurance coverage offered to individuals in the individual market, but does not include STLDI. See PHS Act section 2791(b)(5). See also 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103. Individual health insurance coverage can include dependent coverage and therefore can be self-only coverage or other-than-self-only coverage. “Individual market” means the market for health insurance coverage offered to individuals other than in connection with a group health plan. See PHS Act section 2791(e)(1). See also 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103. As discussed later in this preamble, “group health insurance coverage” means health insurance coverage offered in connection with a group health plan. Individual health insurance coverage reimbursed by the arrangements described in 29 CFR 2510.3–1(l) (which is finalized in this rule) is not offered in connection with a group health plan, and is not group health insurance coverage, provided all the conditions in 29 CFR 2510.3–1(l) are satisfied. See ERISA section 733(b)(4) and PHS Act section 2791(b)(4). See also 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103.

HRA<sup>50</sup> (the proposed PTC rules). DOL proposed a clarification to provide HRA and QSEHRA plan sponsors with assurance that the individual health insurance coverage the premiums of which are reimbursed by the HRA or QSEHRA does not become part of an ERISA plan when certain conditions are satisfied. Finally, HHS proposed changes to rules regarding SEPs in the individual market that would provide an SEP for individuals who gain access to individual coverage HRAs or who are provided QSEHRAs (the proposed SEP rules).<sup>51</sup>

The Departments requested comments on all aspects of the proposed rules, as well as requesting comments on a number of specific issues. The Departments received over 500 comments in response to the proposed rules from a range of stakeholders, including employers, health insurance issuers, State Exchanges, state regulators, unions, and individuals. No requests for a public hearing were received. After careful consideration of all of the comments, the Departments are finalizing the proposed rules with certain modifications made in response to comments. These modifications are discussed later in this preamble.

## II. Overview of the Final Rules on Individual Coverage HRAs and Excepted Benefit HRAs—the Departments of the Treasury, Labor, and Health and Human Services

### A. Integration Rules

#### 1. Integration—In General

Consistent with the objectives in Executive Order 13813 to consider proposing rules to expand and facilitate access to HRAs, the proposed rules included a proposal to remove the prohibition on integration of an HRA with individual health insurance coverage, if certain conditions were satisfied. More specifically, in order to ensure compliance with PHS Act sections 2711 and 2713, the proposed rules provided that to be integrated with individual health insurance coverage, the HRA must require participants<sup>52</sup>

<sup>50</sup> References in the preamble to “an offer of an individual coverage HRA” or to similar phrases mean an offer of an HRA designed to be integrated with individual health insurance coverage under the final rules that will be considered integrated with that individual health insurance coverage for an individual who enrolls in that coverage.

<sup>51</sup> On November 19, 2018, the Treasury Department and the IRS issued Notice 2018–88. IRS Notice 2018–88 described a number of proposals related to the application of Code sections 4980H and 105(h) to individual coverage HRAs. For additional discussion of IRS Notice 2018–88, see elsewhere in this preamble.

<sup>52</sup> For this purpose, the definition of participant under 26 CFR 54.9801–2, 29 CFR 2590.701–2, and

and any dependents<sup>53</sup> covered by the HRA<sup>54</sup> to be enrolled in individual health insurance coverage and to substantiate compliance with this requirement.

Further, in order to prevent a plan sponsor from intentionally or unintentionally, directly or indirectly, steering any participants or dependents with adverse health factors away from the plan sponsor's traditional group health plan and into the individual market, the proposed rules prohibited a plan sponsor from offering employees within a class of employees a choice between a traditional group health plan and an individual coverage HRA. The proposed rules also required that an individual coverage HRA be offered on the same terms to all employees within a class of employees, subject to certain exceptions, and the proposed rules included proposed classes of employees that employers could use for this purpose.

The proposed rules also required individual coverage HRAs to allow employees to opt out of and waive future reimbursements under the HRA at certain times, and to provide a notice to eligible participants regarding how the offer of the HRA, or enrollment in the HRA, affects the ability to claim the PTC. This was proposed because an offer of an HRA may affect an individual's eligibility for the PTC, and enrollment in an HRA does affect an individual's eligibility for the PTC.

45 CFR 144.103 applies, which is defined as a participant within the meaning of ERISA section 3(7). Under ERISA section 3(7), "the term 'participant' means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit."

<sup>53</sup>For this purpose, the definition of dependent under 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103 applies, which is defined as "any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant."

<sup>54</sup>The final rules use several terms interchangeably regarding an individual's individual coverage HRA status. These terms generally parallel those used when referring to group or individual health insurance coverage. Specifically, "enrolled in" and "covered by," both refer to the status of an individual who is participating in an individual coverage HRA and can request reimbursements for medical care expenses reimbursable under the HRA. The date on which an individual coverage HRA "takes effect" or "begins" refers to the first date on which reimbursable medical care expenses may be incurred. For example, an employee whose individual coverage HRA takes effect on June 1 may request reimbursements for medical care expenses incurred on or after that date, if the individual is enrolled in individual health insurance coverage or Medicare on or before June 1.

Each of these conditions, and the related comments received, are discussed in the following sections of this preamble. This section of the preamble addresses the more general comments on allowing HRAs to be integrated with individual health insurance coverage.

Many commenters supported the proposed rules. Some of these commenters expressed general support for the Departments' efforts to expand the availability and use of HRAs and the priority the Departments have placed on HRAs. Some commenters stated that the proposed rules would enable employers to offer more affordable health coverage alternatives to employees and could expand health insurance coverage, including for lower-wage and part-time and other particular groups of employees. Some commenters focused on the potential benefits for small employers, commenting that the proposed HRA expansion would create new options for small employers that have otherwise been unable to offer health insurance coverage due to PPACA-related requirements. These commenters asserted that the proposed HRA expansion would help small employers provide meaningful benefits, attract talent, and keep their workforce healthy. Some commenters expressed general support for allowing employers to move to a defined contribution approach for health insurance coverage, including because this likely permits greater employee choice.

Some commenters noted that allowing individual coverage HRAs could expand and stabilize the individual health insurance market while providing greater administrative simplicity and reducing administrative costs for employers. In particular, some commenters expressed the view that the proposed rules would strengthen the individual market due to an increased number of individuals in the individual market and because working individuals who would be added to the individual market tend to be of lower health risk than those currently comprising the individual market risk pool. Some commenters also stated that employers may not necessarily be incentivized to segment their risk and, therefore, concerns about adverse selection may be overstated.

Some commenters who generally supported the proposed rules emphasized that their support was contingent on any final rules retaining the conditions intended to prevent adverse selection. And some commenters opposed allowing individual coverage HRAs. These commenters stated that the safeguards

in the proposed rules were insufficient to prevent market segmentation and destabilization of the individual market. Several of these commenters argued that market segmentation could occur if employers that choose to offer an individual coverage HRA have higher-risk employees than those employers that choose not to offer an individual coverage HRA and that employers may still be able to segment risk based on the proposed classes of employees. Some of these commenters asked that the rules be withdrawn, or at least delayed, until the potential effects on the individual and group markets could be better understood.

More generally, commenters expressed a number of concerns regarding adverse selection and risk-pool effects of the proposed rules, including that the proposed rules would change the composition of the risk pools for the individual and small group markets, making coverage more expensive and less accessible overall. Some commenters were concerned that the proposed rules would be particularly harmful to self-employed individuals and small business employees because those individuals generally rely on coverage in the individual market and, according to the commenters, the proposed rules would increase premiums in the individual market. Some commenters were also concerned that employers may substantially alter traditional group health plans to the detriment of all employees who rely on that coverage and that there could be negative implications in the small group market for states that have merged their individual and small group market risk pools. One commenter stated that the negative effects of the proposed rules, particularly the increase in individual market premiums and the attendant fiscal cost that the commenter expects to occur, are likely to outweigh the benefits to employers and their employees. Another commenter asserted that the proposed rules would increase premiums due to both adverse selection and issuers' increased uncertainty regarding the effect of individual coverage HRAs on the individual market.

The Departments agree with the commenters who asserted that allowing individual coverage HRAs will expand flexibility and use of HRAs to provide additional options for employers and employees to offer and obtain quality, affordable healthcare. The Departments also agree that individual coverage HRAs would expand coverage and may provide greater administrative

simplicity and reduce administrative costs for employers.

The Departments acknowledge the concerns expressed by commenters that allowing individual coverage HRAs could cause adverse selection in the individual market. As explained in the preamble to the proposed rules, allowing individual coverage HRAs could theoretically result in opportunities for employers to encourage higher-risk employees (that is, employees with high expected medical claims or employees with family members with high expected medical claims) to obtain coverage in the individual market, external to the traditional group health plan sponsored by the employer, in order to reduce the cost of traditional group health plan coverage provided by the employer to lower-risk employees. This could happen in a number of ways. For example, if employees were permitted to choose between participating in an employer's traditional group health plan or an individual coverage HRA, some higher-risk employees might have an incentive to select the HRA and enroll in individual health insurance coverage, depending on the relative generosity of the individual coverage HRA and the individual health insurance coverage as compared to the traditional group health plan. There could be significant differences between these coverage options because individual health insurance coverage generally is required to cover all categories of EHBs, and large group market and self-insured group health plans are not required to do so. An employer could also deliberately attempt to steer employees with certain medical conditions away from the employer's traditional group health plan. In either case, if disproportionately higher-risk employees enrolled in individual coverage HRAs, this adverse selection could raise premiums in the individual market.

Both in promulgating the proposed rules and again in response to comments provided on the proposed rules, the Departments considered the possibility that the individual market could instead be positively impacted. Lower-risk employees might choose individual coverage HRAs, while higher-risk employees might elect to remain in their employer's traditional group health plan. Such an outcome could result for a host of reasons, including because higher-risk employees may be more risk averse to changing health benefits. Additionally, individual health insurance coverage might have more restrictive provider networks than traditional group health

plans and higher-risk employees are generally more sensitive to the make-up of the provider network than lower-risk employees. In addition, lower-risk employees might prefer an individual coverage HRA because it could allow them to spend less on premiums—reducing or potentially eliminating out-of-pocket premiums and potentially leaving more funds to cover cost sharing. Further, employers might be discouraged by the legal risk involved with attempting to steer higher-risk employees away from the traditional group health plan.

However, employers also would face strong countervailing incentives to maintain (or improve) the average health risk of participants in their traditional group health plans. Therefore, the Departments have determined that there is a risk of some market segmentation and health factor discrimination that could result from allowing individual coverage HRAs, but the Departments also have determined that the risk can be sufficiently mitigated with conditions of the type provided in the proposed rules (and in the final rules) designed to limit adverse selection. Moreover, as discussed in more detail later in this preamble, the Departments considered the comments requesting that the Departments strengthen the conditions intended to limit adverse selection, and the Departments are finalizing those proposed conditions with some changes in response to comments, including adding a minimum class size requirement that will apply to certain classes of employees in certain instances. Regarding the concern raised by commenters that the proposed conditions would not prevent adverse selection if employers with higher-risk employees chose to offer individual coverage HRAs, the Departments took that possibility into account in the regulatory impact analysis.

Therefore, taking all of these considerations into account, the Departments have determined that allowing individual coverage HRAs will produce significant benefits, including increased options and coverage, and is not likely to create a material risk of adverse selection in the individual market due to the sufficiency of, and changes to strengthen, the integration conditions intended to mitigate that risk that are finalized in this rulemaking. Accordingly, the Departments are finalizing the proposed rules, including each of the conditions included in the proposed rules, but with various changes and clarifications, as explained later in this preamble.

A number of commenters expressed concern about the impact on employees shifting from traditional group health plans to the individual market. Some commenters emphasized that in order to achieve the goals of expanding coverage and increasing choice and flexibility for employers, it is vital that the individual market be stable and well-functioning; otherwise, employers will be unwilling to utilize the expanded flexibility. Some commenters recommended that the Departments delay issuing the final integration rules until insurance in the individual market is more affordable or until clearer information is available regarding the long-term stability of the individual market, including the impacts of other recent changes such as the expansion of STLDI and changes to the PPACA section 1332 waiver program. Some commenters asked the Departments to withdraw the proposed integration rules and, instead, take other actions to stabilize the individual market. One commenter requested that HRA integration with individual health insurance coverage be allowed only if each employee is provided at least three choices for coverage in the individual market.

The Departments acknowledge that the extent to which the goals of expanding coverage and options through individual coverage HRAs will be achieved depends on the existence of a stable individual market. Accordingly, the Departments are finalizing the proposed rules with conditions on individual coverage HRAs intended to prevent a negative impact on the individual market. The Departments expect individual coverage HRAs, with the safeguards in the final rules, will substantially increase the size of the individual market and will not result in significant changes in the average health risk of the individual market risk pool. The Departments also understand that currently the stability of the individual market varies a great deal across the country, and that in some places improvement will likely be needed before employers elect to offer individual coverage HRAs. The Departments considered these issues in developing the proposed and final rules and incorporated significant flexibility, including geographic flexibility, to address these issues so that each employer may choose what is best for its workforce. However, the final rules do not require that a minimum number of individual health insurance plans be available to employees in order for the employer to offer an individual coverage HRA. There is no compelling justification for such a requirement, and

it is not necessary to ensure compliance with PHS Act sections 2711 and 2713. Employees often have limited choices with respect to the traditional group health plans they are offered, if any, and adopting this type of requirement would unnecessarily prevent certain employers from offering an individual coverage HRA. Further, suggestions regarding changes to the other rules that affect the individual market, in order to improve the individual market, are outside the scope of this rulemaking.

Some commenters stated that the proposed rules failed to adequately take into account the differences between traditional group health plans and individual health insurance coverage, the increased burden on employees in choosing and enrolling in a plan in the individual market relative to the burden on employees under a traditional group health plan, and the significance of the change, from the employee's perspective. Other commenters stated that individuals in the individual market could face more expensive plans, lower employer contributions, narrower networks, and higher cost sharing. Some commenters stated that these individuals could also face more confusion and be provided less assistance, in part due to decreased federal funding for outreach and assistance in the individual market. Some of these commenters asserted what they believed to be the comparative advantages of traditional group health plans, including that those plans are more robust, cost-effective, and consumer-friendly. One commenter expressed general concern about the shifting of employees from a defined benefit health plan system to a defined contribution health plan system, because, according to the commenter, it may result in less comprehensive coverage.

The Departments considered, and are aware, that an employee's experience enrolling in and having coverage under an individual coverage HRA may be different than the experience of enrolling in and having coverage under a traditional group health plan. The Departments took this into account in developing the proposed and final rules, including by requiring the individual coverage HRA to provide a notice to eligible participants explaining the individual coverage HRA and the possible consequences of the HRA being offered and accepted. The Departments understand that employers tend to act in the best interest of their workers in order to recruit and retain talent. Therefore, an employer offering an individual coverage HRA generally will do so because it is a better alternative

for a substantial share of their employees than a traditional group health plan or no offer of employer-sponsored coverage. Further, as described later in this preamble, DOL is also clarifying the extent to which employers may assist employees with regard to enrollment in individual health insurance coverage without resulting in the individual health insurance coverage becoming part of an ERISA plan. In addition, the Departments are continuing to consider ways to assist employees offered an individual coverage HRA, including through clear instructions in the Exchange application process and other possible methods of outreach and assistance. As to the more general comments asserting that traditional group health plans have advantages as compared to individual health insurance coverage, the Departments acknowledge that there are differences. The Departments intend with the final rules to expand the choices available to employers and employees and to make an additional option available for employers, including those that have not previously offered traditional group health plan coverage.

Some commenters questioned the Departments' legal authority with regard to certain aspects of the proposed rules. A few commenters questioned whether the Departments have the authority to allow HRAs to satisfy PHS Act sections 2711 and 2713 by virtue of integration with other coverage, and a few stated that the Departments failed to justify the removal of the regulatory prohibition on integration of an HRA with individual health insurance coverage. Further, a few commenters asserted that the Departments do not have the authority to allow individual coverage HRAs because Congress enacted the Cures Act, which provided a limited exception to the prohibition on HRAs provided in conjunction with individual health insurance coverage in the form of QSEHRAs, and the commenters believe this indicates that Congress did not intend to allow the Departments to otherwise remove the regulatory prohibition on integration of an HRA with individual health insurance coverage.

The Departments disagree with these commenters and, instead, have determined that the final rules are justified and within the Departments' authority. While HRAs are group health plans subject to PHS Act sections 2711 and 2713 and would fail to comply with those provisions if they were offered on their own, PHS Act sections 2711 and 2713 do not speak directly to situations in which an HRA is integrated with

other coverage that satisfies those statutory requirements. The Departments have determined that it is reasonable, and consistent with the statutory scheme, to apply PHS Act sections 2711 and 2713 to the integrated arrangement rather than to each of its component parts.

As explained earlier in this preamble, the Departments previously determined that it was reasonable to consider an HRA to be compliant with PHS Act sections 2711 and 2713 as long as individuals covered by the HRA had other employer-provided group health plan coverage (including coverage offered by a different employer, such as a spouse's employer) that satisfied the conditions in PHS Act sections 2711 and 2713, subject to certain other conditions.<sup>55</sup> In that case, under the combined arrangement, individuals have the protections intended by PPACA, in addition to the HRA that they generally may use to pay for premiums or other medical care expenses not covered by the group health plan. The Departments now extend this same approach to integration with individual health insurance coverage, which the Departments have determined is similarly justified and appropriate, as individual health insurance coverage is generally subject to and compliant with PHS Act sections 2711 and 2713.<sup>56</sup>

In developing the proposed and final rules, the Departments considered that the Cures Act provided for QSEHRAs. However, in creating QSEHRAs, Congress did not enact a general prohibition on integrating an HRA with individual health insurance coverage. Instead, Congress allowed a limited HRA that certain small employers may provide that is not a group health plan subject to the market requirements and, thus, need not be integrated with any

<sup>55</sup> The Departments note that under IRS Notice 2015-17, HRAs that reimburse certain Medicare premiums and TRICARE expenses may be considered integrated with the group health plan coverage offered to the employee by the employer although the employee is not enrolled in that group coverage and is instead enrolled in Medicare or TRICARE, subject to certain conditions. Further, under 26 CFR 54.9815-2711(d)(5), 29 CFR 2590.715-2711(d)(5), and 45 CFR 147.126(d)(5), an employer payment plan for Medicare premiums offered by certain employers may be considered integrated with Medicare (and considered to be compliant with PHS Act sections 2711 and 2713), subject to certain conditions.

<sup>56</sup> Further, for the reasons discussed later in this preamble, the Departments have determined that permitting integration of individual coverage HRAs with Medicare is also justified and appropriate, subject to certain conditions. References in this preamble to an individual coverage HRA integrated with Medicare refer to an individual coverage HRA integrated with Medicare Part A and B or Medicare Part C.

other health coverage to satisfy PHS Act sections 2711 and 2713. The fact that Congress provided some flexibility for certain employers by creating QSEHRAs does not preclude the Departments from providing additional flexibility through rulemaking to allow individual coverage HRAs.<sup>57</sup> The final rules do not change the ability of eligible employers to provide QSEHRAs. Rather, the final rules provide an opportunity for all employers, including those who may or may not qualify to sponsor a QSEHRA, to sponsor an individual coverage HRA.<sup>58</sup> Moreover, by virtue of providing for QSEHRAs, Congress acknowledged and left intact the Departments' regulations allowing for integration of HRAs with other group health plan coverage. In so doing, Congress recognized the Departments' authority to allow HRAs to be integrated with other group health plan coverage, which is the same authority the Departments now extend to allow integration of HRAs with individual health insurance coverage.

The Departments acknowledge that the final rules, in allowing individual coverage HRAs, remove the prohibition on an HRA being integrated with individual health insurance coverage that the Departments had previously imposed. As noted earlier in this section of the preamble, in the 2015 rules and the guidance that preceded those rules, the Departments determined that HRAs should not be allowed to be integrated with individual health insurance coverage, even though that insurance coverage is generally subject to and compliant with PHS Act sections 2711 and 2713. The Departments at that time declined to allow integration with individual health insurance coverage because of concerns about adverse selection in the individual market. Since that time, the Departments have observed that many employers, especially small employers, continue to struggle to offer health insurance coverage to their employees.<sup>59</sup> Further,

<sup>57</sup> Congress has granted the Departments the authority to promulgate regulations as may be necessary or appropriate to carry out the provisions of the Code, ERISA, and the PHS Act that were added as a result of HIPAA and PPACA. See Code section 9833, ERISA section 734, and PHS Act section 2792.

<sup>58</sup> The Departments note that an employer may not both offer an individual coverage HRA and provide a QSEHRA, as a result of the QSEHRA rules under Code section 9831(d) and as a result of the conditions that apply to individual coverage HRAs.

<sup>59</sup> In 2018, 57 percent of firms offered health benefits to at least some of their workers; 47 percent of employers with three to nine workers offered coverage, while virtually all firms with 1,000 or more workers offered coverage. See Kaiser Family Foundation, "Employer Health Benefits 2018 Annual Survey", Figure 2.2 at <http://files.kff.org/>

the Departments have had additional time to consider whether, and what type of, conditions would be sufficient to mitigate the risk of adverse selection and health factor discrimination that might otherwise result from allowing HRAs to be integrated with individual health insurance coverage.

The Departments have determined that the advantages to employers and employees of individual coverage HRAs warrant allowing them to be offered,<sup>60</sup> notwithstanding the concerns regarding potential adverse selection risk to the individual market. This is because the Departments expect that the conditions adopted in the final rules will significantly mitigate the risk of adverse selection. As to the benefits, the final rules will increase flexibility and choices of health coverage options for employers and employees. The increased use of individual coverage HRAs could potentially reduce healthcare spending, particularly less efficient spending, and ultimately result in increased taxable wages for workers in firms that currently offer traditional group health plans. The final rules are also expected to increase the number of low- and moderate-wage workers (and their family members) with health insurance coverage.

Accordingly, the Departments disagree with commenters who asserted that the Departments are precluded from allowing individual coverage HRAs because those arrangements were not previously allowed and that such a change is not sufficiently justified. The Departments have considered whether to allow HRAs to be integrated with individual health insurance coverage, and have determined that a change allowing that integration is warranted, subject to a number of significant conditions intended to protect against the risk of adverse selection and health factor discrimination. This change comes after the Departments' consideration of various factors, including the need to provide employers and employees additional choices with respect to healthcare coverage, the ability of the conditions in

*attachment/Report-Employer-Health-Benefits-Annual-Survey-2018.*

<sup>60</sup> HRA expansion is an Administration priority. In October 2017, the President issued Executive Order 13813, directing the Departments "to consider proposing regulations or revising guidance, to the extent permitted by law and supported by sound policy, to increase the usability of HRAs, to expand employers' ability to offer HRAs to their employees, and to allow HRAs to be used in conjunction with nongroup coverage." The Executive Order further provides that expanding "the flexibility and use of HRAs would provide many Americans, including employees who work at small businesses, with more options for financing their healthcare."

the final rules to mitigate against adverse selection and health factor discrimination, and the anticipated effect of the final rules to increase choice and competition and decrease the number of uninsured individuals.

One commenter stated that allowing individual coverage HRAs is contrary to PPACA's intent to create a stable individual market. The Departments acknowledge that allowing individual coverage HRAs in a way that could lead to large-scale destabilization of the individual market could undermine one purpose of PPACA. However, the Departments have carefully designed the final rules to be consistent with Congress's intent in enacting both PPACA and HIPAA.<sup>61</sup> In developing the proposed and final rules, the Departments considered how to avoid permitting discrimination based on health status or similar practices with respect to offering individual coverage HRAs to employees that might have destabilizing effects on the individual market or lead to higher premiums in that market. The Departments have determined that the risk of market segmentation and health factor discrimination is sufficiently significant to justify including conditions in the final rules intended to mitigate those risks, including strengthening certain conditions provided for in the proposed rules. Additionally, the Departments have determined that the strengthened conditions in the final rules, which are described at length later in this preamble, are both sufficient to mitigate those risks and consistent with HIPAA and PPACA.

One commenter stated that it would make little sense to expect individual coverage HRAs to comply with PHS Act sections 2711 and 2713 because HRAs function more like bank accounts than health insurance policies. The Departments recognize that HRAs and health insurance policies can function

<sup>61</sup> In 1996, Congress enacted the HIPAA nondiscrimination provisions, which now generally prohibit group health plans and health insurance issuers in the group and individual markets from discriminating against individual participants and beneficiaries in eligibility, benefits, or premiums based on a health factor. In 2010, Congress enacted PPACA, in part, because individual health insurance coverage was not a viable option for many individuals who lacked access to group health plan coverage, given that individual market issuers in many states could deny coverage, charge higher premiums based on an individual's health risk, or impose preexisting condition exclusions based on an individual's health risk. To address these issues, PPACA included numerous provisions that were intended to create a competitive individual market that would make affordable coverage available to individuals who do not have access to other health coverage, as set forth in detail in the preamble to the proposed rules. See 83 FR 54420, 54428–54429 (Oct. 29, 2018).

differently. However, HRAs are group health plans and, therefore, generally are subject to the market requirements under the PHS Act, except to the extent that they are excepted benefits or are retiree-only HRAs. The Departments lack the statutory authority to exempt HRAs that are otherwise subject to the market requirements from the category of group health plans subject to the market requirements. The final rules allow individual coverage HRAs to comply with the requirements of PHS Act sections 2711 and 2713 in a manner that preserves the protections of those sections.

## 2. Requirement That All Individuals Covered by an Individual Coverage HRA Be Enrolled in Individual Health Insurance Coverage

### a. In General

The proposed rules provided that an HRA may be integrated with individual health insurance coverage, and would be considered compliant with PHS Act sections 2711 and 2713, if the HRA requires the participant and any dependent(s) to be enrolled in individual health insurance coverage (other than coverage that consists solely of excepted benefits)<sup>62</sup> for each month each individual is covered by the HRA. Under the proposed rules, if the participants and dependents merely have the ability to obtain individual health insurance coverage, but do not actually have that coverage, the HRA would fail to comply with PHS Act sections 2711 and 2713.

Many commenters supported this condition and strongly recommended it be included in the final rules. Commenters that supported the condition stated that it would reduce or prevent the risk of adverse selection and would ensure that employees directed out of the group market have access to a stable individual market. The Departments agree that the requirement to have individual health insurance coverage in order to be covered by an individual coverage HRA is essential and, in order to ensure compliance with PHS Act sections 2711 and 2713, the final rules adopt this requirement, generally as set forth in the proposed integration rules, but with some

<sup>62</sup> Throughout this preamble, references to individual health insurance coverage in the context of the integration rules do not include coverage that consists solely of excepted benefits unless otherwise specified. Also, see later in this preamble for a discussion of the conditions that apply if an individual coverage HRA is integrated with Medicare, in which case references to individual health insurance coverage generally are considered to also refer to Medicare.

clarifications as explained later in this section of the preamble.<sup>63</sup>

One commenter suggested that the final rules should allow an individual coverage HRA to provide benefits to dependents who are not enrolled in individual health insurance coverage so long as the employee-participant is enrolled in individual health insurance coverage. The Departments decline to adopt this suggestion because the requirements of PHS Act sections 2711 and 2713 apply to group health plans with respect to both participants and dependents.<sup>64</sup>

### b. Individual Health Insurance Coverage With Which an Individual Coverage HRA May Be Integrated

Commenters generally supported the rule that individual coverage HRAs must be integrated with individual health insurance coverage as defined in the PHS Act. As discussed in this section of the preamble, several commenters requested clarification regarding whether integration with various types of individual health insurance coverage would be allowed under the proposed rules.

Some commenters requested that the final rules only permit integration with individual health insurance coverage that covers all EHBs or that provides comprehensive mental health and substance use disorder benefits. The Departments decline to make revisions in response to these comments because under PPACA, individual health insurance coverage generally is required to cover all EHBs, including mental

<sup>63</sup> The Departments note that when an individual enrolls in individual health insurance coverage, the coverage generally will have an effective date that is the first day of a calendar month. Other than for mid-month enrollment of a new child, individual health insurance plans generally are not made available for coverage to start mid-month. Therefore, individual coverage HRA plan sponsors will need to take this into account in designing plan terms for eligibility for individual coverage HRAs, both with respect to employees offered the HRA for the full plan year and for those who become covered by the HRA subsequent to the first day of the plan year, to ensure compliance with the enrollment requirement under the final rules.

<sup>64</sup> In addition, the commenter expressed confusion as to how this integration requirement applies to a dependent who is not covered by the individual coverage HRA, including a dependent covered by another type of coverage or a dependent the employee does not want to identify to the employer. While under the final rules an individual coverage HRA must require that each individual covered by the HRA be enrolled in individual health insurance coverage, the final rules do not include a requirement that the HRA cover any particular dependent(s), provided the HRA complies with PHS Act section 2714 and 26 CFR 54.9815-2714, 29 CFR 2590.715-2714, and 45 CFR 147.120 (relating to dependent coverage of children to age 26), nor is there a prohibition on allowing the participant to exclude certain dependents from coverage under the HRA.

health and substance use disorder services.<sup>65</sup>

Commenters also requested that the final rules clarify whether an individual coverage HRA may be integrated with individual health insurance coverage sold in a state that has a waiver under PPACA section 1332.<sup>66</sup> Some commenters stated that integration with that coverage should be permitted so long as the waiver does not allow coverage to impose annual or lifetime dollar limits or exclude benefits for preventive services. Other commenters argued that integration with that coverage should not be permitted because it might not satisfy all of the PPACA requirements.

The Departments note that although PPACA section 1332 allows states to waive certain provisions of PPACA, it does not allow states to waive PHS Act sections 2711 and 2713. Therefore, the final rules do not prohibit integration of an HRA with individual health insurance coverage obtained in a state with a PPACA section 1332 waiver because individual health insurance coverage obtained in that state will be subject to PHS Act sections 2711 and 2713.<sup>67</sup> Other issues with regard to PPACA section 1332 are beyond the scope of this rulemaking.

One commenter requested confirmation that HRAs may be integrated with catastrophic plans in the individual market. Another commenter requested that the final rules not allow integration of HRAs with catastrophic plans because of the limited nature of those plans. The Departments note that catastrophic plans, as set forth in PPACA section 1302(e), are a type of individual health insurance coverage available to only certain individuals and that provide only limited benefits until the individual has incurred expenses

<sup>65</sup> See PPACA section 1302 and PHS Act section 2707(a). However, the Departments note that grandfathered individual health insurance coverage and "grandmothered" individual health insurance coverage subject to the HHS non-enforcement policy might not cover all EHBs. See later in this preamble for a discussion of "grandmothered" individual health insurance coverage.

<sup>66</sup> Under PPACA section 1332, a state can apply for a state innovation waiver from HHS and the Treasury Department, which allows the state, if approved, to implement innovative programs to provide access to quality healthcare. States seeking approval for a state innovation waiver must demonstrate that the waiver will provide access to health insurance coverage that is at least as comprehensive and affordable as would be provided under PPACA without the waiver, will provide coverage to at least a comparable number of residents of the state as would be provided without a waiver, and will not increase the federal deficit.

<sup>67</sup> HHS and the Treasury Department evaluate state PPACA section 1332 waiver applications on a case-by-case basis and will include a determination of the interaction with the final rules (if any).

sufficient to reach the maximum out-of-pocket limit under PPACA.<sup>68</sup> However, catastrophic plans are subject to the market requirements, including PHS Act sections 2711 and 2713. Therefore, the final rules do not prohibit integration of an individual coverage HRA with catastrophic plans.

One commenter asked that the Departments prohibit integration with “grandmothered” individual health insurance coverage, as it is not compliant with PPACA. Grandmothered individual health insurance coverage refers to certain non-grandfathered health insurance coverage with respect to which CMS has announced it will not take enforcement action even though the coverage is out of compliance with certain specified market requirements. To date, the CMS non-enforcement policy has been extended to apply to renewals of such coverage through policy years beginning on or before October 1, 2020, provided that all such coverage comes into compliance with the specified requirements by January 1, 2021.<sup>69</sup> The Departments note that although grandmothered individual health insurance coverage is subject to a non-enforcement policy for some market requirements, the non-enforcement policy does not extend to compliance with PHS Act sections 2711 and 2713. Accordingly, grandmothered plans are subject to PHS Act sections 2711 and 2713, and under the final rules, an individual coverage HRA may be integrated with grandmothered individual health insurance coverage.

One commenter requested clarification as to whether individual health insurance coverage sold through a private exchange model qualifies as coverage that may be integrated with an HRA. To the extent coverage sold through a private exchange model is individual health insurance coverage, within the meaning of the PHS Act,<sup>70</sup> an HRA may be integrated with that coverage. However, the Departments note that as part of the final rules DOL is issuing a safe harbor to clarify to

stakeholders when individual health insurance coverage obtained by a participant in an individual coverage HRA would not be part of an employee welfare benefit plan under ERISA, which would avoid the individual health insurance coverage effectively becoming group coverage. See later in this preamble for discussion of how this safe harbor would apply with respect to individual health insurance coverage offered through web-based platforms, such as private exchanges.

One commenter supported the proposal to prohibit integration with individual health insurance coverage that consists solely of excepted benefits, noting that this aspect of the rule is consistent with the limited nature of excepted benefits. The Departments agree. Because coverage consisting solely of excepted benefits is not subject to or generally compliant with PHS Act sections 2711 and 2713, the final rules provide that individual coverage HRAs may not be integrated with individual health insurance coverage that consists solely of excepted benefits. However, as discussed later in this preamble, an HRA that reimburses only excepted benefits is not subject to the market requirements or the final rules.

See later in this preamble for a discussion of comments received regarding integration of HRAs with student health insurance coverage, as well as types of coverage other than individual health insurance coverage. Also, see later in this preamble for a discussion of the conditions under which an individual coverage HRA may be integrated with Medicare.

#### c. Proxy Approach To Verify Compliance

Under the proposed rules, all individual health insurance coverage (except for coverage that consists solely of excepted benefits) would be treated as being subject to and compliant with PHS Act sections 2711 and 2713. The Departments explained that requiring a participant or an individual coverage HRA to substantiate compliance with PHS Act sections 2711 and 2713 separately for each individual health insurance policy in which a participant or dependent is enrolled would be an unwieldy and overly burdensome task.

The Departments acknowledged that this approach would allow integration with grandfathered individual health insurance coverage, which is not subject to, and might not be compliant with, PHS Act sections 2711 and 2713. However, the Departments reasoned that requiring participants or HRAs to substantiate compliance with PHS Act sections 2711 and 2713 separately for

each individual health insurance policy in which a participant or dependent is enrolled would be impracticable. An independent assessment of compliance could require the participant or the HRA to identify for each individual health insurance policy in which a participant or dependent is enrolled: (1) Which benefits are considered EHBs for purposes of PHS Act section 2711, and (2) whether all recommended preventive services are covered without cost sharing as required under PHS Act section 2713.

The Departments also noted that only a small number of individuals currently are enrolled in grandfathered individual health insurance coverage, and that grandfathered individual health insurance coverage may not be sold to new enrollees and may be renewed by current enrollees only so long as the coverage satisfies strict conditions. Additionally, the Departments noted that the number of individuals with grandfathered individual health insurance coverage has declined each year since PPACA was enacted, and the already small number of individuals who have retained grandfathered coverage is expected to continue to decline each year. Further, the Departments stated that because there are few individuals covered by grandfathered individual health insurance coverage, the Departments anticipate that there will only be extremely limited instances in which these individuals will be offered and accept an individual coverage HRA. Moreover, because new enrollees cannot enroll in grandfathered individual health insurance coverage, employers offering traditional group health plans would not be able to shift workers into this coverage. The Departments also explained that although plans are required to disclose grandfathered status in any summary of benefits provided under the plan, the Departments were concerned that the frequency of this disclosure to participants may be insufficient to substantiate compliance if integration with these policies were prohibited.

For these reasons, the Departments preliminarily determined that deeming a policy to be compliant with PHS Act sections 2711 and 2713 for purposes of the proposed rules if it is sold in the individual market, referred to as the proxy approach, strikes an appropriate balance. The Departments also solicited comments on methods by which an HRA could substantiate whether individual health insurance coverage is subject to and complies with PHS Act sections 2711 and 2713, including how an HRA might identify which benefits

<sup>68</sup> To be eligible for a catastrophic plan, an individual must either be under the age of 30 or qualify for a hardship or affordability exemption under Code section 5000A. See PPACA section 1302(e) and 45 CFR 156.155. One commenter suggested that the Departments change the definition of catastrophic plan so that it is available to individuals other than those who are eligible under PPACA section 1302(e). That change is outside the scope of this rulemaking.

<sup>69</sup> See CMS Insurance Standards Bulletin Series—INFORMATION—Extension of Limited Non-Enforcement Policy through 2020 (March 25, 2019), available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Limited-Non-Enforcement-Policy-Extension-Through-CY2020.pdf>.

<sup>70</sup> See PHS Act section 2791(b)(5).

under the individual health insurance coverage are considered EHBs for purposes of PHS Act section 2711 and whether all recommended preventive services are covered without cost sharing. The Departments solicited comments on whether an alternative approach, such as a requirement that an issuer make a representation about compliance and/or grandfathered status upon request, would be practical, or whether any other methods might be appropriate as an alternative to the proposed proxy approach.

Some commenters expressed support for the proxy approach, stating that it would be unreasonable to require employers or participants to substantiate that individual health insurance coverage is compliant with PHS Act sections 2711 and 2713. They stated that the proxy approach is reasonable with respect to grandfathered individual health insurance coverage because the number of individuals with that coverage is declining and consumers may not newly purchase grandfathered individual health insurance coverage.<sup>71</sup>

However, some commenters encouraged the Departments to prohibit integration with grandfathered coverage because it is not required to comply with the annual dollar limit prohibition or the preventive services requirement.<sup>72</sup> Some of these commenters questioned whether the Departments had the legal authority to deem such coverage to be in compliance with PHS Act sections 2711 and 2713. One commenter disagreed with the Departments' assumption that

<sup>71</sup> A few commenters expressed concern with what they understood to be a proposed requirement that the employer verify that each individual health insurance policy in which an employee enrolls complies with PHS Act sections 2711 and 2713. Due to this concern, they suggested safe harbors to avoid imposing this burden on employers, such as only allowing integration with QHPs or plans of a certain metal level, and one commenter suggested implementing a plan compliance certification system. However, the proposed rules did not impose a requirement on the employer to verify the compliance of each individual health insurance policy in which an employee enrolls with PHS Act sections 2711 and 2713. Furthermore, the Departments are not imposing such a requirement in the final rules, and are finalizing the proxy approach.

<sup>72</sup> One commenter objected to the Departments' assertion in the preamble to the proposed rules that only a small number of individuals are currently enrolled in grandfathered individual health insurance coverage. However, the study the commenter cited to support the assertion that there is a substantial amount of grandfathered individual health insurance coverage remaining relates to grandfathered group coverage (not grandfathered individual health insurance coverage). See Kaiser Family Foundation, "Employer Health Benefits 2018 Annual Survey", <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018>.

employers and employees would be unable to determine if the individual health insurance coverage was compliant with PHS Act sections 2711 and 2713. Another commenter noted that if only a small number of individuals currently are enrolled in grandfathered individual health insurance coverage, prohibiting integration with that coverage should impact very few individuals. One commenter suggested, as an alternative to the proxy approach, that issuers could be required to provide a list of enrolled individuals to the individual coverage HRA.

The Departments considered these comments and have determined that requiring a participant or an HRA to substantiate each individual health insurance policy's compliance with PHS Act sections 2711 and 2713 would be an unwieldy and burdensome task. Further, state and federal regulators review policy forms of issuers in the individual market for compliance with the federal requirements before the products can be offered for sale in the states and undertake market conduct examinations to ensure compliance with federal requirements. Thus, it is reasonable to assume, as a general matter, that a policy sold in the individual market complies with PHS Act sections 2711 and 2713 for purposes of the final rules.<sup>73</sup>

With respect to grandfathered individual health insurance coverage, the Departments have concluded that it is appropriate to adopt the proxy approach as proposed because the number of individuals with grandfathered individual health insurance coverage is low and expected to decrease; individual coverage HRAs and participants may have difficulty confirming which benefits under the grandfathered plan are considered EHBs for purposes of PHS Act section 2711, whether all recommended preventive services are covered without cost sharing, and whether a particular policy is grandfathered; and grandfathered

<sup>73</sup> With respect to the suggested alternative approach to the proxy approach that the Departments could require issuers to provide employers who sponsor individual coverage HRAs with a list of individuals covered by individual health insurance coverage, that alternative approach appears to also include an assumption that the policies sold are in compliance with PHS Act sections 2711 and 2713 (to avoid requiring confirmation of the compliance of each policy enrolled in), while adding burdens on the issuers to track and communicate with employers with whom they would not otherwise interact. For these reasons, the final rules do not adopt this alternative approach.

coverage may not be sold to new enrollees.<sup>74</sup>

#### d. Forfeiture

The proposed rules provided that the requirement that each individual covered by an individual coverage HRA must be enrolled in individual health insurance coverage would apply for each month that the individual is covered by the HRA. The proposed rules further provided that if an individual covered by the HRA fails to have individual health insurance coverage for any month, the HRA would fail to comply with PHS Act sections 2711 and 2713 for that month. Accordingly, the proposed rules required that an individual coverage HRA provide that if any individual covered by the HRA ceases to be covered by individual health insurance coverage, the individual may not seek reimbursement under the HRA for claims that are incurred after the individual health insurance coverage ceases, subject to any applicable continuation-of-coverage requirements. Further, under the proposed rules, if all individuals in a given family who are covered by the individual coverage HRA cease to be covered by individual health insurance coverage, the participant must forfeit the HRA, in accordance with applicable laws (including COBRA and other continuation-of-coverage requirements).

One commenter requested that the Departments clarify how the COBRA rules apply when an individual loses access to an individual coverage HRA due to failing to maintain individual health insurance coverage. Other commenters generally requested guidance on the interaction between COBRA and individual coverage HRAs.

Generally, HRAs are group health plans subject to COBRA continuation coverage requirements under Code section 4980B and ERISA sections 601 through 608 (COBRA continuation coverage), unless an exception applies.<sup>75</sup> Under the COBRA continuation coverage rules, certain individuals who lose employer-sponsored coverage may elect to continue the coverage by paying a premium.<sup>76</sup> In order to qualify for

<sup>74</sup> See later in this preamble for a discussion of the conditions that apply to an individual coverage HRA integrated with Medicare, including that the combined arrangement is considered to comply with PHS Act sections 2711 and 2713.

<sup>75</sup> Plans sponsored by certain small employers, churches, or governments are not subject to Code section 4980B. See Code section 4980B(d).

<sup>76</sup> See Code section 4980B and ERISA sections 601–608. See also 26 CFR 54.4980B–1 *et seq.* and 29 CFR 2590.606–1, 2590.606–2, 2590.606–3, and 2590.606–4. Non-federal governmental group health

COBRA continuation coverage, the loss of coverage must be the result of a “qualifying event.” The Departments clarify that failure by an individual to satisfy the integration requirement of maintaining individual health insurance coverage is not a qualifying event for purposes of COBRA or other continuation of coverage rules. Thus, the loss of eligibility to participate in an individual coverage HRA due to the failure of the individual to maintain individual health insurance coverage does not create a right to COBRA or other group continuation coverage in the individual coverage HRA.

However, a loss of coverage due to a termination of employment or a reduction in the number of hours of employment generally is a loss of coverage due to a qualifying event. Thus, for example, an employee covered by an individual coverage HRA who, due to a reduction in hours, is moved to a class of employees who are not offered any group health coverage would have a right to COBRA or other group continuation coverage in the HRA, as would an individual who loses coverage under the HRA due to termination of employment. That HRA COBRA or other group continuation coverage would be conditioned on a timely election of COBRA or other group continuation coverage and payment of COBRA or other group continuation coverage premiums, as well as maintaining (or enrolling in) individual health insurance coverage.<sup>77</sup> Alternatively, an employee who loses coverage under an individual coverage HRA for these reasons may qualify for an SEP to change his or her individual coverage either on- or off-Exchange.<sup>78</sup>

One commenter requested clarification regarding whether a failure to maintain individual health insurance coverage causes retroactive forfeiture of the individual coverage HRA. Under the final rules, the required forfeiture applies prospectively. The individual coverage HRA must allow an employee who loses coverage under the HRA due to failure to maintain individual health insurance coverage to seek reimbursement for substantiated medical care expenses that were incurred during the coverage period prior to the failure to maintain individual health insurance coverage. However, the individual coverage HRA

plans offered by state or local governments to their respective employees are subject to parallel continuation of coverage requirements under the PHS Act. See 42 U.S.C. 300bb–1 *et seq.*

<sup>77</sup> See IRS Notice 2002–45 for more information on providing COBRA continuation coverage under an HRA.

<sup>78</sup> See 45 CFR 147.104(b)(2) and 155.420(d)(1)(i).

may limit the time to submit expenses to a reasonable specified period. The final rules include some modifications to clarify these rules. The final rules also clarify that the prohibition on reimbursing amounts for expenses incurred after an individual’s individual health insurance coverage ceases applies to the individual coverage HRA, rather than to the individual seeking reimbursement.

One commenter requested clarification regarding whether an individual with individual health insurance coverage who is in an Exchange grace period<sup>79</sup> is considered to be enrolled in individual health insurance coverage for purposes of this integration requirement. Under the final rules, in the event an individual initially enrolled in individual health insurance coverage fails to pay premiums for the individual health insurance coverage timely and is, therefore, in a grace period, the individual is considered to be enrolled in individual health insurance coverage for purposes of the enrollment requirement, and the HRA must reimburse the individual for expenses incurred during that time period according to the terms of the HRA. If the individual fails to pay the applicable premium(s) by the end of the grace period and individual health insurance coverage is cancelled or terminated, including retroactively, the HRA must require the individual to notify the HRA that the individual health insurance coverage has been cancelled or terminated and the date on which the cancellation or termination is effective. After the individual coverage HRA has received the notice of cancellation or termination, the HRA may not reimburse expenses incurred on and after the date of cancellation or termination of the individual health insurance coverage, which is considered to be the date of termination of coverage under the HRA. Although the commenter specifically asked about grace periods, the final rules have also been revised to address other situations in which coverage is cancelled or terminated retroactively, including rescissions,<sup>80</sup> and in those cases, the same rules regarding notification,

<sup>79</sup> The Departments note that while 45 CFR 156.270 provides a specific grace period for individuals enrolled in the Exchange who are receiving APTC, this grace period would not be applicable for an individual covered by an individual coverage HRA because the individual will be ineligible for the PTC and APTC. Outside of the context of Exchange coverage for which APTC is being provided, grace periods are determined by state law.

<sup>80</sup> See 45 CFR 147.128 for rules regarding rescissions of individual health insurance coverage.

reimbursement, and date of termination of coverage would apply.<sup>81</sup>

One commenter requested that, following separation from service, amounts should remain in a former employee’s individual coverage HRA for out-of-pocket costs and should remain available after the individual has access to other coverage. Under the final rules, a plan sponsor may permit a former employee to have continued access to an individual coverage HRA, and in some circumstances a former employee may be able to elect to continue the HRA under the applicable continuation of coverage requirements. However, the final rules do not include an exception for former employees to the requirement that individuals covered by an individual coverage HRA must be enrolled in individual health insurance coverage. This is because PHS Act sections 2711 and 2713 apply with respect to each individual covered by a group health plan, including any former employee. Therefore, a former employee with an individual coverage HRA is required to be enrolled in individual health insurance coverage to ensure that the former employee has a combined arrangement that is in compliance with PHS Act sections 2711 and 2713.<sup>82</sup>

### 3. Prohibition Against Offering a Choice Between an Individual Coverage HRA and a Traditional Group Health Plan to the Same Class of Employees

#### a. In General

To address the previously described concerns about potential adverse selection and health factor discrimination, the proposed rules provided that a plan sponsor may offer an individual coverage HRA to a class of employees only if the plan sponsor

<sup>81</sup> The Departments note that in considering whether to attempt to recoup reimbursements paid for medical care expenses under an individual coverage HRA, including expenses incurred during a period in which an individual did not have individual health insurance coverage due to a retroactive cancellation or termination of coverage, the individual coverage HRA must consider PHS Act section 2712, which limits a plan’s ability to rescind coverage to instances in which an individual has committed fraud or intentionally misrepresented a material fact. See 26 CFR 54.9815–2712, 29 CFR 2590.715–2712, and 45 CFR 147.128. See also DOL Advisory Opinion 77–08A (advising a health plan that depending on the facts and circumstances, the hardship to the participant or beneficiary resulting from such recovery or the cost to the fund of collection efforts may be such that it would be prudent, within the meaning of ERISA section 404(a)(1)(B), for the fund not to seek recovery from the participant or beneficiary).

<sup>82</sup> However, as explained earlier in this preamble, a retiree-only HRA is not subject to the market requirements. Therefore, a retiree-only HRA need not comply with the final integration rules, including the requirement that individuals receiving the HRA enroll in individual health insurance coverage.

does not also offer a traditional group health plan to the same class of employees. Therefore, a plan sponsor would not be permitted to offer any employee a choice between a traditional group health plan and an individual coverage HRA.

Many commenters expressed support for the prohibition against allowing a plan sponsor to offer a class of employees a choice between an individual coverage HRA and a traditional group health plan. These commenters generally stated that this prohibition is essential to prevent market segmentation and health status discrimination. They noted that, while on its face allowing a choice between the two types of coverage may seem appealing, in practice it would lead employers to encourage higher-risk employees to go into the individual market, by making plan design changes to traditional group health plans to make them less attractive to higher-risk employees. This, in turn, could have significant detrimental effects on the individual market due to the small size of the individual market compared to the size of the group market. One commenter noted that the prohibition against offering employees a choice between a traditional group health plan and an individual coverage HRA would protect employers from baseless claims of discrimination. Another commenter stated that permitting employers to offer a choice between an individual coverage HRA and a traditional group health plan could raise practical and administrative issues for employers and issuers, including in estimating participation in the traditional group health plan.

A few commenters opposed the prohibition on offering employees a choice between a traditional group health plan and an individual coverage HRA, asserting that such a rule would restrict choice for employees and flexibility for employers. Some of these commenters asserted that the other conditions in the proposed rules, such as the same terms requirement and the prohibition on integration with STLDI, each described later in this preamble, were sufficient to prevent adverse selection.

A few commenters acknowledged the risk of market segmentation by employers in the large group market or that offer self-insured plans, but requested that small employers generally, or small employers offering plans in the fully insured small group market, be allowed to offer their employees a choice between an individual coverage HRA and a traditional group health plan. They noted that small employers would not

have an incentive to send their higher-risk employees to the individual market because insured traditional group health plans in the small group market are part of a community rated single risk pool. A few commenters also noted that allowing small employers to offer employees a choice would be consistent with Executive Order 13813, which one commenter noted specifically referred to small employers. One commenter indicated that the prohibition on choice might dissuade employers from offering individual coverage HRAs to their employees. The commenter also noted that if given the choice, lower-risk employees, rather than higher-risk employees, may leave the employer's traditional group health plan and purchase individual health insurance coverage.<sup>83</sup>

The Departments generally agree with commenters that stated that permitting employers to offer an employee a choice between an individual coverage HRA and a traditional group health plan could lead to market segmentation.<sup>84</sup> Although some lower-risk employees may choose to enroll in individual health insurance coverage if offered a choice, many employers would have strong economic incentives to encourage lower-risk employees to retain traditional group health plan coverage and higher-risk employees to enroll in individual health insurance coverage.

With respect to the suggestion that the Departments allow employers in the small group market to offer a choice to employees, the Departments acknowledge that the incentives for these employers to segment risk are substantially lower than for other employers offering experience-rated

<sup>83</sup> One commenter requested that the prohibition against choice not apply to spouses and dependents, noting that many employers do not contribute to family premiums under group health plans. Although the Departments anticipate that employers will generally not offer dependents an independent benefit package, for the sake of clarity, and in response to this comment, the Departments note that the prohibition is intended to apply to both participants and dependents, and the final rules are revised to clarify this intent.

<sup>84</sup> Although this condition generally is finalized as proposed, the text of the final rules is updated to include a reference to the special rule for new hires, explained later in this preamble. In general, under the special rule for new hires, a plan sponsor may continue to offer some employees in a class of employees a traditional group health plan (that is, current employees), while offering new employees in that class an individual coverage HRA, and, therefore, in that limited case, a plan sponsor may offer a traditional group health plan to some employees in a class of employees and an individual coverage HRA to other employees in the same class of employees. However, the special rule for new hires does not provide an exception to the rule that no participant may be given a choice between a traditional group health plan and an individual coverage HRA.

coverage or self-insured plans. However, the Departments would not expect many small employers to offer this choice because the coverage in the small group market and individual market is quite similar and because, as the commenters note, small employers that purchase health insurance would not have an incentive to segment their risk pool. Although allowing small employers to offer a choice would not provide small employers much benefit, it would increase the complexity of the final rules for entities involved in implementation, such as the Exchanges. Additionally, it could cause some uncertainty for issuers, and, therefore, increased premiums, in both the individual and small group markets. Accordingly, in the final rules, the Departments decline to provide an exception for small employers to the condition that a plan sponsor may not offer an employee a choice between a traditional group health plan and an individual coverage HRA. While the Departments are finalizing the proposal to prohibit choice between an individual coverage HRA and a traditional group health plan, the Departments are generally supportive of maximizing employee choice and employer flexibility and so may revisit this issue in future rulemaking once the Departments have had the opportunity to gauge the results of the initial implementation of individual coverage HRAs.

#### b. Definition of Traditional Group Health Plan

For purposes of the condition that a plan sponsor may not offer any employee a choice between an individual coverage HRA and a traditional group health plan, under the proposed rules, the term "traditional group health plan" was defined as any group health plan other than: (1) An account-based group health plan, or (2) a group health plan that consists solely of excepted benefits.

Several commenters supported the proposed definition, which provided that a "traditional group health plan" excludes a group health plan that consists solely of excepted benefits, so that a plan sponsor may offer an employee both an individual coverage HRA and a group health plan that consists solely of excepted benefits.<sup>85</sup>

<sup>85</sup> One commenter asked that the Departments confirm that a traditional group health plan means a major medical plan and not a group health plan that consists solely of excepted benefits. The Departments confirm the definition of traditional group health plan does not include a group health plan that consists solely of excepted benefits. The

After considering these comments, the Departments finalize the definition of “traditional group health plan” in the proposed rules without change. Notwithstanding different QSEHRA rules,<sup>86</sup> under the final rules, a traditional group health plan does not include a group health plan that consists solely of excepted benefits and, therefore, a plan sponsor generally may offer an employee both an individual coverage HRA and a group health plan that consists solely of excepted benefits.<sup>87</sup>

One commenter requested that the Departments clarify that the final rules would not preclude an employer that offers an individual coverage HRA from offering a separate HRA under which only premiums for excepted benefits may be reimbursed. The Departments agree that such an arrangement is not precluded by these final rules. An HRA under which only excepted benefit premiums may be reimbursed is an account-based group health plan (and, therefore, not considered a traditional group health plan). Further, the HRA under which only excepted benefit premiums may be reimbursed is a group health plan that provides only excepted benefits (and, therefore, not considered a traditional group health plan). See later in this preamble for a discussion of the interaction of an excepted benefit HRA and an individual coverage HRA, and the difference between an excepted benefit HRA and an HRA that only provides excepted benefits.

#### c. Salary Reduction Arrangements

The preamble to the proposed rules noted that the Departments were aware that some employers may want to allow employees to pay the portion of the premium for individual health insurance coverage that is not covered by an individual coverage HRA, if any, through a salary reduction arrangement under a cafeteria plan. Pursuant to Code section 125(f)(3), an employer generally may not provide a QHP offered through an Exchange as a benefit under its cafeteria plan.<sup>88</sup> Therefore, an employer generally may not permit employees to make salary reduction contributions to a cafeteria plan to purchase a QHP offered through an Exchange.

However, Code section 125(f)(3) does not apply to individual health insurance

coverage that is not purchased on an Exchange. Therefore, for an employee covered by an individual coverage HRA who purchases individual health insurance coverage outside of an Exchange, the employer may permit the employee to pay the balance of the premium for the coverage through its cafeteria plan, subject to all applicable cafeteria plan guidance. Such an arrangement would not be considered to be a traditional group health plan for purposes of the final rules.

Some commenters supported allowing a salary reduction arrangement under a cafeteria plan alongside an individual coverage HRA, with one commenter noting that this flexibility is essential to ensuring successful take-up of individual coverage HRAs. One commenter recommended against allowing a salary reduction arrangement alongside an individual coverage HRA unless further guidance is issued on cafeteria plans addressing nondiscrimination rules and penalties. One commenter requested that the Departments work with Congress to eliminate the prohibition, under Code section 125(f)(3), against purchasing Exchange coverage under a cafeteria plan.

Under the final rules, as under the proposed rules, an employer may permit an employee covered by an individual coverage HRA who purchases individual health insurance coverage outside of an Exchange to pay the balance of the premium for the coverage through its cafeteria plan, subject to all applicable cafeteria plan guidance. This arrangement would not be considered to be a traditional group health plan for purposes of the final rules. Changes to the statutory prohibition regarding the use of cafeteria plans to purchase Exchange coverage are outside of the scope of this rulemaking.

Commenters also raised various other issues related to the interaction between individual coverage HRAs and cafeteria plans under Code section 125. A few commenters expressed support for the ability to integrate a stand-alone cafeteria plan with individual health insurance coverage.<sup>89</sup> And some commenters requested that the Departments provide answers to hypothetical scenarios involving the intersection of cafeteria plans, HSAs, and HRAs. Neither the proposed rules nor the final rules make any changes to the rules under Code section 125. Thus,

any issues arising under Code section 125, and any guidance requested by commenters to address those issues, are beyond the scope of this rulemaking. The Treasury Department and the IRS, however, appreciate the comments and will consider whether to address some of these issues in future guidance.

#### 4. Same Terms Requirement

##### a. In General

To address concerns about health status discrimination leading to adverse selection in the individual market, the proposed rules generally required that a plan sponsor that offers an individual coverage HRA to a class of employees must offer the HRA on the same terms (that is, both in the same amount and otherwise on the same terms and conditions) to all employees within the class of employees.<sup>90</sup> As part of this proposed condition, the Departments made clear that offering a more generous HRA to individuals based on an adverse health factor would violate the integration rules.

Commenters generally supported the same terms requirement as a condition essential to protecting against market segmentation and recommended that it be retained in the final rules. Some commenters specifically supported the ability under the proposed rules to vary the HRA terms and amounts between different classes of employees. Because the Departments have concluded that the same terms requirement is critical to protecting against adverse selection in the individual market, the final rules retain this requirement, but with some revisions and clarifications in response to comments as explained later in this section of the preamble.

One commenter stated that the same terms requirement prohibits discrimination that could occur either by offering less generous benefits to only certain employees in a class of employees or by offering more generous benefits to only certain employees in a class of employees. The commenter stated that it is critical that this prohibition against “benign” discrimination be retained in the final rules. The Departments agree, and this aspect of the rule is being adopted as proposed.

##### b. Exceptions to the Same Terms Requirement

The Departments recognize that premiums for individual health

commenter also noted that an employer may not provide both a QSEHRA and a group health plan that consists solely of excepted benefits.

<sup>86</sup> See Code section 9831(d)(3)(B)(ii) and IRS Notice 2017-67.

<sup>87</sup> But see later in this preamble for a discussion of the interaction between excepted benefit HRAs and individual coverage HRAs.

<sup>88</sup> But see Code section 125(f)(3)(B).

<sup>89</sup> As noted earlier in this preamble, for purposes of the final rules, the term “HRA or other account-based group health plan” does not include an employer arrangement that reimburses the cost of individual health insurance coverage through a cafeteria plan under Code section 125.

<sup>90</sup> The Departments note that if an employer chooses not to distinguish its employees based on the classes of employees permitted under the final rules and offers an individual coverage HRA to all of its employees, the same terms requirement would apply to all of the employer’s employees.

insurance coverage obtained by individual coverage HRA participants and their dependents may vary and, thus, some variation in amounts made available under an individual coverage HRA, even within a class of employees, may be appropriate. Therefore, the proposed rules provided that it would be permissible to increase the maximum dollar amount made available under an individual coverage HRA for participants within a class of employees as the age of the participant increases, so long as the same maximum dollar amount attributable to that increase in age was made available to all participants of the same age within the same class of employees.

Commenters generally supported the provision allowing increases in individual coverage HRA amounts based on the participant's age, as premiums in the individual market generally increase based on age. However, some commenters expressed concern that an unlimited ability to increase amounts made available under an individual coverage HRA based on age could be used to shift older, higher cost workers to the individual market. Therefore, these commenters recommended that, to avoid adverse selection, the ability to increase amounts by age be tied to actual variance in premiums for individual health insurance coverage, such as the 3:1 age rating rule in PPACA<sup>91</sup> or through some other reasonable relationship to the cost of individual coverage.

The Departments agree that imposing an outer bound on the ability of a plan sponsor to vary the maximum amounts made available under an individual coverage HRA based on a participant's age could further protect against adverse selection in the individual market, while not hampering the ability of a plan sponsor to provide benefits that account for increased costs for older workers in the individual market. Therefore, in response to these comments, the same terms requirement is revised under the final rules to provide that an individual coverage HRA does not fail to be provided on the same terms to a class of employees solely because the maximum dollar amount made available under the terms of the HRA increases as the age of the participant increases, so long as the maximum dollar amount made available under the terms of the HRA to the oldest participant(s) is not more than three times the maximum dollar amount made available under the terms of the HRA to the youngest participant(s). The

final rules retain the rule that the same maximum dollar amount attributable to the increase in age must be made available to all participants in a class of employees who are the same age.

The Departments considered a number of different ways to design the limitation on age variation, including by incorporating the federal and state age curves, tying the variation to a specific premium for a specific policy that a participant in the class of employees could purchase, and basing the maximum dollar amount made available by the individual coverage HRA on the degree of age variation in individual market premiums in the rating area where each employee resides. However, the Departments determined that these options would be unduly complex and that imposing the 3:1 limit, which is generally based on the degree of age variation allowed in individual market premiums under PHS Act section 2701, sufficiently limits the potential for abuse.<sup>92</sup>

One commenter expressed concern that permitting, rather than requiring, increases in the maximum amount available under an individual coverage HRA based on age could invite age discrimination. Thus, the commenter argued that the final rules should require employers to vary individual coverage HRA amounts based on age to account for increases in costs for older workers. The Departments note that other federal laws and rules address age discrimination and are the more appropriate area of regulation in which to address these concerns. Accordingly, the Departments decline to require, but will permit, employers to increase individual coverage HRA amounts based on participants' ages under the final rules. However, individual coverage HRAs may be subject to restrictions imposed under other laws,

<sup>92</sup> Relatedly, on November 19, 2018, the Treasury Department and the IRS issued Notice 2018-88, which addressed the application of the rules under Code section 105(h) to individual coverage HRAs. HRAs generally are subject to the rules under Code section 105(h) and its related rules because they are self-insured medical reimbursement plans. However, HRAs that reimburse employees only for premiums paid to purchase health insurance policies, including individual health insurance policies, are not subject to the rules under Code section 105(h) and its related rules. See 26 CFR 1.105-11(b)(2). Notice 2018-88 described an anticipated safe harbor that would apply to individual coverage HRAs that are subject to Code section 105(h) to address the fact that under the Code section 105(h) rules, variation in employer contributions based on age is not allowed. The Treasury Department and the IRS intend to propose rules under Code section 105(h) in the near term that set forth an age variation standard that is consistent with the rule included in these final integration rules, and the proposed rules under Code section 105(h) will be subject to notice and comment.

such as those that protect against age discrimination.

One commenter requested that the Departments clarify the date as of which the age of the participant may be determined for this purpose and suggested the first day of the HRA plan year. The final rules clarify that a participant's age, for purposes of the same terms requirement, may be determined by the plan sponsor using any reasonable method for a plan year, so long as the plan sponsor determines each participant's age for this purpose using the same method for all participants in the class of employees for the plan year and the method is determined prior to the plan year. For example, as the commenter suggests, the plan sponsor may determine each participant's age based on their age on the first day of the individual coverage HRA plan year.

Additionally, the proposed rules included a proposal to permit the maximum dollar amount made available under an individual coverage HRA within a class of employees to increase as the number of the participant's dependents covered under the HRA increased, so long as the same maximum dollar amount attributable to that increase in the number of dependents is made available to all participants in that class of employees with the same number of dependents covered by the HRA. Commenters generally supported this provision, as the cost of individual health insurance coverage generally increases with an increase in the number of dependents covered. Some commenters asked for clarification on the extent to which employers may increase amounts made available under an individual coverage HRA based on an increase in the number of the participant's dependents. One commenter recommended that any permitted increase be tied to individual market premium variance in order to prevent employers from varying HRA amounts to encourage higher-risk employees to shift to the individual market. Another commenter recommended that employers be required to vary individual coverage HRA amounts based on the number of dependents covered by the HRA in order to put employees on equal footing with other individuals and allow them to purchase insurance based on their relevant circumstances.

The Departments considered these comments, but have determined that providing employers flexibility as to if and how they vary HRA amounts based on family size does not raise a significant risk of adverse selection or health factor discrimination and,

<sup>91</sup> See PHS Act section 2701(a)(1)(A)(iii).

instead, avoids unnecessary complexity. Therefore, under the final rules, it remains permissible to vary HRA amounts based on the number of a participant's dependents covered by the individual coverage HRA as proposed. Moreover, there is no specific limit on an employer's ability to increase HRA amounts based on the number of a participant's dependents covered by the HRA, so long as the same maximum dollar amount attributable to that increase in the number of dependents is made available to all participants in that class of employees with the same number of dependents covered by the HRA.

Commenters also suggested additional factors for which employers should be allowed to vary amounts provided under an individual coverage HRA within a class of employees, including earnings or salary, role/title, and geographic region. The Departments note that the suggestions that individual coverage HRA amounts be allowed to vary within a class of employees based on earnings, salary, or role/title raise adverse selection and health factor discrimination concerns, as these classes are more susceptible to manipulation by an employer. Accordingly, the Departments decline to adopt any of these suggestions. Regarding geographic region, the Departments acknowledge that individual health insurance costs vary based on geography, but the Departments decline to adopt this suggestion because the issue is already addressed under the final rules through the ability to classify employees based on the rating area of their primary site of employment.

A few commenters recommended that the Departments consider an employer that contributes the same percentage of an employee's individual health insurance premium (for example, 80 percent) to an individual coverage HRA to be considered to be providing the individual coverage HRA on the same terms to the employees in the class. The Departments decline to adopt this suggestion because this type of rule would add significant complexity to the same terms requirement, particularly with respect to determining how to coordinate the ability to vary based on age and family size, and would also raise adverse selection concerns, as well as more general concerns about the inherent incentives of a percentage-based standard and its effect on healthcare spending.

See later in this preamble for a discussion of the same terms requirement as applied to an employer that offers both an HSA-compatible

individual coverage HRA and an individual coverage HRA that is not HSA compatible to the same class of employees and for a discussion of how the same terms requirement applies if an individual coverage HRA makes amounts available based on amounts remaining in another HRA by which the participant was previously covered.

#### c. Former Employees

The proposed rules generally would apply to an individual coverage HRA that includes participants who are former employees in the same way that they would apply if the HRA only provided benefits to current employees. However, the Departments recognized that eligibility for post-employment group health plan coverage, if any, varies widely and may be subject to age, service, or other conditions. To avoid undue disruption of employers' practices relating to the provision of post-employment health coverage, the proposed rules provided that an individual coverage HRA may be treated as provided on the same terms even if the plan sponsor offers the individual coverage HRA to some, but not all, former employees within a class of employees (for example, to all former employees with a minimum tenure of employment). But, under the proposed rules, if a plan sponsor offers the individual coverage HRA to one or more former employee(s) within a class of employees, the HRA must be offered to those former employee(s) on the same terms as all other employees within the class.

One commenter expressed concern that allowing employers to offer some retirees an individual coverage HRA, but not all retirees, creates the potential for health status discrimination. The Departments note, however, that many nondiscriminatory reasons may influence an employer's decisions whether to offer retiree health coverage. For example, it is not uncommon for employers to offer retiree health coverage only to workers that have been with the company at least 5 years prior to retirement.<sup>93</sup> Moreover, the HIPAA nondiscrimination rules (as well as other applicable federal and state laws) address discrimination based on a health factor.

One commenter supported treating former employees under the same terms as all members of the class of employees. Another commenter requested confirmation that employers providing retirees and current employees with different amounts in individual coverage HRAs would satisfy

the same terms requirement and requested confirmation that contributing different amounts to former employees based on years of service would satisfy the same terms requirement. The final rules provide that former employees within a class of employees offered an individual coverage HRA need not be offered an individual coverage HRA, but if they are, the HRA must be provided to them on the same terms as other employees in that class of employees (based on the class in which the former employee was included immediately prior to separation from service). Therefore, a plan sponsor would not comply with the same terms requirement if it provided some employees in a class of employees larger or smaller HRA amounts based on years of service or status as a former employee.<sup>94</sup>

The Departments received a number of comments on retiree-only HRAs in response to the proposed rules. Although the final rules do not modify the rules for retiree-only HRAs, the Departments note that the market requirements do not apply to a group health plan that has fewer than two participants who are current employees on the first day of the plan year.<sup>95</sup> Therefore, a retiree-only HRA need not satisfy the requirements of any integration test, including the same terms requirement.

#### d. New Employees or New Dependents

One commenter asked for clarification regarding the application of the same terms requirement in the case of coverage changes during the plan year, including in cases in which an employee gains a dependent. In response to this comment, in the final rules, the Departments clarify the application of the same terms requirement both for new employees and new dependents. Therefore, in the final rules, the Departments clarify that, under the same terms requirement, in the case of a participant who becomes covered by an individual coverage HRA after the first day of the plan year, the individual coverage HRA may make the full annual amount available or adopt a reasonable proration methodology. The Departments also clarify in the final rules how the same terms requirement

<sup>94</sup> Also, eligibility conditions that are based solely on the lapse of a time period are permissible for no more than 90 days under PHS Act section 2708. See 26 CFR 54.9815-2708, 29 CFR 2590.715-2708, and 45 CFR 147.116.

<sup>95</sup> See Code section 9831(a)(2) and ERISA section 732(a). HHS follows a similar approach for non-federal governmental retiree-only plans and encourages states to adopt a similar approach with respect to issuers of retiree-only plans. See 75 FR 34537, 34539 (June 17, 2010).

<sup>93</sup> See e.g., 5 U.S.C. 8905(b).

applies if the individual coverage HRA varies the maximum amount available based on the number of a participant's dependents covered by the HRA and the number of the participant's dependents covered by the HRA either increases or decreases during the plan year. In that case, the individual coverage HRA may make available the same amount made available to participants in the class who had the same number of dependents covered by the HRA on the first day of the plan year or may adopt a reasonable proration methodology of that amount for the remainder of the plan year. The method the individual coverage HRA uses to determine amounts made available for participants who enroll during the plan year or who have changes in the number of dependents covered by the HRA during a plan year must be the same for all participants in the class of employees, and the method must be determined prior to the beginning of the plan year.

## 5. Classes of Employees

### a. In General

The proposed and final rules require a plan sponsor that offers an individual coverage HRA to a class of employees to offer the individual coverage HRA on the same terms to each participant within the class of employees, subject to certain exceptions. Also, the proposed and final rules provide that a plan sponsor may offer individual coverage HRAs on different terms to different classes of employees, and may offer either an individual coverage HRA or a traditional group health plan to different classes of employees. However, within a class of employees, a plan sponsor generally may not offer some employees a traditional group health plan and others an individual coverage HRA<sup>96</sup> (or offer any employee a choice between a traditional group health plan or an individual coverage HRA). The proposed rules enumerated the classes of employees that would apply for these purposes. As discussed in more detail in this section of the preamble, the final rules make a number of changes to the list of permissible classes of employees in response to comments.

Many commenters supported the general ability of a plan sponsor to offer individual coverage HRAs on different terms to different classes of employees and to offer either a traditional group health plan or an individual coverage

HRA to different classes of employees. These commenters applauded the flexibility provided by this aspect of the proposed rules, emphasizing that such flexibility is critical for plan sponsors that want to offer individual coverage HRAs.

However, some commenters objected to this aspect of the proposed rules, expressing concerns about the ability of plan sponsors to use the classes of employees to segment risk. These commenters suggested that a plan sponsor that wants to offer an individual coverage HRA should not be allowed to offer a traditional group health plan to any of its employees and, instead, should be required to offer the HRA, on the same terms, to all of its employees and, therefore, fully replace the traditional group health plan(s) it may have offered. One commenter requested that the Departments disallow the use of different classes of employees in applying the final rules as a transitional measure, so that plan sponsors would not be allowed to offer some classes of employees a traditional group health plan and other classes of employees an individual coverage HRA for some transitional period of time. A number of commenters, including some of those who generally supported the ability to vary benefits on a class-by-class basis, expressed concerns about the possibility of adverse selection and, therefore, recommended that additional safeguards be provided, or, at a minimum, no further flexibility be provided.

The Departments considered these comments and have determined that permitting plan sponsors to offer different benefits to certain classes of employees is essential to providing the flexibility needed to achieve increased HRA usability and to maximize employee welfare. The Departments understand that employers commonly use certain job-based classifications for employee benefits and other purposes and that failing to provide flexibility to offer different benefits to different classes of employees, even for a transitional period of time, could reduce the use and availability of individual coverage HRAs. However, the Departments acknowledge the concerns regarding the potential for adverse selection and health factor discrimination and, therefore, have concluded that additional parameters in certain circumstances are needed for employers to offer different benefits to different classes of employees in order to address the potential for adverse selection and health factor discrimination. Accordingly, the final rules permit employers to apply the

integration rules on a class-by-class basis, as was allowed under the proposed rules. However, as explained later in this section of the preamble, the final rules make a number of changes, including revisions to the list of permissible classes of employees, the addition of a minimum class size requirement that applies in certain instances, and clarifications of a number of other related issues in response to comments.

### b. Proposed and Final Classes

The proposed rules included the following proposed classes of employees: (1) Full-time employees (using either the definition that applies for purposes of Code section 105(h) or 4980H, as determined by the plan sponsor); (2) part-time employees (using either the definition that applies for purposes of Code section 105(h) or 4980H, as determined by the plan sponsor); (3) seasonal employees (using either the definition that applies for purposes of Code section 105(h) or 4980H, as determined by the plan sponsor); (4) employees who are included in a unit of employees covered by a collective bargaining agreement (CBA) in which the plan sponsor participates (as described in 26 CFR 1.105-11(c)(2)(iii)(D)) (the CBA class of employees); (5) employees who have not satisfied a waiting period for coverage (if the waiting period complies with the waiting period rules in PHS Act section 2708 and its implementing rules) (the waiting period class); (6) employees who have not attained age 25 prior to the beginning of the plan year (as described in 26 CFR 1.105-11(c)(2)(iii)(B)) (the under-age-25 class); (7) employees who are non-resident aliens with no U.S.-based income (as described in 26 CFR 1.105-11(c)(2)(iii)(E)) (generally, foreign employees who work abroad) (the non-resident alien class); and (8) employees whose primary site of employment is in the same rating area, as defined in 45 CFR 147.102(b) (the rating area class). In addition, the proposed rules permitted, as additional classes of employees, groups of employees described as a combination of two or more of the enumerated classes.

As explained in the preamble to the proposed rules, the Departments took a number of considerations into account in determining the proposed classes of employees. First, the proposed classes were ones that, based on the Departments' experience, employers historically have used for employee benefit purposes other than inducing higher-risk employees to leave the plan sponsor's traditional group health plan.

<sup>96</sup> The one exception to this general rule, described later in this preamble, is the special rule for new hires. However, even under the special rule for new hires, no employee may be offered a choice between an individual coverage HRA and a traditional group health plan.

Second, the proposed classes of employees were not ones that could be easily manipulated in order to transfer higher-risk individuals (and perceived higher costs) from the employer's traditional group health plan to the individual market, as it would be burdensome for employers to shift employees from one of these classes of employees to another merely for the purpose of offering different types of health benefits to employees based on a health factor. Therefore, the Departments determined that these proposed classes of employees would balance employers' reasonable need to make distinctions among employees with respect to offering health benefits with the need to protect against adverse selection and health factor discrimination. The Departments requested comments on the proposed classes of employees, including whether additional classes of employees should be provided and whether the proposed classes of employees and any potential additional classes are sufficient to mitigate adverse selection concerns.

Several commenters supported the proposed classes of employees, with some insisting that no additional classes be added because of the increased likelihood of risk pool manipulation. Several commenters expressed support for the proposed list of specific enumerated classes, as opposed to an open-ended standard, as a way to mitigate adverse selection.

Some commenters objected to the proposed classes, expressing general concern that the rules would provide employers too much flexibility, which would lead to manipulation of classes and risk segmentation. Some commenters requested that specific classes be eliminated or modified. In particular, several commenters expressed concern that the under-age-25 class of employees would lead to adverse selection. These commenters stated that this class is not justified based on a bona fide relationship to employment or the need to provide employers flexibility because employers do not typically structure benefits based on whether an employee has attained age 25. Some commenters raised administrative complexity concerns in their objections to this proposed class because employees under age 25 may be eligible for coverage under their parents' group health plans. One commenter, however, supported this class, stating that it may lead to healthier risk entering the individual market. The Departments agree with the commenters who raised concerns about the under-age-25 class of employees, both as to the potential for adverse selection and the

fact that employers do not typically structure benefits based on this classification and, therefore, do not need the flexibility the proposed rules provided.<sup>97</sup> Therefore, the final rules do not include the under-age-25 class of employees as a permitted class of employees.

With regard to the proposed part-time employee class, several commenters supported including the class because of the additional flexibility it would provide to employers when determining whether to offer any benefits to part-time employees. One commenter highlighted that some large employers (who would not be able to provide a QSEHRA) may want to offer their part-time employees some level of tax-preferred health benefits but have no options today other than offering a traditional group health plan. Some commenters also argued that providing additional flexibility for employers to offer individual coverage HRAs to part-time employees who might otherwise not have been offered any benefits could lead to increased enrollment in individual health insurance coverage, thereby stabilizing the individual market risk pool and reducing premiums. One commenter suggested that the Departments should allow multiple gradations of part-time employees (for example, employees who work 10 to 20 hours per week, employees who work 20 to 30 hours per week, etc.). However, one commenter expressed concern that a part-time employee class could be a proxy for higher-risk employees, and could, therefore, lead to adverse selection, as the commenter asserted that many employees who work part-time do so due to health issues.

The Departments agree with those commenters who asserted that a part-time employee class should be included in the final rules, as it could provide necessary flexibility to allow some employers to offer an individual coverage HRA to part-time employees who might otherwise not be offered any group health plan benefits. While the Departments do not dispute that some employees may change from full-time employee status to part-time employee status due to health issues, the Departments have determined that allowing full-time employees and part-time employees as separate classes of employees is essential for employer

flexibility, increasing HRA usability, and maximizing employee welfare. Further, the Departments have concluded that the requirements of the final rules, including these employee classifications, are sufficiently robust to mitigate market segmentation. Therefore, the final rules include full-time employees and part-time employees as separate permitted classes for individual coverage HRAs. However, see the discussion later in this preamble regarding the definitions of these terms and the application of a minimum class size requirement to these classes in certain circumstances.

With regard to a class of employees based on a geographic area, some commenters expressed concern that basing the class on the rating area of the work site could be too granular, increasing adverse selection. Thus, the commenters asserted that a class based on geography should instead be determined at the state level. While the Departments understand and considered the concern raised by commenters, the Departments have determined, based on information regarding the significant differences in individual market premiums between rating areas within some states and significant differences in the number of individual health insurance plans available between rating areas within some states, that it would be an unreasonable limitation on employer flexibility to prohibit employers from offering different benefits based on different work-site rating areas. The Departments concluded that a rule that would prohibit employers from differentiating between these particular classes of employees for purposes of offering individual coverage HRAs would pose significant costs that might undermine the willingness of employers to offer an individual coverage HRA. Therefore, the final rules allow a class of employees to be based on the rating area of the employees' primary work site. However, in response to concerns raised by commenters regarding the potential for adverse selection and health factor discrimination with this class of employees in particular, see the discussion later in this preamble regarding the application of a minimum class size requirement to this class in certain circumstances.

With regard to the waiting period class of employees, one commenter recommended that this class of employees be limited to a 30-day waiting period maximum to provide an additional market segmentation safeguard. Another commenter specifically supported this class. The final rules include the waiting period

<sup>97</sup> The Departments note that the under-age-25 class of employees was included in the proposed rules because it is a class of employees that may be excluded for certain purposes under Code section 105(h) and under the QSEHRA rules. See earlier in this preamble for a discussion of the application of Code section 105(h) to individual coverage HRAs.

class of employees, which aligns with the waiting periods allowed under PHS Act section 2708 and its implementing rules, because this avoids unneeded complexity and burden and the Departments do not consider this class of employees to raise significant adverse selection concerns.

Several commenters requested clarification regarding the CBA class of employees, which under the proposed rules was defined as “employees included in a unit of employees covered by a collective bargaining agreement in which the plan sponsor participates (as described in 26 CFR 1.105–11(c)(2)(iii)(D)).” Commenters sought clarification as to whether employers may establish separate classes for employees subject to different CBAs or whether all employees subject to various CBAs entered into by the employer would be aggregated and considered one class of employees for purposes of offering individual coverage HRAs. One commenter requested that the Departments clarify whether a class of employees based on a CBA would include all the employees subject to that CBA or could be based on distinctions within the CBA. Under the final rules, employers may establish separate classes of employees for employees covered by separate CBAs. However, under the final rules, an employer is not specifically permitted to create its own classes of employees based on any distinctions relating to employees within one CBA. However, an employer is permitted to combine a CBA classification with other permitted classes of employees (for example, combining the CBA class with the full-time employee and part-time employee classes to create full-time and part-time CBA subclasses), thereby allowing the employer to make certain further distinctions within the group of employees subject to the CBA. The Departments have revised the definition of this class of employees in the text of the rules and added an example to the text to clarify its meaning in response to comments. Further, to account for, and to avoid disruption of, the way in which multiemployer plan coverage is sometimes offered, the final rules also clarify that the CBA class may include employees covered by a CBA and employees covered by an appropriate related participation agreement.<sup>98</sup>

<sup>98</sup> A participation agreement allows non-collectively bargained employees to participate in a multiemployer plan. Non-collectively bargained employees can only participate in a multiemployer plan if the plan specifically allows it, and a participation agreement will set forth who is eligible and the benefits for which they are eligible.

With regard to the proposed ability to combine classes of employees more generally to create subclasses, some commenters supported the flexibility, but others expressed concern with the potential for risk segmentation. Some commenters recommended that the final rules not permit combinations of classes of employees or that, if permitted, the final rules apply certain additional safeguards, including a minimum class size requirement. Several commenters recommended not allowing combinations of classes of employees for small employers but permitting combinations of classes of employees for large employers, as long as the number of employees in a combined class satisfies a minimum. The Departments determined that it is important to provide employers with the flexibility to combine classes of employees but, as discussed later in this preamble, it is also appropriate to apply a minimum class size requirement in certain circumstances to mitigate adverse selection and health factor discrimination concerns. Therefore, the final rules continue to allow for the combination of classes of employees as proposed but, in certain circumstances, apply a minimum class size requirement. The final rules also include additional examples to illustrate the ability of plan sponsors to combine classes of employees.

#### c. Additional Classes

Some commenters recommended against adding any classes to the list of proposed permitted classes of employees, stating that the proposed classes of employees were sufficient and that additional classes of employees could lead to an increased risk of adverse selection. However, as discussed in this section of the preamble, several other commenters requested that certain additional classes of employees be added to the final rules.

In the proposed rules, the Departments acknowledged that permitting plan sponsors to treat salaried and hourly employees as different classes of employees was considered, but not proposed. The Departments noted that employers might easily be able to change an employee’s status from salaried to hourly (and in certain circumstances, from hourly to salaried) with seemingly minimal economic or other consequences for either the employer or the employees. Some commenters agreed and strongly opposed adding hourly and salaried employees as classes of employees, expressing concern that classes of employees based on pay status could facilitate health

status discrimination and be easily manipulated.

However, several commenters requested that salaried and hourly employees be added as separate classes of employees. These commenters disagreed with the Departments’ assertion that employers might be able to easily change employee status from salaried to hourly and vice versa. The commenters noted that changing status from salaried to hourly in particular has substantial economic and other consequences for both employers and employees and that doing so on the basis of the health of an employee could violate ERISA section 510. One commenter noted that employers historically have provided different benefits to hourly and salaried workers and that adding these as permitted classes of employees could facilitate increased use of individual coverage HRAs for employers that might otherwise decline to offer an individual coverage HRA. The Departments considered the issues raised in these comments. The Departments have concluded that the benefits of employer flexibility, increased utilization of individual coverage HRAs, and maximizing employee welfare outweigh the potential risk of adverse selection and health factor discrimination, due to a reconsideration of the extent to which these categories could be manipulated and because of the application of a minimum class size requirement, as described later in this preamble. Therefore, the final rules include salaried and non-salaried employees as permitted classes of employees.

One commenter requested that employees employed by a staffing firm for temporary placement at entities unrelated to the staffing firm (temporary workers) be treated as a separate class. The commenter stated that this rule would facilitate offering of individual coverage HRAs by staffing firms to full-time temporary workers (while it is likely that regular full-time employees of the staffing firm would continue to receive an offer of a traditional group health plan). The commenter further stated that staffing firms historically have offered temporary workers different benefits than regular full-time employees for reasons other than to segment risk. The commenter further stated that it would be burdensome for staffing firms to shift workers between the temporary worker and regular employee classes merely to shift risk. The Departments agree that adding this class could increase the usability of HRAs for staffing firms and benefit their employees, that this class would be difficult to manipulate, and, that,

therefore, this class does not raise a substantial risk of adverse selection or health factor discrimination. Therefore, the final rules include as a permitted class of employees individuals who, under all the facts and circumstances, are the employees of an entity that hired the employees for temporary placement at an unrelated entity (that is, another entity that is not the common law employer of the employees and that is not treated as a single employer under Code section 414(b), (c), (m), or (o) with the entity that hired the employees for temporary placement).

One commenter requested that independent contractors be permitted as a separate class of employees, and one commenter requested that the Departments allow self-employed business owners to participate in an individual coverage HRA. HRAs were established<sup>99</sup> as a means for employers to provide tax-favored benefits to employees, but the exclusion from federal income tax for reimbursements of medical expenses by HRAs is set forth in Code sections 105 and 106, both of which generally are restricted to employer-provided coverage to employees. Moreover, Code section 105(g) specifically provides that the exclusion under Code section 105(b) is not available to an individual who is an employee within the meaning of Code section 401(c)(1) (relating to self-employed individuals). For these reasons, businesses that utilize the services of independent contractors cannot provide those self-employed individuals with a tax-favored individual coverage HRA nor may a self-employed business owner be provided a tax-favored individual coverage HRA. Therefore, the final rules do not adopt the suggestion to add independent contractors, or self-employed individuals more generally, as a permitted class of employees because these individuals cannot be provided tax-favored HRAs.

One commenter requested that employees eligible for Medicare and employees enrolled in Medicare be treated as two separate classes. The Departments decline to adopt this suggestion. Sections 1862(b)(1)(A), (B), and (C) of the Social Security Act (SSA) generally provide that an employer that is subject to its provisions may not take into account an employee's (or employee spouse's) eligibility for Medicare in the design or offering of its group health plan.<sup>100</sup> Section

1862(b)(1)(A)(i)(II) provides that a group health plan must provide to any employee or spouse age 65 or older the same benefits, under the same conditions, that it provides to employees and spouses under age 65, regardless of whether the individual or spouse age 65 or older is entitled to Medicare. Because Medicare is also generally available to people with end-stage renal disease (ESRD) regardless of their age, SSA section 1862(b)(1)(C) further provides that a group health plan may not differentiate in the benefits it provides between individuals having ESRD and other individuals on the basis of the existence of ESRD, the need for dialysis, or in any other manner (except during a 30-month coordination period). Because these SSA provisions generally prohibit an employer that is subject to them from discriminating on the basis of an employee's (or the employee's spouse's) Medicare eligibility and treating Medicare employees (other than retirees) differently for benefits under the plan, the Departments decline to establish separate classes of employees for employees who are eligible for or enrolled in Medicare. However, see later in this preamble for a discussion of the conditions under which an individual coverage HRA may be integrated with Medicare.

Commenters also requested a number of other classes of employees, with different commenters suggesting different classes of employees, such as classes based on status as a field worker (such as craft workers and laborers), role or job title, employee tenure, being subject to the Davis Bacon Act and Related Acts or the Service Contract Act, exempt or non-exempt status under the Fair Labor Standards Act, and religion or status as a minister. The Departments considered each of these suggestions and have determined that these suggested classes of employees raise various issues including ease of manipulation and potential for adverse selection and health factor discrimination, industry-specificity, and administrability and definitional challenges. The Departments also took into account that, in general, the more classes that are permitted, the greater the risk of adverse selection and health factor discrimination. With respect to the requested class based on employee tenure, the Departments determined that such a class could be inconsistent with

the prohibition on waiting periods that exceed 90 days under PHS Act section 2708, in addition to raising concerns regarding ease of manipulation and potential for adverse selection and health factor discrimination. Therefore, the Departments have determined that, on balance, for these suggested additional classes, the potential risks posed outweigh the potential benefits, and the Departments decline to add these suggested classes of employees to the final rules. However, see the discussion later in this preamble regarding the special rule for new hires, which is related in part to the comments suggesting a new class based on employee tenure.

#### d. Additional Safeguards

In the preamble to the proposed rules, the Departments stated that to minimize burden and complexity, the Departments had not proposed a minimum employer size or employee class size. The Departments identified a concern that very small employers could manipulate the classes of employees, but noted that other economic incentives related to attracting and retaining talented workers would discourage employers from doing so. Accordingly, the Departments invited comments on whether employer size or employee class size should be considered in determining permissible classes of employees.

With regard to employer size, some commenters stated that the risk of health factor discrimination is higher with small employers and that the final rules should prohibit small employers from using, or combining, classes of employees to make health coverage distinctions. However, other commenters asserted that the concern that small employers may discriminate based on health status is invalid, arguing that small employers are less likely to discriminate because of both the complexity required to design discriminatory programs and the minimal incentives that small employers have to remove risk from their small group market traditional group health plans that are part of a community rated single risk pool. For these reasons, one commenter requested that the final rules include less restrictive guardrails for small employers. The commenter also requested that large employers offering only an individual coverage HRA be permitted additional flexibility to structure their classes of employees because the risk of discrimination would be mitigated as the employer is not offering a traditional group health

working aged beneficiaries, the rules apply to employers with 20 or more employees. For disabled beneficiaries, the rules apply to employers with at least 100 employees. For ESRD beneficiaries, they rules apply to employers of any size. See 42 CFR 411.100 *et seq.*

<sup>99</sup> See IRS Notice 2002-45.

<sup>100</sup> The applicability of the Medicare nondiscrimination rules depends on the size of the employer and the type of Medicare beneficiary. For

plan and, therefore, would not have incentives to remove risk from its plan.

With regard to minimum class size, a number of commenters requested that individual coverage HRAs only be available to classes of employees that include a minimum number of employees or are a minimum percentage of an employer's workforce. A few commenters noted that although a minimum class size requirement would be restrictive, and perhaps inhibit the use of individual coverage HRAs, it would be necessary to prevent risk segmentation. Some commenters supported applying a minimum class size requirement in all cases and some supported applying such a requirement only when separate classes of employees are combined to make smaller subclasses of employees. Some commenters made general requests for a minimum class size requirement (for example, requests for a meaningful threshold) and others included specific suggestions, such as requiring a minimum class size of 10 percent of employees, at least 10 percent of the employer's workforce or 100 workers, at least 20 employees, or prohibiting employers with fewer than 10 employees from being able to create classes. One commenter requested that there be no minimum class size requirement, in particular to provide flexibility to small employers.

In response to these comments, the Departments have concluded that it is appropriate to apply a minimum class size requirement under the final rules in certain circumstances. The Departments sought to develop a rule that is narrowly tailored both to mitigate the risk of adverse selection and health factor discrimination while also avoiding overly burdening employers or unnecessarily hampering the use and flexibility of HRAs to maximize employee welfare.

In order to balance these various considerations, the final rules include a minimum class size requirement that varies based on employer size and that applies only to certain classes of employees in certain circumstances in which the potential for adverse selection is greatest. If a class of employees is subject to the minimum class size requirement, the class must include a minimum number of employees for the individual coverage HRA to be offered to that class. The final rules explain the circumstances in which the minimum class size requirement applies, how to determine the applicable class size minimum, and how an individual coverage HRA determines if a particular class of employees satisfies the applicable class

size minimum. The final rules also provide a number of examples to illustrate each aspect of the minimum class size requirement.

As to the circumstances in which the minimum class size requirement applies, it applies only if the plan sponsor offers a traditional group health plan to at least one other class of employees and offers an individual coverage HRA to at least one class of employees. To the extent the minimum class size requirement applies, it applies only to certain classes that are offered an individual coverage HRA. The minimum class size requirement does not apply to a class of employees offered a traditional group health plan or to a class of employees that is not offered any group health plan.

Under the final rules, the minimum class size requirement generally applies to the following classes of employees offered an individual coverage HRA: (1) Salaried employees, (2) non-salaried employees, (3) full-time employees, (4) part-time employees, and (5) employees whose primary site of employment is in the same rating area (although the minimum class size requirement does not apply if the geographic area defining the class is a state or a combination of two or more entire states) (these classes are referred to collectively as the applicable classes). However, in the case of full-time employees and part-time employees, the minimum class size requirement applies only to those classes if the employees in either the part-time or full-time class are offered a traditional group health plan while the employees in the other class are offered an individual coverage HRA. The Departments considered each of the classes of employees permitted under the final rules to determine which classes, if any, present a risk of adverse selection sufficiently significant to justify the imposition of the minimum class size requirement. The Departments determined that classes composed of salaried employees, non-salaried employees, full-time employees, part-time employees, and employees whose primary site of employment is in the same rating area (except if the geographic area defining the class is a state or a combination of two or more entire states) present a substantial risk that employers could apply each of these classes in a way that targets certain higher-risk employees and, therefore, could lead to health factor discrimination and adverse selection. However, the Departments determined that the other permitted classes of employees (that is, the seasonal employee class, the CBA class, the waiting period class, the class based on

non-resident aliens with no U.S.-based income, and the class of employees for temporary workers employed by a staffing firm) are unlikely to be manipulated by employers in a way that would lead to health factor discrimination or adverse selection.

Under the final rules, the minimum class size requirement applies to a class of employees created by combining any of the applicable classes with any other class of employees, except that the minimum class size requirement does not apply to a class that is the result of any combination of an applicable class and the waiting period class. Waiting periods are most typically applied to new hires, and it is not uncommon for employers to hire new employees in small numbers, to respond to attrition and as workflow increases. Further, the Departments are of the view that combinations of classes that include the waiting period class do not raise a significant risk of manipulation that could lead to adverse selection or health factor discrimination. Therefore, taking these factors into account, the Departments have determined that applying the minimum class size requirement to a class comprised of an applicable class and a waiting period class is not warranted.

Consistent with the comments received on this topic, the minimum number of employees that must be included in a class of employees subject to the minimum class size requirement (the applicable class size minimum) depends on the number of employees employed by the employer. The plan sponsor must determine the applicable class size minimum for each plan year of the individual coverage HRA. The applicable class size minimum is: (a) 10, for an employer with fewer than 100 employees; (b) a number, rounded down to a whole number, equal to 10 percent of the total number of employees, for an employer with 100 to 200 employees; and (c) 20, for an employer that has more than 200 employees. In selecting these thresholds, the Departments considered the suggestions made by commenters and sought to strike a balance between providing employers with flexibility to offer different healthcare packages as part of their compensation framework and design, and limiting employers' ability to use the classes in ways that would create adverse selection in the individual market. The Departments agree with commenters that small employers may not have significant incentives to establish classes in a way that would result in adverse selection or health discrimination, but also are of the view that it could be easier for smaller

employers to manipulate the classes of employees. Further, the Departments selected thresholds for larger employers taking into account that, despite their total size, the classes of employees could also be manipulated by larger employers in ways that could lead to adverse selection and health factor discrimination. Therefore, the minimum class size requirement applies to small employers and large employers, but at lower thresholds for smaller employers than for large employers. For the purpose of applying the minimum class size requirement, an employer must determine the number of its employees based on its reasonable expectation of the number of employees it expects to employ on the first day of the plan year of the individual coverage HRA.

The annual determination of whether a class of employees satisfies the applicable class size minimum is based on the number of employees in the class who are offered the individual coverage HRA as of the first day of the plan year.<sup>101</sup> Therefore, the determination of whether a class of employees satisfies the minimum class size requirement is not based on the number of employees who enroll in the individual coverage HRA and is not affected by changes that occur during the plan year.

Some commenters requested that, in addition to, or instead of, a minimum class size requirement, the Departments should add an anti-abuse rule that would give the Departments the discretion to determine whether an individual coverage HRA is offered in a manner that is intended to segment sicker workers based on all the facts and circumstances. Therefore, even if an employer followed the other rules set forth in the final rules, this additional rule would nevertheless permit the Departments to address instances of discrimination based on a health factor. The Departments decline to add a facts and circumstances test to the final rules because the Departments have concluded that the minimum class size requirement, as set forth in the final rules, adequately balances the need to prevent health factor discrimination with the need to provide employers with certainty in order to encourage expansion and use of individual coverage HRAs. Moreover, other applicable nondiscrimination laws continue to apply. Under the HIPAA nondiscrimination provisions, for example, a group health plan (including

an individual coverage HRA) may not discriminate in eligibility for benefits, or in premiums or contributions, based on one or more health factors.<sup>102</sup> In addition, for ERISA-covered plans, it is unlawful for any person to discriminate against a participant or beneficiary for the purpose of interfering with the attainment of any right to which the participant may become entitled under a health plan or ERISA.<sup>103</sup> Further, under the SSA, an employer generally may not take into account that an individual is entitled to Medicare on the basis of age or disability, or eligible for, or entitled to Medicare on the basis of ESRD, and may not differentiate in the benefits it provides between individuals who have ESRD and other individuals covered under the plan.<sup>104</sup> In addition, other nondiscrimination laws (such as the Americans with Disabilities Act) may also apply, and the Departments note that compliance with the final rules is not determinative of compliance with any other applicable law. A new facts and circumstances test would add significant uncertainty for employers while adding little additional protection mitigating adverse selection and health factor discrimination.

#### e. Former Employees

Under the proposed rules, if an individual coverage HRA were offered to former employees, former employees would be considered to be in the same class of employees in which they were included immediately before separation from service. While the plan sponsor would not be required to offer the individual coverage HRA to all former employees (or to all former employees in the applicable class of employees), if it did offer the HRA to a former employee, it would have to do so on the same terms as for the other employees in that class.

A few commenters requested that employers be permitted to treat former employees as a separate class of employees, stating that the rule under the proposed rules treating former employees as part of the class of employees in which they would have been included immediately prior to separation from service will impose a barrier to offering individual coverage HRAs. These commenters stated that such a new class of employees would not raise manipulation concerns because whether to terminate employment generally is an

independent decision made by the employee. Commenters further suggested that if a class of employees were created for former employees, the final rules should also permit subclasses within the class of former employees based on years of service.

Some commenters supported the proposed treatment of former employees and commented that former employees should not be permitted as a separate class of employees under the final rules because the general age and health status of former employees would present adverse selection concerns. One commenter included a number of requests regarding retiree-only HRAs in the context of rehired employees.

Notwithstanding that employers may continue to offer retiree-only HRAs that are not subject to the market requirements (and, therefore, are not subject to any integration requirements), the Departments understand the commenters' concern regarding adverse selection and are not aware of a compelling need to treat former employees as a separate class of employees under the final rules in light of the continued allowance of retiree-only HRAs that are not subject to any integration requirements. All of the rules and eligibility criteria related to retiree-only HRAs continue to apply without change.<sup>105</sup> Therefore, the final rules provide that a former employee is considered to be a member of the same class of employees the former employee was in immediately before separation from service, as proposed.

Several commenters raised other classification and administration issues related to retirees. One commenter requested clarification that the final rules would not affect the status of former employees who participate in their employer's traditional group health plan through COBRA. The Departments note that the impact of the final rules on any former employee participating in an employer's traditional group health plan through COBRA continuation coverage depends on the facts and circumstances. For example, COBRA continuation coverage ends on the date the employer ceases to provide any group health plan (including successor plans). If a former employee is participating in a

<sup>101</sup> The Departments reiterate that under the same terms requirement, an employer offering an individual coverage HRA to any employee in a class of employees must offer the HRA, generally on the same terms and conditions, to all employees in the class.

<sup>102</sup> Code section 9802, ERISA section 702, and PHS Act section 2705. *See also* 26 CFR 54.9802-1, 29 CFR 2590.702, and 45 CFR 146.121.

<sup>103</sup> ERISA section 510.

<sup>104</sup> SSA section 1862(b)(1)(A), (B), and (C) and 42 CFR 411.102, 411.161, and 411.170.

<sup>105</sup> *See* Code section 9831(a)(2) and ERISA section 732(a). While title XXVII of the PHS Act, as amended by PPACA, no longer contains a parallel provision at PHS Act section 2721(a), HHS has explained that it will not enforce the requirements of title XXVII of the PHS Act with respect to non-federal governmental retiree-only plans and encourages states to adopt a similar approach with respect to retiree-only plans offered by health insurance issuers. *See* 75 FR 34537, 34540 (June 17, 2010).

traditional group health plan that is replaced by an individual coverage HRA, the former employee would have a right to elect to participate in the successor plan, the individual coverage HRA (conditioned on the payment of premiums and enrollment in individual health insurance coverage), but would generally not have a right to continue coverage in the traditional group health plan. One commenter requested that the final rules define “former employee.” The final rules provide that for purposes of this rule a former employee is an employee who is no longer performing services for the employer.

#### f. Controlled Group

Commenters requested clarification as to whether the classes of employees are identified based on the employees of the common law employer or, rather, whether the determination is made at the controlled group level (generally referring to a group of employers treated as a single employer with the common law employer under Code section 414(b), (c), (m), or (o)), such that all employees of a controlled group of employers would be combined to create the classes of employees. Some commenters recommended that the Departments confirm that the controlled group rules do not apply for this purpose, and some recommended that the controlled group rules be used to determine the classes of employees as a way to reduce the number of small classes and prevent adverse selection.

After consideration of these comments, the Departments have concluded that determining the classes of employees at the common law employer level will avoid complexity for employers and that applying the minimum class size requirement (to the extent applicable), as described earlier in this preamble, at the common law employer level, is a more straightforward way of addressing the adverse selection concerns raised by some commenters. Accordingly, the final rules clarify that the classes of employees are determined based on the employees of a common law employer, rather than the employees of a controlled group of employers.

#### g. Movement Among Classes

A few commenters requested clarification regarding the application of the final rules in the situation in which an employee moves out of a class of employees that is offered an individual coverage HRA and into a different class of employees that is offered either a traditional group health plan, a different individual coverage HRA, or no coverage. As discussed earlier in this

preamble, the Departments note that as group health plans, HRAs generally are subject to the COBRA or other group continuation of coverage rules. However, if the change in the employee’s classification is not the result of termination of employment or reduction in hours, there generally is not a qualifying event resulting in a COBRA or other group continuation of coverage right.

Even if an employee who ceases enrollment in an individual coverage HRA does not have a right to continuation of coverage, the HRA must allow the individual to submit for reimbursement substantiated medical care expenses that were incurred during the coverage period prior to the termination date of the individual coverage HRA. In this case, the individual coverage HRA may limit the period of time to submit expenses to a reasonable specified time period after termination of coverage under the individual coverage HRA during which the participant may submit those claims. Additionally, an employee who loses coverage under an individual coverage HRA may qualify for an SEP for loss of MEC to change his or her individual health insurance coverage either on or off an Exchange.

One commenter asked whether an employee who changes classes of employees and loses coverage under an individual coverage HRA may convert unused amounts to another type of HRA. The Departments note that under existing rules, employers generally may provide employees enrolled in a traditional group health plan an HRA that is integrated with that traditional group health plan and in some circumstances may provide an HRA that can be integrated with TRICARE or Medicare. Nothing in the final rules or current guidance would prevent employers from basing the amount in these types of HRAs on unused amounts in an individual coverage HRA in which the individual was previously enrolled, nor are employers precluded from basing the amount of an individual coverage HRA on unused amounts in these types of HRAs in which the individual was previously enrolled. Also, if an employee moves from a class of employees offered an individual coverage HRA to a class of employees offered a different individual coverage HRA, nothing in the final rules would prevent the employer from permitting the unused amounts in the first individual coverage HRA to be considered transferred to the second. Therefore, the final rules are revised to clarify that amounts made available in an individual coverage HRA based on

amounts remaining in another HRA under which the participant was previously covered are disregarded for purposes of determining whether the individual coverage HRA is offered on the same terms, provided that if the HRA takes these amounts into account, it does so on the same terms for all participants in the class of employees.<sup>106</sup>

Further, with regard to amounts remaining in an individual coverage HRA after the individual is no longer covered by the HRA, the HRA must allow a participant (and the participant on behalf of dependents) to submit claims to the HRA for reimbursement of substantiated expenses that were incurred during the coverage period prior to the termination of the individual’s coverage under the individual coverage HRA, even if the claim is submitted after the individual is no longer covered by the individual coverage HRA. However, the HRA may limit the period to submit expenses to a reasonable specified time period.

One commenter requested guidance on situations in which employees are currently receiving treatment for health conditions when an employer switches from a traditional group health plan to an individual coverage HRA. The Departments note that a similar issue arises under existing rules when an employer switches from one group health plan to another group health plan with a different network of providers, so that providers participating under the first plan are no longer in network. The final rules do not address this issue because it is not specific to this rulemaking. To the extent an employee or dependent is switching from an insured traditional group health plan to individual health insurance coverage purchased with an individual coverage HRA, state “succeeding carrier” or “extension of benefit” laws may regulate the obligations of the prior or succeeding issuer to cover an individual’s ongoing health conditions at the time of the coverage switch.

<sup>106</sup> However, employers may not permit unused amounts in an individual coverage HRA, or any other type of HRA, to be considered transferred to an excepted benefit HRA because amounts made available under an excepted benefit HRA are necessarily limited in order for the HRA to constitute an excepted benefit. Allowing amounts remaining in other types of HRAs to be transferred to an excepted benefit HRA could lead to significant circumvention of that limit. Also, note that under the final excepted benefit HRA rules, if the plan sponsor offers more than one HRA to the participant for the same time period, the amounts made available under all such plans are aggregated to determine whether the benefits are limited in amount, except that HRAs that reimburse only excepted benefits are not included in determining whether the benefits are limited in amount.

h. Definition of Full-Time Employee, Part-Time Employee, and Seasonal Employee

For purposes of identifying classes of employees, the proposed rules provided that a plan sponsor may define full-time employees, part-time employees, and seasonal employees in accordance with either the applicable definitions under Code section 105(h) or those under Code section 4980H to avoid overlapping classes of employees. The proposed rules included a proposal that a plan sponsor's choice of which statutory definitions to apply must be consistent across these three classes of employees, to the extent the plan sponsor differentiates based on these classes.

A few commenters requested that only one definition for each term be permitted and requested that the final rules adopt the definitions in Code section 4980H. One commenter recommended that only the definition of full-time employee under Code section 4980H (which is based on 30 hours per week) should be permitted. This commenter asserted that use of the definition under Code section 105(h) (which is based on 35 hours per week) could lead to adverse selection, because many plans currently offer traditional group health plan coverage to employees based on the Code section 4980H definition, and use of another definition could lead to subdivision of full-time employees. A few commenters supported the proposed ability to choose either set of definitions, including the requirement to use either the definitions under Code section 4980H or those under Code section 105(h) consistently across these classes of employees.

The Departments considered these comments and have determined that the final rules should adopt the definitions provided in the proposed rules. This approach provides employers with flexibility, while limiting opportunities for risk segmentation. The Departments understand that, to avoid the inclusion of amounts in income, plan sponsors of self-insured plans subject to Code section 105(h) (in particular small employers not subject to Code section 4980H) may want to design their health plans to offer a traditional group health plan and individual coverage HRAs (or individual coverage HRAs in different amounts or under different terms and conditions) to different classes of employees that are identified in a manner that complies with the requirements of Code section 105(h). The Departments also acknowledge that certain larger employers have already determined how to apply the definitions

under Code section 4980H to their workforces and using those same definitions for purposes of applying the integration rules may reduce burden for those employers. Therefore, the final rules include flexibility for each employer to determine which set of definitions is appropriate for its workforce, provided the employer uses the same set of definitions for classifying its full-time, part-time, and seasonal employees to the extent it uses one or more of these classes of employees.

The proposed rules further provided that the HRA plan document must set forth the applicable definitions of full-time employee, part-time employee, and seasonal employee prior to the beginning of the plan year in which the definitions will apply and that nothing would prevent an employer from changing the definitions for a subsequent plan year. Some commenters supported that provision, asserting that it minimizes the potential for adverse selection, with one requesting clarification whether it is permissible to change the definitions of the classes of employees during the plan year. One commenter stated that plan sponsors should not be allowed to change the definitions each plan year, asserting that this flexibility could allow small employers in particular to segment risk.

The Departments have determined that in order to mitigate the risk of market segmentation and minimize disruption to employees with respect to a coverage period, it is important for plan sponsors to determine prior to the plan year which definitions will apply and to apply them consistently throughout the plan year. The Departments also have concluded that limiting an employer's ability to revise the definitions it applies from one plan year to the next would be unnecessarily restrictive. Accordingly, the final rules generally retain the rules in the proposed rules. However, the final rules clarify that adjustments during the plan year to the definitions used to identify the classes of employees are not permitted.

#### 6. Special Rule for New Hires

As explained earlier in this preamble, some commenters expressed concerns about the challenges employees may experience in transitioning from a traditional group health plan to individual health insurance coverage, with some stating that the proposed rules failed to adequately take into account the differences between the coverage types and the significance of the change from the employee's

perspective. The Departments are aware that the transition from coverage under a traditional group health plan to coverage under an individual coverage HRA could represent a substantial change from an employee perspective, and, as a result, employers may want to phase in individual coverage HRAs. By allowing plan sponsors to offer traditional group health plans to some classes of employees while offering other classes of employees an individual coverage HRA, the final rules provide plan sponsors with some flexibility to manage the transition to individual coverage HRAs. However, in response to comments, including those expressing concern about the transition from traditional group health plans to individual coverage HRAs and those expressing interest in being able to provide different benefits based on employee tenure, the Departments have determined that it is appropriate to provide additional flexibility to plan sponsors, in particular for employers that offer traditional group health plans that would like to continue to offer that type of coverage to current employees who are accustomed to that coverage, but offer individual coverage HRAs to newly hired employees.

Therefore, notwithstanding the general rule that a plan sponsor may only offer either a traditional group health plan or an individual coverage HRA to a class of employees, the final rules provide that a plan sponsor that offers a traditional group health plan to a class of employees may prospectively offer employees in that class hired on or after a certain date in the future (the new hire date) an individual coverage HRA (the new hire subclass), while continuing to offer employees in the class hired before the new hire date a traditional group health plan (the special rule for new hires). A plan sponsor may set the new hire date prospectively for a class of employees as any date on or after January 1, 2020. A plan sponsor may set different new hire dates prospectively for separate classes of employees.

Although this special rule provides additional flexibility, it is still the case that for the new hire subclass, the individual coverage HRA must be offered on the same terms to all participants within the new hire subclass, in accordance with the generally applicable rules under the same terms requirement. Further, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any participant, whether a current employee or a newly hired employee in the new hire subclass.

A plan sponsor may discontinue the special rule for new hires at any time for a class of employees. In that case, the new hire subclass would no longer be treated as a separate subclass of employees, and each employee that was previously treated as part of the new hire subclass would then be treated as an employee in the class of which he or she would have otherwise belonged for purposes of the final rules. In that case, if the plan sponsor wanted to offer an individual coverage HRA, it would need to do so for all the employees in the class and generally on the same terms, as explained earlier in this preamble. It could also choose instead to offer a traditional group health plan to some or all of the employees<sup>107</sup> in the class or to offer no coverage.

In the event a plan sponsor applies the special rule for new hires to a class of employees and later discontinues using the rule for the class of employees, the plan sponsor may apply the special rule for new hires to the class of employees again, at a later time, under the same rules as the initial application of the rule. For example, as under the basic requirements for the application of the special rule for new hires, the plan sponsor would only be allowed to apply the rule to a class to which it is offering a traditional group health plan. If a plan sponsor applies the special rule for new hires again, in accordance with the general rules under the special rule for new hires, the plan sponsor would choose a prospective new hire date. In no circumstances may the special rule for new hires be applied to a class of employees (including a new hire subclass) already being offered an individual coverage HRA, in an attempt to offer different HRA amounts or other different terms within a class of employees based on different hire dates.

The minimum class size requirement described earlier in this preamble does not apply to a new hire subclass. This is because the Departments recognize that many employers hire only a few employees, or even only one employee, at a time and a subclass based on a new hire date does not present a high risk of manipulation that could lead to adverse selection. However, if a plan sponsor subdivides the new hire subclass based on a permissible class of employees subsequent to creating the new hire subclass, the minimum class size requirement applies to any class of employees created by subdividing the new hire subclass, if the minimum class size requirement otherwise applies. The

<sup>107</sup> To the extent such an arrangement is available to active employees it may be subject to restrictions under other laws, such as the MSP provisions.

text of the final rules includes examples to illustrate these rules.

#### 7. Opt-Out Provision

If an individual is covered by an HRA, including an individual coverage HRA, for a month, regardless of the amount of reimbursement available under the HRA, the individual is not eligible for the PTC for that month. Because in some circumstances an individual may benefit more from claiming the PTC than from having funds in an HRA available for reimbursement, the Departments' existing rules regarding integration with non-HRA group coverage and with Medicare require a plan sponsor that offers an HRA to allow participants to opt out of and waive future reimbursements from the HRA at least annually.<sup>108</sup> The proposed rules also included this requirement with respect to the individual coverage HRA, so that employees would be allowed the PTC, if they are otherwise eligible, if they opt out of and waive future reimbursements from the HRA and the HRA is either unaffordable or does not provide MV.<sup>109</sup> The Departments have concluded that this condition is important as a result of the PTC consequences of HRA coverage, and, therefore, the final rules retain this condition, with some clarifications.

Furthermore, consistent with the current rules for integration with a group health plan and with Medicare, the proposed rules required that upon termination of employment, either the remaining amounts in the HRA must be forfeited or the participant must be allowed to permanently opt out of and waive future reimbursements from the HRA. This requirement ensures that the HRA participant may choose whether to claim the PTC, if otherwise eligible, or to continue to participate in the HRA after the participant's separation from service.<sup>110</sup>

Commenters generally supported these opt-out requirements as necessary to protect PTC eligibility for employees. Some commenters expressed concern that due to the complexity of the PTC affordability rules, employees are likely to have difficulty understanding

<sup>108</sup> See 26 CFR 54.9815–2711(d)(2)(i)(E), (d)(2)(ii)(D), and (d)(5)(iv); 29 CFR 2590.715–2711(d)(2)(i)(E), (d)(2)(ii)(D), and (d)(5)(iv); and 45 CFR 147.126(d)(2)(i)(E), (d)(2)(ii)(D), and (d)(5)(iv).

<sup>109</sup> See later in this preamble for a discussion of the final rules regarding the circumstances in which an offer of an individual coverage HRA is affordable and provides MV for purposes of Code section 36B.

<sup>110</sup> Note that a former employee is only rendered ineligible for the PTC if the former employee enrolls in employer-sponsored coverage; an offer of coverage (even if it is affordable and provides MV) does not preclude a former employee from claiming the PTC. See 26 CFR 1.36B–2(c)(3)(iv).

whether or not they should opt out of an individual coverage HRA. Similarly, some commenters expressed concern that some low- and moderate-income employees may opt into the individual coverage HRA although they may have been better off opting out of the HRA and receiving the PTC, while others expressed concern that some employees may opt out of the HRA based on the misimpression that they will receive the PTC, when actually they are ineligible for the PTC.

The Departments appreciate the concerns expressed regarding the burden on employees to properly determine whether the individual coverage HRA they have been offered is affordable and provides MV and to determine whether they will be better off with the HRA or, if otherwise eligible, the PTC. These concerns are the primary reason that the Departments proposed and are finalizing the requirement for individual coverage HRAs to provide a written notice to each participant. Further, the Departments will work with the FFEs and State Exchanges to ensure that their applications and other relevant materials are updated to accommodate individuals who are offered an individual coverage HRA and are applying for individual health insurance coverage with APTC.

Some commenters requested clarification regarding the timing of the annual opt-out condition. One commenter asked the Departments to clarify how the annual opt-out condition applies in the case of an HRA with a non-calendar year plan year. In response, the final rules clarify that an HRA may establish timeframes for enrollment in (and opting out of) the HRA, but participants generally<sup>111</sup> must be provided an opportunity to opt out of the individual coverage HRA once for each plan year, which must occur in advance of, and with respect to, the plan year. That is, individual coverage HRAs must provide participants with one advance opportunity to accept, or opt out of, the individual coverage HRA for each plan year, but the individual coverage HRA may not provide participants with multiple opportunities

<sup>111</sup> The final rules also clarify that for participants or dependents who become eligible for the individual coverage HRA on a date other than the first day of the plan year (or participants who are not required to be provided the HRA notice at least 90 days in advance of the plan year (that is, employees who become eligible less than 90 days prior to the plan year and employees of newly established employers)), the option to opt out must be provided during the HRA enrollment period established by the HRA for these individuals and then subsequently on an annual basis in advance of the plan year.

to opt into, or out of, the individual coverage HRA over the course of the plan year, except that the final rules require HRAs to provide an opt out opportunity upon termination of employment. This is generally consistent with employees' ability to decline traditional group health plan coverage that is not affordable or does not provide MV in order to claim the PTC, if otherwise eligible. See later in this preamble for a discussion of comments received on the proposed PTC rules and an explanation of the final PTC rules, including for additional discussion of the application of the PTC rules to an employee opting out of, or accepting, an individual coverage HRA with a non-calendar year plan year.

One commenter requested clarification as to whether a former employee offered an individual coverage HRA must be provided the annual opportunity to opt out of the individual coverage HRA. The Departments clarify that the annual opt-out condition applies for all participants eligible to enroll in an individual coverage HRA, including former employees. Another commenter requested clarification whether an employee's choice to opt out of an individual coverage HRA also applies to the employee's dependents who are otherwise eligible for the individual coverage HRA. The Departments intend for the opt-out opportunity to extend to dependents, but expect that an employer would provide an individual coverage HRA to an employee's dependent only if the employee participates in the individual coverage HRA. Therefore, the final rules clarify that if an employee opts out of an individual coverage HRA, the individual coverage HRA is considered waived for the employee's eligible dependents as well.<sup>112</sup> See later in this preamble for a discussion of the circumstance in which the offer of an individual coverage HRA to an employee's dependents will render the dependents ineligible for the PTC.

One commenter requested clarification as to whether, instead of permanently forfeiting an individual coverage HRA upon termination of employment, an individual coverage

HRA may be suspended for a period of time, allowing the individual to receive the PTC during that period of time if otherwise eligible, and then have the HRA amounts reinstated in the individual coverage HRA years in the future. Although the current rules for integration of an HRA with other group coverage allow certain HRA amounts that would otherwise be permanently forfeited to be reinstated in the future upon a fixed date, a participant's death, or the earlier of the two events, the final rules do not include a similar provision for individual coverage HRAs. The final rules do not include such a provision due to the Departments' concerns about complexity and burden on employers in needing to establish procedures for substantiation of enrollment in individual health insurance coverage upon reinstatement, and on an ongoing basis, possibly many years in the future; the lack of demand for such a rule from employers; and potential complexities related to the interaction with the PTC.<sup>113</sup> However, as explained earlier in this section of the preamble, the final rules require an individual coverage HRA to provide an annual opportunity for participants to opt out of the HRA, which may, depending on the individual coverage HRA offered, allow the participant, if otherwise eligible, to claim the PTC.

#### 8. Substantiation of Coverage Under Individual Health Insurance Coverage

##### a. In General

The proposed rules required that individuals whose medical care expenses may be reimbursed under an individual coverage HRA must be enrolled in individual health insurance coverage. To facilitate the administration of this requirement, under the proposed rules, an individual coverage HRA would be required to implement, and comply with, reasonable procedures to verify that individuals whose medical care expenses are reimbursable by the individual coverage HRA are, or will be,<sup>114</sup> enrolled in individual health insurance coverage during the plan year (annual coverage substantiation requirement).

Commenters generally supported the annual coverage substantiation requirement, asserting that it is necessary to ensure the effectiveness of the requirement that individuals

covered by an individual coverage HRA must be enrolled in individual health insurance coverage. The Departments agree; therefore, the final rules adopt the annual coverage substantiation requirement, with minor clarifications described in this section of the preamble.<sup>115</sup>

Some commenters asked the Departments to clarify the timeframe within which the substantiation must be provided, including requests for clarification as to whether it would be acceptable for the substantiation to occur during the individual coverage HRA enrollment period or prior to the first request for reimbursement under the individual coverage HRA, which commenters stated would be consistent with typical administrative procedures for HRAs. For individuals who seek enrollment in an individual coverage HRA for the entire HRA plan year, the Departments intend for the annual coverage substantiation requirement to provide verification of an individual's enrollment in individual health insurance coverage for the entire HRA plan year (and, therefore, that coverage is in effect as of the first day of the HRA plan year). Accordingly, the final rules clarify that the HRA may establish the date by which the annual coverage substantiation requirement must be satisfied, but, in general, the date may be no later than the first day of the HRA plan year. Nothing in the final rules prevents an HRA from setting reasonable parameters for when the substantiation must be provided to the HRA (for example, by the end of the individual coverage HRA open enrollment period).<sup>116</sup>

<sup>115</sup> One commenter asserted that the substantiation requirements in the proposed rules are not sufficient but the commenter appears to have understood that the annual coverage substantiation requirement is the sole substantiation requirement. The Departments note that the final rules, like the proposed rules, also require that the HRA satisfy the ongoing substantiation requirement. The Departments determined that both the annual coverage substantiation requirement and the ongoing substantiation requirement are necessary to ensure that individuals covered by an individual coverage HRA have individual health insurance coverage. Also, this commenter asserted that in the proposed rules the Departments acknowledged that employees may fail to obtain coverage, and cited to 83 FR 54445 (Oct. 29, 2018), where, in the regulatory impact analysis the Departments stated that loss of coverage could occur as a result of the integration rules "if some previously covered employees do not accept the HRA and fail to obtain their own coverage." The Departments clarify that this statement related to individuals who opt out of the HRA and did not address the circumstance in which an individual with an individual coverage HRA does not have individual health insurance coverage.

<sup>116</sup> The Departments note that in establishing the enrollment period for an individual coverage HRA,

<sup>112</sup> The Departments note that this provision addresses the right of participants to opt out of the HRA generally, including for their dependents, and is not intended to preclude an HRA from allowing a participant who enrolls in the HRA from enrolling some, but not all, dependents (including new dependents added during the year). The Departments also clarify that in the event a participant gains a dependent during the year, the HRA must provide the participant the right to decline to enroll that dependent, if the participant had enrolled for the plan year.

<sup>113</sup> See 26 CFR 54.9815-2711(d)(3), 29 CFR 2590.715-2711(d)(3), and 45 CFR 147.126(d)(3).

<sup>114</sup> The Departments clarify that the reference to "will be" applies for participants who provide the substantiation in advance of when their individual coverage HRA coverage begins.

However, for individuals who become eligible for the HRA during the HRA plan year, including dependents, or who otherwise are not required to be provided the HRA notice described later in this preamble 90 days prior to the plan year (that is, employees who become eligible fewer than 90 days prior to the plan year or employees of newly established employers), the HRA may establish the date by which the substantiation must be provided, but the date may be no later than the date the HRA coverage begins. These individuals may not have sufficient time to enroll in individual health insurance coverage that is effective on or before the first day of the HRA plan year. Thus, the final rules provide a timing requirement that is consistent with the annual coverage substantiation requirement to provide verification of an individual's enrollment in individual health insurance coverage for the portion of the HRA plan year during which the individual is covered by the HRA. The final rules also clarify that, for these individuals, whether the individual is a participant or a dependent, the annual coverage substantiation requirement requires substantiation that the individual will have individual health insurance coverage for the portion of the HRA plan year during which the individual is covered by the HRA (rather than requiring substantiation of coverage for the entire plan year). The final rules also clarify that to the extent a new dependent's coverage is effective retroactively, the HRA may establish any reasonable timeframe for the annual coverage substantiation but must require it be provided before the HRA will reimburse medical care expenses for the newly added dependent.

In addition to the annual coverage substantiation requirement, the proposed rules provided that an individual coverage HRA may not reimburse a participant for any medical care expenses unless, prior to each reimbursement, the participant provides substantiation that the participant and, if applicable, any dependent(s) whose medical care expenses are requested to be reimbursed, continues to be enrolled in individual health insurance coverage for the month during which the medical care expenses were incurred (ongoing substantiation requirement).

Several commenters expressed support for the ongoing substantiation requirement, as necessary to ensure the effectiveness of the requirement that individuals covered by an individual coverage HRA must be enrolled in

individual health insurance coverage. Several commenters, however, were concerned about what they characterized as the complexity, burdens, and liabilities associated with the ongoing substantiation requirement, in particular for smaller employers, and noted that those burdens could deter employers from adopting individual coverage HRAs. Some commenters asserted that the annual coverage substantiation requirement would be sufficient to verify enrollment in individual health insurance coverage and, therefore, ongoing substantiation would be unnecessary.

The Departments note that currently, separate from the market requirements or integration rules, HRAs are subject to substantiation requirements with respect to each request for reimbursement. This is because in order to provide a benefit excludable from income for federal tax purposes, employer-provided accident or health plans, including HRAs, may only reimburse medical care expenses that have been substantiated as an expense for medical care.<sup>117</sup> Consequently, each reimbursement for medical care expenses by an HRA may only be paid after the expense has been substantiated as being for medical care.<sup>118</sup> Each claim for reimbursement also generally must include the employee's certification that the expense has not otherwise been reimbursed and that the employee will not seek reimbursement for the expense from any other plan.<sup>119</sup>

The Departments have determined that requiring ongoing substantiation of an individual's continued enrollment in individual health insurance coverage for the month in which the expense was incurred is not unduly burdensome because of these existing substantiation requirements. Further, the Departments have determined that the ongoing substantiation requirement is essential to ensure compliance with the requirement that an individual covered by an individual coverage HRA be enrolled in individual health insurance coverage and, as explained later in this section of the preamble, will impose minimal burden because it can be satisfied by collecting a written attestation from the participant on the same form used for requesting reimbursement. Thus, the final rules

<sup>117</sup> See Code section 105(b), 26 CFR 1.105-2, and IRS Notice 2002-45.

<sup>118</sup> See Prop. Treas. Reg. 1.125-6(d) for rules regarding reimbursement of medical care expenses through electronic methods, including some debit cards that satisfy certain requirements.

<sup>119</sup> See IRS Notice 2006-69, 2006-31 IRB 107; Revenue Ruling 2003-43, 2003-1 CB 935; and Prop. Treas. Reg. 1.125-6(b)(3)(ii), (d)(i).

retain the ongoing substantiation requirement.<sup>120</sup>

Commenters requested that the Departments confirm the entity to which the substantiation requirements apply. Under the final rules, the substantiation requirements (both the annual coverage substantiation requirement and the ongoing substantiation requirement) apply to the individual coverage HRA, rather than to any other entity or individual, such as an issuer or employee, because the requirements relate to compliance of the individual coverage HRA with PHS Act sections 2711 and 2713. The substantiation requirements do not impose any new requirements on issuers, although individual coverage HRAs may accept certain documentation provided by issuers in the normal course of business to verify individual health insurance coverage enrollment.

#### b. Methods of Substantiation

The proposed rules included a proposal that the reasonable procedures an individual coverage HRA may use to verify enrollment in individual health insurance coverage for purposes of the annual coverage substantiation requirement include the individual coverage HRA requiring the participant to provide either: (1) A document from a third party (for example, the issuer or Exchange) showing that the participant and any dependent(s) covered by the individual coverage HRA are, or will be, enrolled in individual health insurance coverage during the plan year (for example, an insurance card or an explanation of benefits pertaining to the plan year or relevant month, as applicable);<sup>121</sup> or (2) an attestation by the participant stating that the participant and any dependent(s) are, or will be, enrolled in individual health insurance coverage, the date coverage began or will begin, and the name of the provider of the coverage. For the ongoing substantiation requirement, the

<sup>120</sup> The Departments note that the final rules clarify that the ongoing substantiation requirement applies with respect to the individual on whose behalf reimbursement is being sought.

<sup>121</sup> The Departments are aware that in the case of an individual coverage HRA with a non-calendar year plan year, the individual may not have documentation showing an individual health insurance policy that spans the entire plan year as individual health insurance policy years are based on the calendar year. However, such an HRA may establish reasonable procedures to implement the annual coverage substantiation requirement, including documentation showing coverage for the first part of the plan year combined with an attestation that the participant intends to obtain individual health insurance coverage for the second part of the plan year or an attestation with respect to the full plan year.

plan sponsors should consider the timeframes for the relevant individual market enrollment periods.

proposed rules permitted that substantiation could be in the form of a written attestation by the participant, which could be part of the form used for requesting reimbursement.

Commenters generally supported that the proposed rules provided that attestation by a participant would be sufficient to satisfy both the annual coverage substantiation requirement and the ongoing substantiation requirement. However, one commenter stated that allowing attestation to be used to satisfy the annual coverage substantiation requirement is not sufficient to ensure that individuals covered by an individual coverage HRA have individual health insurance coverage. The Departments acknowledge the importance of the requirement under the final rules that individuals with an individual coverage HRA be enrolled in individual health insurance coverage and, therefore, the need for related substantiation requirements that ensure that requirement is satisfied. The Departments note that attestation is permitted to be used to satisfy similar requirements in related contexts and that the Departments generally are not aware of issues with regard to the accuracy of attestations used to satisfy those rules.<sup>122</sup> Further, in setting out one type of attestation that is sufficient to satisfy the annual coverage substantiation requirement, the final rules state that, in addition to providing that the individual is (or will be) enrolled in individual health insurance coverage, the attestation would also provide the date coverage began or will begin and the name of the provider of the coverage. Moreover, HRAs can use other reasonable methods to satisfy the substantiation requirements and, in fact, the Departments generally expect that employees will use individual coverage HRAs to reimburse premiums for the individual health insurance coverage in which they are enrolled and, therefore, employers will be able to confirm enrollment in individual health insurance coverage by virtue of reimbursing the premiums for such coverage (or paying the premiums for such coverage directly). Taking these factors into consideration, the Departments have determined that allowing participant attestation, among other options, to satisfy the

<sup>122</sup> See IRS Notice 2013–54, Q&A–4 (providing that attestation is sufficient to show that an individual is enrolled in group coverage, as required by the rules allowing HRA integration with a traditional group health plan) and IRS Notice 2017–67, Q&A–41 (providing that attestation is sufficient to satisfy the QSEHRA requirement that individuals provide proof that they are covered by MEC).

substantiation requirements strikes the appropriate balance between ensuring individuals with individual coverage HRAs are enrolled in individual health insurance coverage and minimizing burdens on employers and employees. Accordingly, the final rules retain this provision and permit substantiation by participant attestation.

Some commenters requested that the final rules provide a model attestation. In response, to reduce burden on individual coverage HRAs and their participants, the Departments are providing model attestation language contemporaneously with, but separate from, the final rules. However, the Departments note that individual coverage HRAs will not be required to use the model attestation.

Some commenters requested clarification as to whether other substantiation methods, in addition to collection of an attestation, would satisfy the substantiation requirements. One commenter suggested that a list of covered individuals provided by the insurance carrier should be sufficient. The Departments agree that this would generally be a type of third-party document that could be used to verify enrollment, assuming the individual coverage HRA timely receives the substantiation. However, the Departments note that the final rules do not require issuers to provide individual coverage HRAs with lists of covered individuals nor are individual coverage HRAs required to contact issuers to substantiate an individual's enrollment in individual health insurance coverage. In addition, the final rules clarify that a document from an Exchange showing that the individual has completed the application and plan selection would be sufficient to satisfy the annual coverage substantiation requirement. This clarification is intended to address the situation in which, due to the SEP verification process, an individual is not yet enrolled in individual health insurance coverage but will be enrolled with a retroactive start date upon successful completion of the SEP verification.<sup>123</sup> See later in this

<sup>123</sup> The Departments note that a document from an Exchange showing that the individual has completed the application and plan selection would not be sufficient to satisfy the ongoing substantiation requirement; to satisfy that requirement the individual on whose behalf reimbursement is sought must be enrolled in individual health insurance coverage. Therefore, individual health insurance coverage must become effective, including retroactively in the case of delayed SEP verification, in which case reimbursement can then be sought for expenses incurred during the coverage period (including during the period to which the individual health insurance coverage applies retroactively, assuming

preamble for a discussion of SEPs, including a new SEP for individuals who newly gain access to an individual coverage HRA.

One commenter requested that the final rules adopt a requirement for issuers similar to the creditable coverage certification requirement created by HIPAA, under which, as suggested by the commenter, issuers would be required to generate a letter for all individuals covered by individual health insurance coverage for each month showing payment was made and that the individual had the coverage for the month.<sup>124</sup> The Departments decline to impose such a requirement because it would increase burden and other reasonable substantiation methods are available. One commenter suggested that the ongoing substantiation requirement should be considered satisfied so long as the employer sends a notice to employees advising them to contact the employer if they no longer are enrolled in individual health insurance coverage. The Departments decline to adopt this suggestion because this method of substantiation would be insufficient to ensure with reasonable accuracy that a participant had continued enrollment in individual health insurance coverage.

Several commenters requested that individual coverage HRAs be permitted to comply with the substantiation requirements electronically, such as through debit card technology.<sup>125</sup> Some commenters noted this would provide consistency with current rules that allow HRAs to satisfy the current requirement to substantiate that an expense is for medical care using debit cards and other electronic means.<sup>126</sup> Nothing in the final rules would prohibit an individual coverage HRA from establishing procedures to comply with the substantiation requirements through electronic means, so long as the procedures are reasonable to verify enrollment.<sup>127</sup> See also the discussion

the individual was covered by the HRA during that time).

<sup>124</sup> Code section 9801(e), ERISA section 701(e), and PHS Act section 2704(e).

<sup>125</sup> A couple of commenters requested clarification that funds in an individual coverage HRA could be accessed via debit cards. The final rules do not change the methods currently allowed for facilitating reimbursements of HRA amounts, electronic or otherwise.

<sup>126</sup> See IRS Notice 2006–69 and Revenue Ruling 2003–43, 2003–1 CB 935.

<sup>127</sup> For purposes of the Code provisions affected by the final rules, the otherwise generally applicable substantiation and recordkeeping requirements under Code section 6001 apply, including the requirements specified in Revenue Procedure 98–25, 1998–1 CB 689, for records maintained within an Automated Data Processing system.

later in this preamble regarding the interaction of these rules with the safe harbor that DOL is finalizing, to clarify that individual health insurance coverage will not be treated as part of an ERISA-covered group health plan so long as certain conditions (including the prohibition on endorsement) are satisfied.

#### c. Reliance on Documentation or Attestation

The proposed rules provided that, for both the annual coverage substantiation requirement and the ongoing substantiation requirement, an individual coverage HRA may rely on the documentation or attestation provided by the participant unless the individual coverage HRA has actual knowledge that any participant or dependent covered by the individual coverage HRA is not, or will not be, enrolled in individual health insurance coverage for the plan year or the month, as applicable.

Despite this provision in the proposed rules, some commenters expressed concern, and requested clarification, regarding liability of an individual coverage HRA if it relies on a participant's misrepresentation regarding enrollment in individual health insurance coverage. In response to these comments, the final rules provide that an individual coverage HRA may rely on the documentation or attestation provided by the participant unless the HRA has actual knowledge that any participant or dependent covered by the individual coverage HRA is not, or will not be, enrolled in individual health insurance coverage for the plan year (or the applicable portion of the plan year) or the month, as applicable. Therefore, the final rules provide that an inaccurate attestation or document will not cause an individual coverage HRA to fail to be considered integrated with individual health insurance coverage unless the HRA has actual knowledge that the attestation or document is inaccurate. The Departments clarify that in the event an individual coverage HRA subsequently gains actual knowledge that the attestation or document was inaccurate, the HRA may not provide further reimbursement on behalf of the individual for expenses incurred during the period to which the inaccurate attestation relates.

One commenter requested that the final rules clarify whose knowledge can be imputed to the individual coverage HRA for purposes of liability and one commenter requested clarification that vendors contracted by the HRA could rely on coverage information provided

by the HRA. The individual coverage HRA will be considered to have actual knowledge that a participant or dependent is not, or will not be, enrolled in individual health insurance coverage for the plan year or the month, as applicable, if the HRA, its plan sponsor, or any other entity acting in an official capacity on behalf of the HRA has such actual knowledge.

One commenter suggested that the final rules apply penalties to individual participants for an inaccurate attestation. The final rules do not impose penalties on participants. Instead, the final rules, like the proposed rules, provide conditions under which an HRA will be considered integrated with individual health insurance coverage and, therefore, in compliance with PHS Act sections 2711 and 2713. Failing to properly integrate will cause an HRA to run afoul of PHS Act sections 2711 and 2713. Therefore, the responsibility to have reasonable procedures in place to ensure coverage is integrated falls on the HRA, not the participants.

One commenter asked that individual coverage HRA amounts made available for a month be treated as taxable income for individuals who do not have individual health insurance coverage for the month and that the attestation requirement and required notice include a related warning. The Departments decline to adopt this suggestion. Whether an individual is enrolled in individual health insurance coverage for a month relates to whether the individual coverage HRA satisfies the conditions for integration for the month and does not affect the tax treatment of reimbursements provided to a participant under the individual coverage HRA.<sup>128</sup>

One commenter suggested that the final rules address substantiation requirements relative to a private exchange. The Departments note that the substantiation requirements set forth in the final rules apply to all individual coverage HRAs, regardless of the manner in which the individual health insurance coverage is purchased. See later in this preamble for a discussion of private exchanges and the DOL clarification regarding the application of ERISA to individual health insurance coverage purchased through an individual coverage HRA.

To mitigate discrimination concerns, one commenter requested that the substantiation requirements be consistent across all classes of

employees. The Departments note that the substantiation requirements set forth in the final rules apply to all individual coverage HRAs, including different individual coverage HRAs offered to different classes of employees. The Departments generally expect plan sponsors to establish similar procedures to satisfy the substantiation requirements for different individual coverage HRAs they may offer. However, the Departments decline to adopt the commenter's specific recommendation in order to allow plan sponsors the flexibility to establish reasonable procedures to satisfy the substantiation requirements, which presumably could differ across the employer's workforce, depending on the characteristics of the workforce or for other legitimate business reasons.

One commenter requested that employers offering an individual coverage HRA to employees or former employees who are either eligible for or enrolled in Medicare should be exempt from the substantiation requirement. However, as discussed in more detail later in this preamble, the final rules permit integration of an individual coverage HRA with Medicare, and the substantiation requirements apply to enrollment in Medicare in the same manner as they apply to enrollment in individual health insurance coverage. Therefore, the final rules do not adopt this suggestion.

#### 9. Notice Requirement

Because HRAs are different from traditional group health plans in many respects, in the preamble to the proposed rules, the Departments expressed a concern that individuals eligible for individual coverage HRAs might not recognize that the offer or acceptance of the individual coverage HRA may have consequences for APTC and PTC eligibility, as described elsewhere in this preamble. In order to ensure that employees who are eligible to participate in an individual coverage HRA understand the potential effect that the offer of and enrollment in the HRA might have on their ability to receive the benefit of APTC and claim the PTC, the proposed rules included a requirement that an individual coverage HRA provide written notice to eligible participants.

Commenters generally supported the notice requirement, sharing the Departments' determination that many individuals will need the information to understand the PTC consequences of the individual coverage HRA. However, a number of commenters expressed concerns about the potential for consumer confusion, notwithstanding

<sup>128</sup> However, see Code section 106(g) regarding the taxation of QSEHRA reimbursements if an individual fails to have MEC.

the notice requirement, and some suggested ways to strengthen the notice. Other commenters expressed concern that the notice requirement could burden employers, with one noting in particular the burden of providing notices to former employees.

The Departments have considered these comments and agree with the commenters that assert that the notice is necessary and appropriate for individuals offered an individual coverage HRA to understand the consequences of the offer. Although the Departments also considered the burden on employers identified by commenters, the Departments have determined that the notice requirement is essential to implementation of the final rules. Along with updates to Exchanges' application processes, the notice, which will include information that individuals will be instructed to provide to Exchanges during the application process, is key to ensuring that APTC and PTC are properly allowed and that improper APTC payments are prevented. The notice will also aid implementation of the new individual market SEP, as explained later in this preamble. Therefore, the final rules retain this requirement, with a number of revisions made in response to comments, including that the Departments are providing model notice language, separate from, but contemporaneously with the final rules, in order to address commenters' concerns about burden on employers. The comments received and changes made in the final rules are described in the remainder of this section of the preamble.

#### a. Notice Content

As proposed, the notice was required to include certain relevant information, including a description of the terms of the individual coverage HRA (including the self-only maximum dollar amount made available, which is used in the affordability determination under the proposed PTC rules); a statement of the right of the participant to opt out of and waive future reimbursement under the HRA; a description of the potential availability of the PTC if the participant opts out of and waives the HRA and the HRA is not affordable under the proposed PTC rules; a description of the PTC eligibility consequences for a participant who accepts the HRA; a statement that the participant must inform any Exchange to which they apply for APTC of certain relevant information; and a statement that the individual coverage HRA is not a QSEHRA.

Commenters generally supported the notice content elements, and the final rules include each of the proposed notice content elements, some with clarifications. Some commenters requested that the notice be required to include additional content, as explained in this section of the preamble, and some commenters requested that the notice be as simple as possible. Some commenters requested that the notice explain the differences between an employer's traditional group health plan and alternative health insurance products. And one commenter requested that the specific dollar amount made available be included in the notice. The Departments note that under the final rules, the notice is required to provide the amount(s) made available under the individual coverage HRA. As to the suggestion that the notice explain common differences between traditional group health plans and individual coverage HRAs and other insurance products, the Departments decline to adopt the suggestion due to concerns that it would cause confusion for participants, as participants are prohibited from being offered both a traditional group health plan and an individual coverage HRA under the final rules. The intent of the notice is to explain the individual coverage HRA that the employee is being offered to avoid consumer confusion. Adding information about other types of coverage would undermine that goal. Further, traditional group health plans differ in cost-sharing structures, network rules, and benefits covered, and any standardized language in the notice would have to be general and would not capture these elements, as standardized language about traditional group health plans would not be describing any particular plan. Moreover, the individual coverage HRA must provide a summary of benefits and coverage (SBC), which will include a description of the coverage, including cost sharing; the exceptions, reductions and limitations on coverage; and other information.<sup>129</sup>

One commenter requested that the notice be required to contain contact information for a specific person that participants can contact with questions. The Departments agree that this could be useful information for participants, without imposing significant additional burden on employers, and therefore the final rules add a requirement that the notice include contact information of an

individual or a group of individuals who participants may contact with questions regarding their individual coverage HRA. For purposes of this new requirement, the plan sponsor may determine which individual or group of individuals is in the best position to answer these questions. The final rules provide that the contact information provided in the notice must, at least, include a telephone number.

The final rules also newly require that the notice include a statement of availability of an SEP for employees and dependents who newly gain access to the HRA. This is in part in response to a commenter who suggested that the notice could be used to improve Exchange program integrity by making it easier for Exchanges that require pre-enrollment verification to use the notice to confirm enrollees' SEP eligibility. Separate from, but contemporaneously with the final rules, HHS is providing model language that will be relevant to employees purchasing coverage through or outside an Exchange, including a State Exchange, which HRAs may use to satisfy this requirement. The final rules also clarify that, to facilitate participants' timely enrollment in individual health insurance coverage using the new SEP described later in this preamble, the notice must also indicate the date as of which coverage under the HRA may first become effective and the date on which the HRA plan year begins and ends. The notice must also include information on when amounts will be made available (for example, monthly or annually).

Commenters also requested that the notice explain the extent to which individuals enrolled in Medicare may use an individual coverage HRA. In response to these comments, and to reflect the content of the final rules, the notice content requirements have been updated to reflect that individual coverage HRAs may be integrated with Medicare and to require inclusion of a statement in that notice that Medicare beneficiaries are ineligible for the PTC, without regard to whether the individual coverage HRA the individual is offered is affordable or provides MV or whether the individual accepts the HRA.

Further, the Departments note that, as under the proposed rules, while the written notice must include the information required by the final rules, it may include other information, as long as the additional content does not conflict with the required information.

#### b. Notice Individualization

The proposed rules did not include a requirement that the notice be

<sup>129</sup> See PHS Act section 2715(b)(3) (incorporated in Code section 9815 and ERISA section 715). See also 26 CFR 54.9815-2715, 29 CFR 2590.715-2715, and 45 CFR 147.200.

individualized for each participant. Although the notice would have been required to include a description of the potential availability of the PTC for a participant who opts out of and waives an unaffordable individual coverage HRA, and the individual coverage HRA amount that is relevant for determining affordability, the proposed rules did not require that the HRA include in the notice a determination of whether the HRA is considered affordable for the specific participant.

Some commenters agreed that the notice should not be required to be tailored to each participant. However, others stated that the notice would be insufficient if not individualized and requested that the final rules require that the notice provide information specific to each participant, including the premium for the relevant lowest cost silver plan, or, at a minimum, detailed instructions for where to find information on the lowest cost silver plan, while others requested that the notice include a completed affordability and MV calculation specific to each participant.

While the Departments understand the concerns about consumer confusion, under the final rules, the notice is not required to include a determination of whether the offer of an individual coverage HRA is affordable for a particular participant. Plan sponsors are not in a position to make this determination for, or provide it to, each participant because it would require information that plan sponsors do not possess (for example, the participant's household income). In addition, requiring a plan sponsor to determine the cost of the lowest cost silver plan that will apply for a specific participant to determine affordability under the PTC rules would be burdensome, and the information is available to the participant through other means. Specifically, by November 1, 2019, HHS will provide resources to assist individuals offered an individual coverage HRA and using the Federal *HealthCare.gov* platform with determining their PTC eligibility based on whether the individual coverage HRA is considered affordable, and with understanding when they must enroll in individual health insurance coverage based on their individual coverage HRA effective date, including whether they may qualify for an SEP. HHS will also begin working with State Exchanges immediately to assist with the development of resources for individuals using State Exchanges' applications for coverage. Further, although some plan sponsors will need to determine whether the offer of the

individual coverage HRA is affordable for purposes of the employer shared responsibility provisions under Code section 4980H, smaller employers are not subject to Code section 4980H. Moreover, the Treasury Department and the IRS intend to issue guidance in the near term providing safe harbors or other methods intended to reduce burdens and provide more predictability regarding the application of Code section 4980H to these arrangements.<sup>130</sup>

The Departments acknowledge that it is critical that participants have the information that they need to determine the affordability of their individual coverage HRA under the PTC rules, and, accordingly, the final rules add a requirement that the notice include a statement about how the participant may find assistance for determining their individual coverage HRA affordability. The model language that the Departments are providing contemporaneously with the final rules includes language that can be used to satisfy this requirement.

One commenter requested that the notice be required to be tailored for each class of employees offered the individual coverage HRA, in cases in which different classes are provided different HRA amounts, rather than allowing an employer to provide one notice for several or all classes. The final rules do not adopt this suggestion because the Departments have concluded any marginal advantages would be outweighed by the additional employer burdens of creating and distributing multiple versions of the notice. However, the Departments note that the final rules do not prohibit an employer from providing more individualized notices, such as different notices for different classes of employees, if the employer so chooses.

#### c. Model Notice

Many commenters requested that the Departments provide a model notice or model language for certain parts of the notice, such as model language to describe the consequences of opting into or out of the individual coverage HRA and language describing the related PTC consequences. One commenter suggested that the Departments provide translations of the model notice into languages other than English.

In response to these requests, and published separately from the final

<sup>130</sup> See IRS Notice 2018–88. Further, lowest cost silver plan data will be made available by HHS for employers in all states that use the Federal *HealthCare.gov* platform to determine whether the individual coverage HRA offer is affordable for purposes of the employer shared responsibility provisions under Code section 4980H.

rules, the Departments are providing model language contemporaneously on certain aspects of the notice that are not employer-specific, including model language describing the PTC consequences of being offered and accepting an individual coverage HRA. In addition, HHS is providing, contemporaneously, model language that relates to all Exchanges that can be used to satisfy the SEP-related notice content requirement and model language that can be used to satisfy the requirement that the notice include a statement describing how the participant may find assistance with determining affordability. While the Departments hope it will be useful, plan sponsors are not required to use the model language.

For individual coverage HRAs, including ERISA-covered plans, other disclosure requirements may require participants to be provided with a reasonable opportunity to become informed as to their rights and obligations under the individual coverage HRA.<sup>131</sup> Those requirements are of general applicability, and the Departments decline to adopt a special requirement, or model non-English translation, here.<sup>132</sup>

#### d. Notice Timing and Delivery

Under the proposed rules, the individual coverage HRA generally would be required to provide a written notice to each participant at least 90 days before the beginning of each plan year. The proposed rules also provided that for participants not eligible to participate at the beginning of the plan year (or not eligible when the notice is otherwise provided to plan participants), the individual coverage HRA would be required to provide the notice no later than the date on which the participant is first eligible to participate in the HRA.

Some commenters supported the notice timing as proposed and others indicated that small employers will not be able to provide notices 90 days prior to the plan year because they do not make benefit decisions that far in

<sup>131</sup> See, e.g., ERISA sections 102, 104(b), and 503 and PHS Act sections 2715 and 2719 (incorporated in Code section 9815 and ERISA section 715). See also 26 CFR 54.9815–2715 and 54.9815–2719; 29 CFR 2520.102–3, 2520.104b–1, 2560.503–1, 2590.715–2715, and 2590.715–2719; and 45 CFR 147.136 and 147.200.

<sup>132</sup> But see 29 CFR 2520.102–2(c) (requiring that plans where either 500 participants or at least 10 percent of all participants (or for plans with fewer than 100 participants, 25 percent of participants) are literate in the same non-English language provide those literate only in a non-English language a reasonable opportunity to become informed as to their rights and obligations under the plan).

advance. Several commenters requested that the notice delivery coincide with the annual Exchange open enrollment period, others requested it coincide with each employer's annual open enrollment period, and others requested that plan sponsors have the flexibility to provide the required notice at any time prior to the plan year, including upon initial enrollment in an individual coverage HRA. One commenter requested the notice be required to be provided within 60 days, instead of 90 days, prior to the start of the plan year. One commenter requested that the Departments apply the distribution requirements that apply for purposes of SBCs and the uniform glossary. One commenter also asked the Departments to clarify the notice timing requirement as applied to individual coverage HRAs that do not have a calendar year plan year.

The Departments considered these comments, but have determined that, with the addition of a rule for newly established employers and certain other clarifications, the final rules should adopt the notice timing requirement as proposed, because, for a calendar year plan year, it ensures that participants who are current employees will receive the notice prior to the individual market annual open enrollment period, and for employers offering an individual coverage HRA on a non-calendar year plan year, it ensures participants who are current employees will receive the notice prior to the applicable individual market SEP. The Departments also clarify that the notice timing requirement applies in the same way to an individual coverage HRA with a calendar year plan year or with a non-calendar year plan year. The notice's primary purpose is to provide necessary information to participants that Exchanges will need in order to accurately determine eligibility for APTC. With that purpose in mind, the Departments have determined that a shorter timing requirement, including one mirroring the requirement for the SBC, or a timing requirement tied to the employer's open enrollment period, would not be sufficient.

As previously noted, the proposed rules provided an exception to the 90 day notice requirement for participants who are not eligible to participate either at the beginning of the plan year or at the time the notice is provided at least 90 days prior to the plan year. For those participants, the proposed rules would allow the individual coverage HRA to provide the notice no later than the date on which the participants are first eligible to participate in the HRA. The final rules adopt this rule generally as

proposed, but clarify the language to provide that the date by which the notice must be provided is the date on which the HRA may first take effect for the participant. Further, the Departments have determined that individual coverage HRAs sponsored by employers that are first established within a short period of time prior to the first plan year of the HRA may not have an adequate amount of time to provide a notice to participants at least 90 days prior to beginning of the first plan year. Therefore, the final rules provide that in the case of an individual coverage HRA sponsored by an employer that is established less than 120 days prior to the beginning of the first plan year of the HRA, the notice may be provided no later than the date on which the HRA may first take effect for the participant, for that first plan year of the HRA.

Moreover, although the final rules provide that for participants not eligible to participate in the individual coverage HRA at the beginning of the plan year (or not eligible when the notice is otherwise provided) and for participants of newly established employers, the HRA is not required to provide the notice until the date on which the HRA may first take effect for the participant, the Departments encourage HRAs to provide the notice as soon as practicable. As explained later in this preamble, individuals who newly gain access to an individual coverage HRA will have an individual market SEP that provides the chance to select an individual health insurance plan in advance of the date when the HRA may first take effect, so that individual health insurance coverage can be effective on the first date the individual is eligible to be covered by the HRA. If the notice is not provided until the day the HRA may first take effect for the participant, individuals may not be aware of the HRA offer and will not be able to enroll in individual health insurance coverage that has an effective date on the earliest effective date of their HRA coverage. However, the Departments are aware that in some circumstances it would not be reasonable to require HRAs to provide the notice well in advance of the date the HRA may first take effect for new employees. Therefore, the final rules continue to require that the notice be provided in these circumstances no later than the date on which the HRA may first take effect, but if possible, HRAs should provide the notice sooner. This will allow new employees to begin coverage in the HRA as soon as possible.

With regard to delivery methods, the proposed rules provided that the notice must be a written notice but did not further address delivery or format.

Several commenters requested that the final rules clarify the notice delivery procedures and requirements, including allowing for electronic delivery (through email delivery, internet/intranet posting, or any other electronic means) if participants are provided the appropriate opportunity to opt out of electronic delivery. One commenter asked specifically if the notice delivery would be subject to ERISA's delivery rules.

Under the final rules, individual coverage HRAs that are subject to ERISA, and individual coverage HRAs sponsored by nonfederal governmental plan sponsors, must provide the notice in a manner reasonably calculated to ensure actual receipt of the material by plan participants covered by the HRA. Additionally, individual coverage HRAs that are subject to ERISA must provide the notice in a manner that complies with the DOL's rules.<sup>133</sup> For ERISA plans using electronic disclosure, the DOL has provided a safe harbor at 29 CFR 2520.104b-1(c). This safe harbor is not intended to represent the exclusive means by which the requirements of 29 CFR 2520.104b-1 may be satisfied using electronic media.<sup>134</sup> As to individual coverage HRAs sponsored by nonfederal governmental plan sponsors, HHS is revising the final rule to provide that the notice must be provided in a manner reasonably calculated to ensure actual receipt of the material by plan participants covered by the HRA, which HHS has determined is sufficient to ensure that participants receive the required notice.

Commenters also requested that the Departments confirm that the notice may be delivered along with other plan materials, including, but not limited to, annual enrollment materials or new hire benefit packages. The Departments confirm that the individual coverage HRA notice may be delivered with other plan materials, so long as it satisfies the content and timing requirements specific to the individual coverage HRA notice.

#### e. Other Notice Requirements and Consumer Assistance

Some commenters suggested that all types of HRAs (including excepted benefit HRAs and HRAs integrated with traditional group health plans) should include notice requirements so that individuals understand which type of arrangement they have and the consequences of the arrangement. The Departments acknowledge the potential for consumer confusion as a result of the

<sup>133</sup> 29 CFR 2520.104b-1.

<sup>134</sup> 67 FR 17263, 17264 (April 9, 2002).

existence of various types of health coverage, including various types of HRAs. However, the Departments generally decline the suggestion to impose new notice requirements under the final rules across all types of HRAs. The Departments note that this type of consumer information notice requirement is typically only imposed in situations in which there is a specific justification for it. For example, individual coverage HRAs are unique in that specific PTC rules apply, and for QSEHRAs, which also have specific PTC rules, notices are already required under the law.<sup>135</sup>

Further, the Departments note that the proposed rules would have required the notice to include a statement that the individual coverage HRA is not a QSEHRA, and the final rules revise the statement in response to comments to clarify further that there are multiple types of HRAs and the type the participant is being offered is an individual coverage HRA (rather than a QSEHRA or any other type).

Moreover, HRAs that are ERISA-covered plans must provide a summary plan description (SPD), summaries of material modifications, and summaries of material reductions in covered services or benefits.<sup>136</sup> The SPD must be sufficiently comprehensive to apprise the plan's participants and beneficiaries of their rights and obligations under the plan. It must also include, for example, the conditions pertaining to eligibility to receive benefits, and a description or summary of the benefits, the circumstances that may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (for example, by exercise of subrogation or reimbursement rights) of any benefits and the procedures governing claims for benefits under the plan. HRAs that are ERISA-covered plans are also required to provide the instruments under which the plan is established or operated and information relevant to a participant's adverse benefit determination upon request.<sup>137</sup> This information should be adequate to enable individuals to understand which type of arrangement they have and the consequences of the arrangement.<sup>138</sup>

<sup>135</sup> Code section 9831(d)(4) and IRS Notice 2017-67.

<sup>136</sup> See 29 CFR 2520.104b-2 and 29 CFR 2520.104b-3(a), (d)(3).

<sup>137</sup> See, e.g., ERISA sections 104(b), 502(c), and 503. See also 29 CFR 2520.104b-1 and 29 CFR 2560.503-1.

<sup>138</sup> The final excepted benefit HRA rules specifically note the ERISA disclosure obligations, and HHS intends to propose similar disclosure requirements for non-federal governmental plan excepted benefit HRAs.

One commenter requested that the Departments clarify the interaction between the notice requirements associated with the Fair Labor Standards Act (FLSA) and the notice requirement for individual coverage HRAs. The Departments note that under FLSA section 18B, an applicable employer is required to provide notice to inform employees of coverage options, including the existence of an Exchange, and the availability of the PTC if the employer's plan does not provide MV. This notice is provided at the time of hiring. The FLSA section 18B requirement to provide a notice to employees of coverage options applies to employers to which the FLSA applies. An employer sponsoring an individual coverage HRA that provides the required notice under the final rules must also provide a notice that satisfies the FLSA notice requirement if the FLSA applies to the employer. However, nothing in the final rules prohibits an employer from combining the notices for employees eligible for the individual coverage HRA, provided that both notice requirements are satisfied.

Commenters also urged the Departments more generally to create tools and resources for employees and employers that are easily accessible to help determine PTC eligibility and to dedicate additional funding to the State Exchanges for increased administration and assistance to individuals trying to determine APTC eligibility. A few commenters suggested that more education for consumers, enrollment assisters, and agents and brokers would be necessary. The Departments acknowledge the crucial role that the Exchanges have in implementation and operationalization of individual coverage HRAs, and the Departments will work closely with the Exchanges on the implementation of the final rules. The Departments note that language will be added to the HealthCare.gov application to help consumers understand that if they are eligible for an individual coverage HRA, this offer may affect their APTC eligibility. As discussed elsewhere in this preamble, HHS also intends to provide technical assistance materials for consumers in HealthCare.gov states, as well as for enrollment assisters and agents and brokers participating in Exchanges that use HealthCare.gov, so they may help consumers understand the implications of their individual coverage HRA offer. The Departments are also continuing to consider other ways to provide outreach and assistance to stakeholders regarding individual coverage HRAs.

#### 10. Student Health Insurance Coverage

Federal rules under PPACA define student health insurance coverage as a type of individual health insurance coverage.<sup>139</sup> Although those rules exempt student health insurance coverage from certain provisions of PPACA and HIPAA,<sup>140</sup> they do not exempt this coverage from PHS Act sections 2711 and 2713. Therefore, given that student health insurance coverage is a type of individual health insurance coverage, and is subject to PHS Act sections 2711 and 2713, in the preamble to the proposed rules, the Departments clarified that an HRA may be integrated with student health insurance coverage that satisfies the requirements in 45 CFR 147.145.

One commenter expressed support for allowing integration of HRAs with student health insurance coverage. Another commenter requested that integration with student health insurance coverage not be permitted due to concerns that HRA plan sponsors would be required to confirm that the student health insurance coverage complies with the market requirements. The final rules permit HRA integration with student health insurance coverage because student health insurance coverage is individual health insurance coverage that is subject to PHS Act sections 2711 and 2713. In response to concerns about the difficulty of determining the compliance of individual health insurance coverage policies with the market requirements generally for all individual health insurance coverage, under the final rules, all individual health insurance coverage is treated as compliant with PHS Act sections 2711 and 2713. Therefore, plan sponsors are not required to confirm that any particular student health insurance policy (or any other individual health insurance policy) complies with PHS Act sections 2711 and 2713.

Further, in the preamble to the proposed rules, the Departments noted that self-insured student health plans

<sup>139</sup> Under this definition, student health insurance coverage must be provided pursuant to a written agreement between an institution of higher education (as defined in the Higher Education Act of 1965) and a health insurance issuer, and provided to students enrolled in that institution and their dependents, and does not make health insurance coverage available other than in connection with enrollment as a student (or as a dependent of a student) in the institution, does not condition eligibility for the health insurance coverage on any health status-related factor (as defined in 45 CFR 146.121(a)) relating to a student (or a dependent of a student), and satisfies any additional requirements that may be imposed under state law. See 45 CFR 147.145(a).

<sup>140</sup> See 45 CFR 147.145(b).

are not a form of individual health insurance coverage.<sup>141</sup> Therefore, the proposed rules did not provide for HRA integration with self-insured student health plans. One commenter expressed concern that it may be difficult for employers to verify whether an individual with student health plan coverage has insured or self-insured coverage. The Departments appreciate the comment and recognize that employers and employees may not know whether a student health plan is insured or self-insured, but expect that employers will take reasonable steps to ensure compliance with the final rules. This includes making reasonable efforts to ensure that, when employees substantiate enrollment in student health coverage, they are correctly substantiating enrollment in a student health plan provided through insurance by a licensed issuer. If a student enrolled in an institution of higher education has questions about the type of student health coverage that is offered by the institution, this information should be available in the governing plan document or by contacting the plan administrator for the student health plan.

The Departments also confirmed in the preamble to the proposed rules that prior guidance,<sup>142</sup> which provided enforcement relief to institutions of higher education for certain healthcare premium reduction arrangements offered to student employees in connection with insured or self-insured student health coverage (student premium reduction arrangements) remains in effect, pending any further guidance. One commenter expressed support for keeping the current enforcement relief in effect.

The Departments reiterate that the previously provided enforcement relief remains in effect for institutions of higher education, pending any future guidance, and the final rules clarify that a student employee who is offered a student premium reduction arrangement is not considered part of the class of employees of which the employee would otherwise be a part for purposes of the final integration rules. This provision applies only for plan sponsors

that are institutions of higher education. For this purpose, a student premium reduction arrangement is defined as any program offered by an institution of higher education where the cost of insured or self-insured student health coverage is reduced for certain students through a credit, offset, reimbursement, stipend or similar arrangement.<sup>143</sup> Therefore, the offer of that type of arrangement to student employees will not affect the compliance of an individual coverage HRA that the institution of higher education may offer to other employees. The final rules also clarify that a student employee offered a student premium reduction arrangement is not counted for purposes of determining whether the minimum class size requirement is satisfied. The text of the final rules includes examples.

However, if a student employee is not offered a student premium reduction arrangement (including if, instead, the student employee is offered an individual coverage HRA), the student employee is considered to be part of the class of employees to which he or she otherwise belongs, and the student employee is counted in determining whether the minimum class size requirement is satisfied. Further, if an individual coverage HRA is offered to student employees, the final integration rules apply to such an arrangement as they would any other individual coverage HRA.

#### 11. Integration With Certain Other Types of Coverage

##### a. Short-Term, Limited-Duration Insurance

The Departments considered whether to propose a rule to permit individual coverage HRAs to be integrated with types of non-group coverage other than individual health insurance coverage, such as STLDI.<sup>144</sup> The Departments declined to do so in the proposed rules because STLDI is not subject to PHS Act sections 2711 and 2713 and, therefore, might not be compliant with these market requirements. However, the Departments requested comments on whether integration with STLDI should be permitted and, if so, what potential advantages and problems might arise.

Most commenters strongly opposed allowing integration with STLDI, expressing concerns that it would cause significant adverse selection in the individual market, which would lead to increased premiums and increased federal spending (through increased PTCs). Some of these commenters

asserted that prohibiting integration with STLDI is necessary to ensure the integrity and sustainability of the individual market and that to allow integration with STLDI would run counter to, and negate, the various other provisions in the proposed rules intended to prevent adverse selection. Some commenters expressed concern that STLDI provides insufficient coverage and consumer protections, that individuals would unknowingly enroll, and that brokers would have incentives to encourage STLDI enrollment. Some commenters raised legal concerns with allowing integration of HRAs with STLDI, noting that STLDI is not subject to, or generally compliant with, PHS Act sections 2711 and 2713 and, therefore, would not be sufficient to ensure that an individual with an HRA integrated with STLDI had coverage that was compliant with these market requirements. One commenter asserted that an HRA integrated with STLDI would fail to comply with the health nondiscrimination rules under HIPAA because STLDI is allowed to discriminate based on health status.

A few commenters supported allowing integration of an individual coverage HRA with STLDI, noting that STLDI is an option that could provide relief to individuals unable to afford individual health insurance coverage and, for some lower-income individuals, such as those in states that did not expand Medicaid under PPACA, may be the only affordable alternative. One commenter supported integration with STLDI as long as additional guardrails were established and another requested additional notice requirements if integration of individual coverage HRAs were to be permitted with STLDI.

The Departments note that STLDI can be a useful option for certain individuals otherwise unable to afford or obtain PPACA-compliant health insurance. The final rules, however, do not allow integration with STLDI because of the concerns raised by commenters, including that the combined arrangement would not necessarily satisfy PHS Act sections 2711 and 2713 and that adverse selection could result. The Departments note that the new excepted benefit HRA finalized elsewhere in the final rules, which is not subject to PHS Act sections 2711 and 2713, generally may be used to reimburse premiums for STLDI. See later in this preamble for a discussion of the excepted benefit HRA, including a discussion of the limited circumstance in which an excepted benefit HRA may not be used to reimburse STLDI premiums.

<sup>141</sup> See 77 FR 16453, 16455 (March 21, 2012).

<sup>142</sup> See FAQs About Affordable Care Act Implementation Part 33, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-33.pdf> or <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ACA-FAQ-Set-33-Final.pdf>. See also IRS Notice 2016-17; DOL Technical Release 2016-1; and CMS Insurance Standards Bulletin, Application of the Market Reforms and Other Provisions of the Affordable Care Act to Student Health Coverage, February 5, 2016.

<sup>143</sup> *Id.*

<sup>144</sup> See 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103 for the definition of STLDI.

#### b. Spousal Coverage

In developing the proposed rules, the Departments considered whether to allow individual coverage HRAs to be integrated with group health plan coverage, such as a group health plan maintained by the employer of the participant's spouse, in addition to individual health insurance coverage. Like individual health insurance coverage, group health plan coverage generally is subject to and compliant with PHS Act sections 2711 and 2713. The Departments indicated they did not propose such a rule because to do so would add significant complexity to the individual health insurance coverage integration test.<sup>145</sup> However, the Departments requested comments, including on the demand for such a rule, and any problems such a rule may raise.

Several commenters requested that integration with spousal coverage be permitted under the individual health insurance coverage integration test, with one stating that most group coverage is likely to cover all EHBs and therefore the issue of an HRA that covers all EHBs being integrated with coverage that does not cover all EHBs is unlikely to arise. One commenter suggested that the Departments allow an employee to be covered by a group health plan and also have access to an HRA that can be used to purchase individual health insurance coverage for a spouse. Other commenters requested that integration of an individual coverage HRA with spousal coverage be prohibited, expressing skepticism that employers would take advantage of this option and

noting that the arrangement would add little value. In light of the Departments' continued concern with the added complexity that would be required and the response from commenters, the final rules do not allow an individual coverage HRA to also be integrated with other group health plan coverage, such as spousal coverage. This is an area that the Departments may explore in future rulemaking. The Departments reiterate that the current rules under PHS Act section 2711 allow HRAs to be integrated with other non-HRA group health plan coverage, including spousal coverage, subject to certain conditions.<sup>146</sup> However, amounts made available under such an HRA may not be used to purchase individual health insurance coverage.<sup>147</sup>

Commenters also requested clarification as to whether two spouses, each offered an individual coverage HRA from their respective employers, may use the separate individual coverage HRAs to buy a single individual health insurance policy that covers both spouses (and any dependents). Nothing in the final rules would prohibit this, if the separate individual coverage HRAs are each in compliance with the final rules. However, under the generally applicable rules for HRAs under the Code, each individual may only seek reimbursement for the portion of a medical care expense that has not already been reimbursed by some other means, including from one of the individual coverage HRAs.

#### c. Health Care Sharing Ministries

Several commenters requested that integration of HRAs with health care sharing ministries be permitted, in part to provide an alternative option that alleviates conscience issues faced by employers and employees with respect to individual health insurance coverage, and in part due to the success of health care sharing ministries in providing affordable, flexible choices.

The Departments are of the view that HRAs cannot be integrated with health care sharing ministries, consistent with PHS Act sections 2711 and 2713. Under current law, health care sharing ministries are not subject to those provisions, nor are they required to comply with other market requirements that apply to individual health insurance coverage. Health care sharing ministry arrangements are also not MEC.<sup>148</sup> Therefore, the integration of an

individual coverage HRA with these arrangements would not result in a combined arrangement sufficient to satisfy PHS Act sections 2711 and 2713, which means that such a combined arrangement would not provide the protections afforded by those provisions.

One commenter asserted that the proposed rules would impermissibly burden the exercise of religion for purposes of the Religious Freedom Restoration Act of 1993 (RFRA)<sup>149</sup> because they would not allow individual coverage HRAs to be integrated with health care sharing ministries and thus would make participation in health care sharing ministries more expensive relative to individual coverage HRAs. Specifically, the commenter asserted that the proposed rules would impermissibly burden the free exercise of religion because, by not allowing HRAs to be integrated with health care sharing ministries, the rules would extend certain tax advantages to individual coverage HRAs that are not extended to participants in health care sharing ministries. However, although the RFRA provides a claim to persons whose religious exercise is substantially burdened by government, the Supreme Court has held that "a generally applicable tax [that] merely decreases the amount of money [an individual or entity] has to spend on its religious activities" does not impose a substantial burden on the exercise of religion.<sup>150</sup> Consequently, the final rules do not allow individual coverage HRAs to be integrated with health care sharing ministries.

#### d. Multiple Employer Welfare Arrangements (Including Association Health Plans)

One commenter requested that integration of HRAs be permitted with association health plans (AHPs)<sup>151</sup> and another commenter opposed allowing integration with AHPs, because coverage offered by an AHP is not required to cover all EHBs, to the extent

<sup>145</sup> PHS Act section 2711 applies with respect to the coverage of EHBs. Because large group market and self-insured group health plans are not required to cover EHBs, unlike individual health insurance coverage which generally is required to cover all EHBs, in the group health plan integration context, situations may arise where non-HRA group coverage with which the HRA is integrated does not cover every category of EHBs that the HRA covers. In that case, the HRA applies an annual dollar limit to a category of EHBs and the non-HRA group coverage with which it is integrated does not cure that limit by providing unlimited coverage of that category of EHBs. In the 2015 rules under PHS Act section 2711, and in subregulatory guidance that preceded the 2015 rules, the Departments addressed this issue by providing two tests. Specifically, if the non-HRA group coverage with which an HRA is integrated provides MV, the HRA will not be considered to fail to comply with PHS Act section 2711, even though the HRA might provide reimbursement of an EHB that the plan with which the HRA is integrated does not. If an HRA is integrated with non-HRA group coverage that does not provide MV, the 2015 rules limit the types of expenses that an HRA may reimburse to reimbursement of co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care that does not constitute an EHB. For additional discussion of the current rules under PHS Act section 2711, see the discussion earlier in this preamble.

<sup>146</sup> 26 CFR 54.9815-2711(d)(2), 29 CFR 2590.715-2711(d)(2), and 45 CFR 147.126(d)(2).

<sup>147</sup> IRS Notice 2015-87, Q&A-2.

<sup>148</sup> See Code section 5000A(d)(2)(B) and 5000A(f).

<sup>149</sup> 42 U.S.C. 2000bb(b).

<sup>150</sup> *Jimmy Swaggart Ministries v. Bd. of Equalization of California*, 493 U.S. 378, 391 (1990).

<sup>151</sup> On June 21, 2018, DOL published a final rule establishing a new test as an alternative to that described in prior DOL sub-regulatory guidance for determining who can sponsor an ERISA-covered AHP as an "employer." See 83 FR 28912 (June 21, 2018). The AHP rule was intended to expand access to affordable, high-quality healthcare options, particularly for employees of small employers and some self-employed individuals. On March 28, 2019, in *State of New York v. United States Department of Labor*, the United States District Court for the District of Columbia vacated most of the DOL rule. On April 26, 2019, the Department of Justice filed a notice of appeal.

the coverage is offered through a large group market or self-insured group health plan. AHPs are a type of Multiple Employer Welfare Arrangement (MEWA) that are group health plans. The Departments current, final regulations at 26 CFR 54.9815–2711(d)(2), 29 CFR 2590.715–2711(d)(2), and 45 CFR 147.126(d)(2) set forth criteria for HRAs to be integrated with other group health plan coverage (including MEWAs).

e. TRICARE

The Departments note that, under the final rules, individual coverage HRAs may not be integrated with TRICARE.<sup>152</sup> However, for the sake of clarity, the Departments note that nothing in the final rules prevents an employer from offering an individual coverage HRA to an individual covered by TRICARE, subject to the provisions of the final rules, including that if an individual coverage HRA is offered to an employee in a class of employees, the HRA must generally be offered on the same terms to all the employees in the class. Further, nothing in the final rules prevents an individual covered by TRICARE from enrolling in an individual coverage HRA, if offered, subject to the conditions in the final rules, including that all individuals covered by an individual coverage HRA must be enrolled in either individual health insurance coverage or Medicare.<sup>153</sup> Consequently, an individual covered by TRICARE who is offered an individual coverage HRA will be enrolled in TRICARE and must also be enrolled in an individual health insurance policy (or Medicare, if applicable) in order to be enrolled in the individual coverage HRA. The individual may not enroll in the individual coverage HRA and only TRICARE without enrolling in an individual health insurance policy (or Medicare). Further, as explained later in this preamble, HRAs may reimburse medical care expenses and the HRA plan sponsor determines which medical care expenses a particular HRA may reimburse, consistent with the discussion later in this preamble. It may be the case that an HRA will be available to pay both the premiums and cost-sharing for individual health

insurance coverage as well as any medical care expenses related to TRICARE, subject to the terms of the HRA.

12. Expenses Eligible for Reimbursement by an Individual Coverage HRA

A number of commenters requested clarification of the expenses that may be reimbursed under an individual coverage HRA, such as whether expenses for premiums for excepted benefit coverage, cost sharing under excepted benefit coverage, and cost sharing under individual health insurance coverage may be reimbursed. One commenter recommended that the final rules require individual coverage HRAs to provide reimbursement for cost sharing in addition to premiums, and another asked for clarification that an individual coverage HRA is not required to be used to reimburse premiums for individual health insurance coverage, so long as the individual coverage HRA otherwise satisfies the requirements under the final rules.

An HRA may provide for reimbursement of expenses for medical care, as defined under Code section 213(d). Consistent with the current rules that apply to HRAs generally, under the final rules, a plan sponsor has discretion to specify which medical care expenses are eligible for reimbursement from an individual coverage HRA it establishes. A plan sponsor may allow an HRA to reimburse all medical care expenses, may limit an HRA to allow reimbursements only for premiums, may limit an HRA to allow reimbursements only for non-premium medical care expenses (such as cost sharing), or may decide which particular medical care expenses will be reimbursable and which will not be reimbursable. However, in the latter case, the designation of the reimbursable expenses must not violate other rules applicable to group health plans, such as the HIPAA nondiscrimination rules or the MSP provisions. The final rules do not require that an individual coverage HRA be used (or be allowed to be used) for reimbursement of premiums for individual health insurance coverage (or Medicare). However, as detailed earlier in this preamble, the final rules require that individuals covered by an individual coverage HRA be enrolled in individual health insurance coverage (or Medicare). Thus, the Departments generally anticipate that employers will allow individual coverage HRAs to reimburse premiums for such coverage. Some commenters requested that the Departments confirm that certain

excepted benefits, including standalone dental coverage, hospital indemnity or other fixed indemnity coverage, and coverage for a specific disease or illness, provide medical care within the meaning of Code section 213(d) and, therefore, that expenses for these types of coverage are reimbursable by an individual coverage HRA. Some commenters requested that expenses paid with regard to direct primary care arrangements be recognized as expenses for medical care under Code section 213(d). In addition, one commenter requested clarification of whether payments for participation in health care sharing ministries qualify as medical care expenses under Code section 213(d).

An HRA, including an individual coverage HRA, generally may reimburse expenses for medical care, as defined under Code section 213(d), of an employee and certain members of the employee's family. Under Code section 213(d), medical care expenses generally include amounts paid (1) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure of function of the body; (2) for transportation primarily for and essential to medical care; (3) for certain qualified long-term care services; and (4) for insurance covering medical care. Neither the proposed rules nor the final rules make any changes to the rules under Code section 213. Thus, any issues arising under Code section 213, and any guidance requested by commenters to address those issues, are beyond the scope of this rulemaking. The Treasury Department and the IRS, however, appreciate the comments and plan to address some of these issues in future rulemaking or guidance.

13. Interaction of Individual Coverage HRAs and HSAs

Commenters raised various issues related to the interaction between individual coverage HRAs and HSAs. Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108–173, added section 223 to the Code to allow eligible individuals to establish HSAs. Among the requirements for an individual to qualify as an eligible individual under Code section 223(c)(1) is that the individual must be covered under a high deductible health plan (HDHP) and have no disqualifying health coverage. If an individual fails to satisfy the requirements to be an eligible individual, contributions to an HSA are disallowed.

Several commenters asked that the Treasury Department and the IRS clarify

<sup>152</sup> See chapter 55 of title 10, United States Code.

<sup>153</sup> IRS Notice 2015–17, Q&A–3, provides that an arrangement under which an employer reimburses certain medical care expenses for employees covered by TRICARE may be considered integrated with a traditional group health plan offered by the employer (even though the employee is not enrolled in the traditional group health plan), subject to certain conditions. The final rules do not affect this guidance provided under Notice 2015–17.

whether an individual covered by an individual coverage HRA may contribute to an HSA. Some commenters specifically asked the Treasury Department and the IRS to address the application of prior guidance under the Code, which provides that certain types of HRAs do not render an individual ineligible to contribute to an HSA. Several commenters expressed support for HSAs and emphasized the importance of allowing individuals who have individual coverage HRAs to contribute to HSAs.

In Revenue Ruling 2004-45,<sup>154</sup> the Treasury Department and the IRS clarified that an otherwise eligible individual (that is, an individual with coverage under an HDHP and no other disqualifying coverage) remains an eligible individual for purposes of making contributions to an HSA for periods during which the individual is covered by, among other things, a limited-purpose HRA, a post-deductible HRA, or combinations of these arrangements.<sup>155</sup> Subsequently, Q&A-1 of IRS Notice 2008-59<sup>156</sup> stated that a limited-purpose HRA that is also available to pay premiums for health coverage does not disqualify an otherwise eligible individual from contributing to an HSA, provided the individual does not use the HRA to, or otherwise, obtain coverage that is not HSA-compatible. This prior guidance applies to all HRAs, including individual coverage HRAs. Therefore, for example, an individual coverage HRA that solely makes available reimbursements of individual health insurance coverage premiums does not disqualify an otherwise eligible individual covered under an HDHP and no other disqualifying coverage from making contributions to an HSA. However, an individual coverage HRA that is not limited in accordance with the relevant guidance under the Code would not be HSA-compatible (for example, an HRA that can reimburse first dollar cost sharing).

One commenter asked whether employers are allowed, or required, to

offer both an HSA-compatible individual coverage HRA and an individual coverage HRA that is not HSA compatible to a class of employees. The Departments recognize that some employees offered an individual coverage HRA may choose individual health insurance coverage that is an HDHP and other employees may choose non-HDHP individual health insurance coverage that is not HSA compatible. While some employers may offer all employees in a class of employees an HSA-compatible individual coverage HRA, some employers may want to offer employees in a class of employees a choice between an HSA-compatible individual coverage HRA and an individual coverage HRA that is not HSA compatible. In response to this comment, the final rules clarify that an employer that offers employees in a class of employees a choice between an HSA-compatible individual coverage HRA and an individual coverage HRA that is not HSA compatible does not fail to satisfy the same terms requirement provided both types of individual coverage HRAs are offered to all employees in the class on the same terms.<sup>157</sup> The final rules have been revised to reflect this rule.

With respect to the post-deductible feature of certain HSA-compatible HRAs, one commenter suggested that the final rules provide that employees may self-administer the post-deductible restriction by tracking medical expenses incurred during the year and refraining from submitting medical expenses to the post-deductible HRA until the minimum deductible is satisfied. The Treasury Department and the IRS decline to adopt this approach because it would be inconsistent with the rules for the administration of HDHPs.<sup>158</sup> If a plan sponsor chooses to offer an HSA-compatible individual coverage HRA that reimburses medical care expenses after the minimum deductible under Code section 223(c)(2)(A)(i) is satisfied, it is the employer's responsibility to track medical care expenses incurred during the year and ensure that the individual coverage HRA does not reimburse medical care expenses (other

than premiums or expenses allowed as limited purpose) incurred prior to the satisfaction of the minimum deductible.<sup>159</sup>

The commenter further requested clarification as to whether unused amounts in an individual coverage HRA at the end of the plan year may be transferred to the employee's HSA. The Treasury Department and the IRS note that amounts available under an HRA, whether an individual coverage HRA or another type of HRA, may not be funded by salary reduction amounts. Moreover, the amounts are available only to reimburse Code section 213(d) medical care expenses and may not be cashed out.<sup>160</sup> However, amounts in an HSA may be withdrawn for non-medical purposes, subject to inclusion in income and an additional tax.<sup>161</sup> In addition, Congress previously provided for one-time distributions from HRAs to HSAs, in certain circumstances, subject to the annual HSA contribution limits, but this special rule was only made available on a temporary basis, and the rule sunset at the end of 2011.<sup>162</sup> Therefore, allowing unused amounts in an individual coverage HRA to be transferred to an HSA would be inconsistent with the relevant provisions of the Code and is not permitted.

Finally, some commenters requested that direct primary care arrangements not be treated as a health plan or coverage under Code section 223, so that an individual may have a direct primary care arrangement without becoming ineligible for HSA contributions. Similar to the discussion of Code section 213 in the preceding section of this preamble, neither the proposed rules nor the final rules make any changes to the rules under Code section 223. Thus, any issues arising under Code section 223, and any guidance requested by commenters to address those issues, are beyond the scope of this rulemaking.

<sup>159</sup> Another commenter inquired about the interaction of individual coverage HRAs and HSAs and the rules for cafeteria plans under Code section 125. These issues are outside the scope of this rulemaking, and the Treasury Department and the IRS are continuing to consider whether future guidance is needed.

<sup>160</sup> See IRS Notice 2002-45.

<sup>161</sup> See Code section 223(f). Notwithstanding that HSA amounts may be withdrawn for non-medical purposes, subject to inclusion in income and additional tax, Code section 106(d) provides that in the case of amounts contributed by an employer to the HSA of an eligible individual, those amounts are treated as employer-provided coverage for medical care expenses under an accident or health plan to the extent the amounts do not exceed the annual limits on contributions to an HSA.

<sup>162</sup> See Code section 106(e).

<sup>154</sup> Revenue Ruling 2004-45, 2004-1 IRB 971.

<sup>155</sup> See Revenue Ruling 2004-45, which defines a limited-purpose HRA as an HRA that pays or reimburses benefits for "permitted insurance" (for a specific disease or illness or that provides a fixed amount per day (or other period) of hospitalization) or "permitted coverage" (for example, vision or dental coverage), but not for long-term care services. In addition, the limited-purpose HRA may pay or reimburse preventive care benefits. The ruling also defines a post-deductible HRA as an HRA that does not pay or reimburse any medical expense incurred before the minimum annual deductible under Code section 223(c)(2)(A)(i) is satisfied.

<sup>156</sup> IRS Notice 2008-59, 2008-29 IRB 123.

<sup>157</sup> The Departments note that under the opt out requirement, described later in this preamble, each participant must be given the chance to opt out of (or into) an individual coverage HRA once, and only once, with respect to a plan year and to the extent a participant is offered a choice between an HSA-compatible HRA and a non-HSA-compatible HRA, the participant will opt into either one or the other, for the plan year (or for the portion of the plan year during which the participant is covered by the HRA). (Note that participants are also generally given the chance to waive the HRA upon termination of employment).

<sup>158</sup> See Revenue Ruling 2004-45.

#### 14. Interaction of Individual Coverage HRAs and Medicare

Commenters raised various issues related to the interaction between individual coverage HRAs and Medicare. The comments focused on the interaction with the Medicare anti-duplication provision under SSA section 1882(d)(3)(A)(i)(I) and the MSP provisions under SSA section 1862(b). In response to these comments, the final rules have been revised to provide that an individual coverage HRA may be integrated with either individual health insurance coverage or Medicare Part A and B or Part C. Also, the Departments clarify that an individual coverage HRA may be used to reimburse premiums for Medicare and Medicare supplemental health insurance (Medigap), as well as other medical care expenses, as discussed in more detail in this section of the preamble.

##### a. Background

Comments regarding the interaction between individual coverage HRAs and Medicare addressed a number of federal laws and rules governing the relationship between group health plans and the Medicare program. This section of the preamble briefly summarizes these laws to provide context for comments received on the proposed rules and the provisions of the final rules related to integration of an individual coverage HRA with Medicare.

Under SSA section 1882(d)(3)(A)(i)(I), it is unlawful for any person to issue or sell to an individual entitled to benefits under Medicare Part A or enrolled in Medicare Part B (including an individual electing a Medicare Part C plan) an individual health insurance policy with the knowledge that the policy duplicates<sup>163</sup> health benefits to which the individual is otherwise entitled under Medicare or Medicaid.<sup>164</sup> Persons who violate SSA section 1882(d)(3)(A)(i)(I) are subject to criminal fines and imprisonment, as well as civil monetary penalties.<sup>165</sup>

The MSP provisions in SSA section 1862(b) make Medicare the secondary payer to certain other health plans and

coverage, including group health plans. These provisions protect the Medicare trust funds by ensuring that Medicare does not pay for items and services that certain health insurance or coverage is primarily responsible for paying. In general, the MSP provisions describe when Medicare is secondary in relation to other health plans or coverage and prohibit Medicare from making payment for an item or service if payment has been made, or can reasonably be expected to be made, by a primary plan when certain conditions are satisfied.<sup>166</sup>

SSA section 1862(b) and 42 CFR 411.20 *et seq.* provide, in part, that Medicare is the secondary payer, under specified conditions, for services covered under any of the following:

- Group health plans of employers that employ at least 20 employees and that cover Medicare beneficiaries age 65 or older who are covered under the plan by virtue of the individual's current employment status<sup>167</sup> with an employer or the current employment status of a spouse of any age.<sup>168</sup>

- Group health plans (without regard to the number of individuals employed and irrespective of current employment status) that cover individuals who have ESRD. Except as provided in 42 CFR 411.163, group health plans are always primary payers throughout the first 30 months of ESRD-based Medicare eligibility or entitlement.<sup>169</sup>

- Large group health plans, as defined by Code section 5000(b)(2) without regard to Code section 5000(d) (that is, plans of employers that employ at least 100 employees), that cover Medicare beneficiaries who are under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of the individual's or a family member's current employment status with an employer.<sup>170</sup>

Generally, under SSA section 1862(b)(1)(A), (B), and (C), a group health plan may not take into account that individuals are entitled to Medicare on the basis of age or disability, or that individuals are eligible for or entitled to Medicare on the basis of ESRD, in the design or offering of the plan. The provisions at SSA section 1862(b)(1)(A), (B), and (C) (including subsections

(b)(1)(A)(i)(II) and (b)(1)(C)(ii)) are collectively referred to as the Medicare nondiscrimination provisions. Examples of actions that constitute taking into account Medicare entitlement are listed in 42 CFR 411.108.

SSA section 1862(b)(1)(A)(i)(II) and (ii) provides that group health plans of employers of 20 or more employees must provide to any employee or spouse age 65 or older the same benefits, under the same conditions, that the plan provides to those individuals under age 65 (equal benefit rule). For example, a group health plan of an employer with 20 or more employees may not provide lesser benefits to individuals age 65 or over, or charge higher premiums for individuals age 65 or over, because these actions would take into account employees' entitlement to Medicare on the basis of age and would provide different benefits based on whether an employee is under or over age 65. This requirement applies regardless of whether the individual or spouse age 65 or older is entitled to Medicare.

SSA section 1862(b)(1)(C)(ii) provides that group health plans may not differentiate in the benefits they provide between individuals who have ESRD and other individuals covered under the plan on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner. Actions that constitute "differentiating" are listed in 42 CFR 411.161(b).

SSA section 1862(b)(3)(C) and 42 CFR 411.103 provide that it is unlawful for an employer or other entity (for example, an issuer) to offer any financial or other benefits as incentives for an individual entitled to Medicare not to enroll in, or to terminate enrollment in, a group health plan that is, or would be, primary to Medicare. For example, employers may not offer benefits to Medicare beneficiaries that are available only as alternatives to the employer's primary group health plan (for example, prescription drug benefits) unless the beneficiary has primary coverage other than Medicare (for example, primary plan coverage through his or her spouse's employer).

##### b. Integration of Individual Coverage HRAs With Medicare

Several commenters requested clarification generally about how employees who are enrolled in Medicare may use amounts in an individual coverage HRA. Some commenters explained that because of the Medicare anti-duplication provision applicable to individual health insurance coverage, employees who are Medicare beneficiaries may not be able to purchase individual health insurance

<sup>163</sup> If benefits under an individual health insurance policy are payable without regard to other health benefit coverage of such individual, the policy is not considered to "duplicate" any health benefits to which the individual is otherwise entitled under Medicare or Medicaid, and therefore, the statutory prohibition on the sale of such coverage does not apply. See SSA section 1882(d)(3)(A)(iv).

<sup>164</sup> Group health plans, including HRAs, are generally exempt from this Medicare anti-duplication provision. See SSA section 1882(d)(3)(C).

<sup>165</sup> SSA section 1882(d)(3)(A)(ii).

<sup>166</sup> See CMS Publication #100-05, Medicare Secondary Payer Manual, available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/internet-Only-Manuals-IOMs-Items/CMS019017.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending>.

<sup>167</sup> An individual has current employment status if the individual is actively working as an employee or is otherwise described in 42 CFR 411.104.

<sup>168</sup> SSA section 1862(b)(1)(A), 42 CFR 411.20(a)(1)(ii), and 42 CFR 411.100(a)(1)(i).

<sup>169</sup> SSA section 1862(b)(1)(C).

<sup>170</sup> SSA section 1862(b)(1)(B).

coverage and, therefore, would be unable to enroll in an individual coverage HRA. One commenter suggested that issuers should have to make their individual health insurance policies available to employees eligible for or enrolled in Medicare, if they are offered an individual coverage HRA.

Some commenters sought clarification about the relationship between the Medicare anti-duplication provision and the Medicare nondiscrimination provisions as they relate to individual coverage HRAs. Specifically, some commenters asked HHS to clarify that the inability of employees who are Medicare beneficiaries to obtain individual health insurance coverage due to the Medicare anti-duplication provision will not cause the individual coverage HRA or its plan sponsor to violate rules prohibiting discrimination based on Medicare status, age, disability, or other factors. One commenter suggested that employers that otherwise comply with the proposed rules should not be precluded from offering an individual coverage HRA because a class of employees includes a Medicare beneficiary who cannot obtain individual health insurance coverage. Another commenter asked whether employers would be required to offer Medicare-eligible employees the same HRA contribution as non-Medicare-eligible employees in the same class even though Medicare beneficiaries may not be able to purchase individual health insurance coverage.

In response to these comments, HHS notes that there is no exception to the Medicare anti-duplication provision under SSA section 1882(d)(3)(A)(i)(I) for individual health insurance coverage purchased with an HRA. Therefore, neither the proposed rules nor the final rules make any changes related to the application of the Medicare anti-duplication provision. Thus, the statutory prohibition against selling an individual health insurance policy to a Medicare beneficiary with knowledge that the policy duplicates benefits under Medicare continues to apply, regardless of whether the individual is offered an individual coverage HRA. However, the Departments have considered commenters' concerns about individual coverage HRAs and the potential effects of the Medicare anti-duplication provision, as well as those related to the interaction of the MSP provisions, and have determined that revisions to the final rules are warranted.

HHS recognizes that, for an individual coverage HRA, it is necessary to address how the Medicare anti-duplication provision interacts with the rules under

SSA section 1862(b)(1) that generally provide that group health plans may not take into account entitlement to Medicare and must provide to any employee or spouse age 65 or older the same benefits, under the same conditions, that the group health plan provides to individuals under age 65. If an employer offers an individual coverage HRA, some employees who are Medicare beneficiaries may not be able to obtain individual health insurance coverage due to the anti-duplication provision at SSA section 1882(d)(3)(A)(i)(I). This might cause such employees to be unable to enroll in the individual coverage HRA, effectively treating them differently in violation of the SSA's equal benefit rule.

To address these comments, the final rules permit an individual coverage HRA to be integrated with either individual health insurance coverage or Medicare for a participant or dependent who is enrolled in Medicare Part A and B or Part C (and the HRA will be deemed to comply with PHS Act sections 2711 and 2713), if certain conditions are satisfied. Under the final rules, an individual coverage HRA may be integrated with Medicare regardless of whether the HRA is subject to the MSP provisions, because the Medicare anti-duplication provision applies without regard to whether the HRA plan sponsor is subject to the MSP provisions.<sup>171</sup>

The Departments are adopting this approach due to the challenges presented by the intersection of the requirements that apply to individual coverage HRAs, the MSP requirements applicable to group health plans, and the Medicare anti-duplication provision applicable to individual health insurance coverage. The Departments have determined that it is appropriate to permit an individual coverage HRA to integrate with Medicare coverage, and therefore, be considered compliant with PHS Act sections 2711 and 2713, because individuals enrolled in Medicare Part A and B or Part C have the comprehensive benefit packages established by Congress, generally with no annual dollar limits and with coverage of preventive services without cost sharing.<sup>172</sup> An individual coverage HRA that helps pay premiums for, or

supplements, the Medicare benefit package established by Congress will not be considered by the Departments to fail to satisfy PHS Act sections 2711 and 2713. Further, the Departments determined in the 2015 rules under PHS Act 2711 that allowing Medicare Part B and D reimbursement arrangements to be integrated with Medicare was sufficient to constitute compliance with PHS Act sections 2711 and 2713 in the circumstances described in that guidance, as discussed earlier in this preamble.

The final integration rules generally apply in the same manner to Medicare coverage as they apply to individual health insurance coverage. Thus, under the final rules, an individual coverage HRA must require individuals whose medical care expenses may be reimbursed under the HRA to be enrolled in either individual health insurance coverage or Medicare Part A and B or Part C for each month such individuals are covered by the HRA. The individual coverage HRA also must implement, and comply with, reasonable procedures to substantiate enrollment in either individual health insurance coverage or Medicare Part A and B or Part C for the HRA plan year (or for the portion of the plan year the individual is covered by the individual coverage HRA) and with each new request for reimbursement of an incurred medical care expense. The Departments clarify that the final rules do not require that a participant and his or her dependents all have the same type of coverage (that is, either individual health insurance coverage or Medicare). Therefore, an individual coverage HRA may be integrated with Medicare for some individuals in a family or household and with individual health insurance coverage for others in the same family or household.

In addition, under the final rules, an individual coverage HRA must be offered on the same terms to all employees within a class of employees, regardless of Medicare eligibility or entitlement, including that the individual coverage HRA must make the same amount available to all employees in the class, subject to the exceptions provided in the final rules under the same terms requirement.<sup>173</sup> Moreover,

<sup>171</sup> For group health plans not subject to the MSP provisions, the existing integration rules permit integration with Medicare Part B and D if certain conditions are satisfied, including that the employer offer traditional group health plan coverage to its non-Medicare employees. See 26 CFR 54.9815–2711(d)(5), 29 CFR 2590.715–2711(d)(5), and 45 CFR 147.126(d)(5).

<sup>172</sup> See, e.g., SSA sections 1861 and 1833, as added by PPACA sections 4103 and 4104.

<sup>173</sup> The Departments note that although there is an exception to the same terms requirement that allows a plan sponsor to offer both an HSA-compatible individual coverage HRA and an individual coverage HRA that is not HSA compatible, Code section 223(b)(7) provides that an individual ceases to be an eligible individual for HSA purposes starting with the month he or she is entitled to benefits under Medicare. IRS Notice 2004–50, 2004–33 IRB 196, Q&A–2, clarifies that

no employee may be offered a choice between an individual coverage HRA and a traditional group health plan, including an employee enrolled in or eligible for Medicare. The individual coverage HRA must also allow participants, whether or not covered by Medicare, to opt-out of and waive future reimbursements from the individual coverage HRA annually and upon termination of employment. Finally, the individual coverage HRA must provide the notice required by the final rules to all individuals eligible for the HRA, including those for whom the HRA would be integrated with Medicare. Relatedly, in the final rules, the Departments clarify the notice content requirements to reflect that an individual coverage HRA may be integrated with Medicare and to include a statement regarding PTC eligibility for Medicare beneficiaries.<sup>174</sup> The final rules also clarify that some of the notice content elements relate only to individual health insurance coverage and not to Medicare.

#### c. Reimbursement of Expenses Under Individual Coverage HRAs for Medicare Beneficiaries

One commenter requested clarification that offering an individual coverage HRA to Medicare-eligible employees will not be considered an improper financial incentive for those individuals to select Medicare as their primary payer. The commenter also suggested that employees be able to use amounts in an individual coverage HRA to pay for medical care expenses not covered by Medicare, such as dental, vision, and other out-of-pocket expenses, including Medicare Part D premiums, as well as premiums for Medigap, without it being viewed as offering an improper incentive.

For group health plans subject to the MSP provisions, offering an HRA to reimburse Medicare premiums is impermissible if it provides a financial incentive for Medicare beneficiaries to decline enrollment in the employer's group health plan and make Medicare the primary payer. Under the final rules, the employer would not be offering Medicare beneficiaries a financial incentive as an inducement to decline

mere eligibility for Medicare does not make an individual ineligible to contribute to an HSA. Rather, the term "entitled to benefits under Medicare," for purposes of an HSA, means both eligibility for, and enrollment in, Medicare.

<sup>174</sup> Although individuals enrolled in Medicare may not be able to purchase individual health insurance coverage for themselves through the Exchange, individuals who do so are not eligible for the PTC for their Exchange coverage in any event. See Code section 36B(c)(2)(B) and 26 CFR 1.36B-2(a)(2).

group health plan coverage. Rather, the individual coverage HRA would be the group health plan coverage offered to a class of employees that includes Medicare beneficiaries. Under these circumstances, unless the employer could offer an individual coverage HRA that may be integrated with Medicare, the employer would risk running afoul of the equal benefit rule under SSA section 1862(b)(1)(A)(i). This is because employees who are Medicare beneficiaries who are unable to purchase individual health insurance coverage would be ineligible for the employer's group health plan (that is, the individual coverage HRA) as a result of the Medicare anti-duplication provision.

HHS recognizes that in other circumstances, offering an HRA to reimburse Medicare premiums might be viewed as impermissible because it would have the effect of making Medicare the primary payer in relation to a group health plan.<sup>175</sup> Nevertheless, for purposes of the final rules, HHS has concluded that employers need the flexibility to offer individual coverage HRAs that may be integrated with Medicare, and that may provide for reimbursement of Medicare premiums. This flexibility does not violate the prohibition against financial incentives under SSA section 1862(b)(3)(C). Where a group health plan is an individual coverage HRA that can be used to pay Medicare premiums or other medical care expenses,<sup>176</sup> there is no incentive for a Medicare beneficiary to decline or terminate enrollment under the group health plan (that is, the individual coverage HRA). Thus, there is no violation of the SSA's financial incentive prohibition.

Therefore, under the final rules, an individual coverage HRA that is integrated with Medicare may reimburse premiums for Medicare Part A, B, C, or D, as well as premiums for Medigap policies. The individual coverage HRA

<sup>175</sup> Under IRS Notice 2015-17, an arrangement under which an employer reimburses (or pays directly) Medicare Part B or D premiums may be considered integrated with the group health plan coverage offered to the employee by the employer although the employee is not enrolled in that group coverage and is instead enrolled in Medicare, subject to certain conditions. IRS Notice 2015-17 also states that to the extent such an arrangement is available to active employees, it may be subject to restrictions under other laws, such as the Medicare secondary payer provisions. For clarity, the Departments confirm that reimbursement of Medicare Part B and D premiums under IRS Notice 2015-17 is permitted only for such arrangements not subject to the MSP provisions.

<sup>176</sup> However, as discussed later in this section of the preamble, an individual coverage HRA may not, under its terms, limit reimbursement only to expenses not covered by Medicare.

may also reimburse other medical care expenses as defined under Code section 213(d) (subject to the exception discussed later in this section of the preamble regarding taking Medicare entitlement into account). Thus, an individual coverage HRA will not be considered to provide unequal benefits to participants who are eligible for Medicare because those participants will be able to receive the same benefits under the HRA regardless of whether they are able to purchase individual health insurance coverage.<sup>177</sup> However, as explained earlier in this preamble, the plan sponsor generally has discretion to specify which medical care expenses (premiums, cost sharing, or otherwise) are eligible for reimbursement under the terms of an individual coverage HRA, as long as the HRA offers the same benefits, on the same terms and conditions, to a class of employees, subject to the exceptions under the same terms requirement in the final rules. In addition, as discussed earlier in this preamble, the designation of the reimbursable expenses must not violate other rules applicable to group health plans, such as the HIPAA nondiscrimination rules or the MSP provisions.

To ensure that an individual coverage HRA that is subject to the MSP provisions does not violate those rules, an individual coverage HRA may not, under its terms, limit reimbursement only to expenses not covered by Medicare, as HHS has determined this could amount to a group health plan taking into account entitlement to Medicare in violation of the MSP provisions. However, an individual coverage HRA may limit reimbursement to only premiums or non-premium medical care expenses (such as cost sharing), or may decide which particular medical care expenses will be reimbursable and which will not be reimbursable under the terms of the HRA.

#### d. Other Medicare Issues

Some commenters sought assurance that a health insurance issuer providing individual health insurance coverage purchased with an individual coverage HRA would not be required to comply with MSP reporting requirements or pay for benefits primary to Medicare where MSP provisions might apply to the

<sup>177</sup> The fact that a participant or dependent in a class of employees may not be able to enroll in individual health insurance coverage or Medicare due to the operation of federal law does not mean the individual coverage HRA that is offered to that class of employees violates the same terms requirement under the final rules or the equal benefit rule under the SSA.

individual's HRA. These commenters recommended clarifying that an HRA plan sponsor's failure to satisfy the conditions of the ERISA safe harbor described later in this preamble will have no effect on the MSP status of the individual health insurance coverage.

HHS notes that individual health insurance coverage is not subject to the MSP provisions, including the reporting, nondiscrimination, and "primary plan" requirements described earlier in this section of the preamble.<sup>178</sup> Nothing in the final rules changes the application of the MSP provisions. This is true even where individual health insurance coverage is integrated with an HRA as allowed under the final rules.<sup>179</sup> However, an individual coverage HRA will generally pay primary to Medicare, consistent with the MSP provisions applicable to group health plans. HHS intends to issue further guidance clarifying the primary versus secondary payer responsibility of individual coverage HRAs for plan sponsors subject to the MSP provisions.

One commenter requested guidance about the MSP reporting requirements that apply to individual coverage HRAs. Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), Public Law 110-173, established mandatory reporting requirements with respect to Medicare beneficiaries who have coverage under group health plan arrangements, as well as for Medicare beneficiaries who receive settlements, judgments, awards, or other payment from liability insurance (including self-insurance), no-fault insurance, or workers' compensation.<sup>180</sup> The purpose of this reporting is to ensure that Medicare correctly pays for covered services provided to Medicare beneficiaries consistent with Medicare payment rules. HRAs (including individual coverage HRAs) are group health plans and, therefore, generally trigger the MMSEA section 111 reporting requirements.<sup>181</sup> HHS will provide

future guidance regarding MMSEA section 111 reporting requirements and individual coverage HRAs. HHS notes that entities that currently do not offer a group health plan and therefore do not have reporting obligations may be required to report if they elect to offer individual coverage HRAs, similar to if they elected to offer other group health plan coverage.

#### 15. Other Integration Issues

Some comments were received regarding dollar limits on individual coverage HRAs. One commenter supported that the proposed rules did not impose any specific dollar limit on the amount that an employer may contribute to an individual coverage HRA. The commenter noted that this is a welcome difference from QSEHRAs, to which a statutory dollar limit applies, and stated that this flexibility will help encourage employers to offer individual coverage HRAs. One commenter requested that the Departments place a limit on contributions to an individual coverage HRA to prevent adverse selection. A few commenters asked that the Departments require employers to make certain minimum amounts available under an individual coverage HRA to approximate the amount the employer generally would contribute to a traditional group health plan as a way to maintain availability and generosity of coverage.

In previous guidance on HRAs, including on integration of HRAs with other coverage, the Departments provided no minimum or maximum contribution amount. Similarly, the Departments decline to impose a minimum or maximum contribution amount on individual coverage HRAs under the final rules, in order to provide employers with flexibility and because the Departments have imposed other conditions to address the potential for adverse selection. However, the Treasury Department and the IRS note that employers subject to the employer shared responsibility provisions under Code section 4980H may want to make sufficient amounts available to employees in order to avoid a potential employer shared responsibility payment. The Treasury Department and the IRS intend to propose separate rules regarding the interaction of individual coverage HRAs and Code section 4980H that will be available for public comment.

Some commenters addressed which employers should be permitted to offer an individual coverage HRA. One commenter applauded the proposed rules for allowing employers of all sizes to offer an individual coverage HRA.

One commenter requested that the Departments only permit individual coverage HRAs to be offered by small employers, because, the commenter asserted, small employers have less incentive to segment risk and are less likely to create classes of employees leading to adverse selection. One commenter asked that the Departments only permit large employers to offer an individual coverage HRA, asserting that small employers would be able to manipulate the rules to create small classes and segment risk. Another commenter requested that only employers that do not currently offer coverage be allowed to offer an individual coverage HRA.

The Departments considered these suggestions and determined that limiting the ability of one or more categories of employers to offer an individual coverage HRA in these ways would unnecessarily restrict the rules and could decrease the usability of individual coverage HRAs and harm employee welfare without a compelling reason for these limitations. Therefore, under the final rules, any employer may offer an individual coverage HRA, subject to compliance with the conditions in the final rules. However, the Departments note that the final rules include a minimum class size requirement which applies in certain instances, to address the issue identified regarding the ability to create small classes and segment risk.

One commenter urged HHS to allow for wellness program demonstration projects in the individual market under PHS Act section 2705(l) because the commenter asserted wellness programs are a popular aspect of traditional employer coverage. Because this comment is outside the scope of this rulemaking, it is not addressed in the final rules. However, HHS appreciates the comment and may consider addressing this issue in future guidance.

Several commenters emphasized the importance of strong enforcement of the conditions in the final rules and requested that the Departments issue guidance detailing how the Departments would enforce the final rules. DOL has enforcement jurisdiction over private sector employer-sponsored group health plans, and HHS has enforcement jurisdiction over public sector group health plans, such as those sponsored by state and local governments. Individual coverage HRAs are group health plans, and DOL and HHS will monitor individual coverage HRAs' compliance with applicable requirements, consistent with the general approach to enforcement with respect to other group health plans. The

<sup>178</sup> See SSA section 1862(b)(1) and (2) (MSP rules apply only to certain group health plans).

<sup>179</sup> The term "group health plan" for purposes of the MSP provisions is not defined by reference to ERISA; therefore, this section of the preamble does not address the application of the ERISA safe harbor described later in this preamble.

<sup>180</sup> See also SSA section 1862(b)(7) and (8).

<sup>181</sup> For information about mandatory MMSEA section 111 reporting for group health plans, see <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Overview.html> and <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/GHP-Training-Material/Downloads/Health-Reimbursement-Arrangement-HRA.pdf>.

Departments believe that it is unnecessary to include specific enforcement guidance for individual coverage HRAs in the final rules. The Departments may provide additional guidance if the Departments become aware of arrangements that are inconsistent with the final rules.

One commenter requested that employers be permitted to pay issuers directly for individual health insurance coverage in which individual coverage HRA participants are enrolled. The Departments note that existing guidance for health plans generally allows employers to pay health insurance premiums to issuers directly,<sup>182</sup> so this is already permitted. Also, see the discussion later in this preamble regarding a safe harbor for determining whether an individual health insurance policy purchased with funds from an individual coverage HRA will be treated as part of an ERISA-covered employee welfare benefit plan.

One commenter requested that the Departments clarify that a plan sponsor may make amounts in an individual coverage HRA available either monthly or annually at the beginning of the plan year. The Departments clarify that the final rules do not change existing rules for HRAs, which do not require the entire annual amount to be available at the beginning of the year and would allow the HRA to only make amounts available pro rata over the 12 months of the year.<sup>183</sup> However, the Departments note that the amounts made available under an individual coverage HRA, including when they will be made available, must be described in the notice that is required under the final rules.<sup>184</sup> The Departments also note that within a class of employees, the terms and conditions of an individual coverage HRA generally must be the same, including the timing of how amounts are made available.

One commenter requested that the Departments interpret “employer” to include non-employer plan sponsors such as boards of trustees for multiemployer plans. The final rules allow plan sponsors to offer an individual coverage HRA, and plan sponsors include, but are not limited to, employers and could include a board of trustees for a multiemployer plan.

Various commenters requested additional reporting requirements or other types of mandatory data collection regarding individual coverage HRAs. The Departments have not identified a compelling need for this information that would justify the significant additional burden this would place on each employer offering this type of coverage. Accordingly, the final rules do not adopt these suggestions. However, to the extent an individual coverage HRA is otherwise subject to reporting requirements under other rules, including PPACA, the Code, the SSA, or ERISA, the final rules do not affect the application of those reporting requirements.<sup>185</sup>

One commenter requested additional time to comment on the proposal. The Administrative Procedure Act grants Executive Agencies discretion to set the timeframe during which public comments will be received and considered. Interested stakeholders were given 60 days from the publication of the proposed rules to submit comments for consideration. Many comments were received and considered by the Departments. This solicitation for public comments allowed the Departments to gather sufficient information from interested stakeholders. The Departments, therefore, declined to extend the timeframe to comment on the proposed rules.

One commenter requested that the final rules consider enrollment in an individual coverage HRA as other group coverage for purposes of determining whether employers satisfy minimum participation thresholds for guaranteed availability. In the large group market, issuers may not apply minimum participation rules to deny guaranteed availability of coverage. In the small group market, issuers may apply minimum participation rules, as allowed under applicable state law. However, failure to satisfy an issuer’s minimum participation rules may not be used to deny guaranteed availability of coverage between November 15 and December 15 of each year. The Departments clarify that in both the large and small group markets, issuers may apply minimum participation rules, pursuant to applicable state law, as an exception to guaranteed renewability of coverage requirements.<sup>186</sup> State law may determine which individuals to include in the minimum participation

calculation, including whether issuers are allowed to include individuals who have other coverage within the total number of eligible individuals and which types of coverage may be counted as other coverage.<sup>187</sup> Neither the proposed rules nor the final rules make changes to these existing, separate requirements.

One commenter requested that the Departments provide information about how an employer would transition from offering a QSEHRA to offering an individual coverage HRA. The Departments note that IRS Notice 2017–67 provides guidance on the requirements for providing a QSEHRA. The guidance in Notice 2017–67 remains unaffected by the final rules. Additional QSEHRA guidance generally is outside of the scope of these final rules, and to the extent an employer wants to transition from offering a QSEHRA to offering an individual coverage HRA, the individual coverage HRA must comply with the requirements set forth in the final rules.

One commenter asked the Departments to clarify that individual coverage HRA participants may contribute to a health FSA even if their employer does not offer traditional group health plan coverage. The Departments note that employers generally may provide excepted benefits (other than an excepted benefit HRA<sup>188</sup>) to employees in a class offered an individual coverage HRA. In addition, the Departments clarify that the individual coverage HRA would qualify as “other group health plan coverage not limited to excepted benefits” under the requirements for the health FSA to qualify as an excepted benefit.<sup>189</sup> Thus, nothing in the final rules prohibits employees in a class of employees offered an individual coverage HRA from participating in a health FSA through salary reduction in a cafeteria plan.

Other comments not responsive to the provisions and topics addressed by the proposed rules, or otherwise beyond the

<sup>187</sup> See Health Care Financing Administration Insurance Standards Bulletin 00–05, Guaranteed Availability Under Title XXVII of the Public Health Service Act—Applicability of Group Participation Rules (Nov. 2000), available at [https://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa\\_00\\_05\\_508.pdf](https://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa_00_05_508.pdf). However, for purposes of participation in a Federally-facilitated Small Business Health Options Program (FF-SHOP), see the methodology for calculating a minimum participation rate specified in 45 CFR 155.706(b)(10)(i).

<sup>188</sup> See later in this preamble for a discussion of the interaction of individual coverage HRAs and excepted benefit HRAs.

<sup>189</sup> 26 CFR 54.9831–1(c)(3)(v)(A), 29 CFR 2590.732(c)(3)(v)(A), and 45 CFR 146.145(b)(3)(v)(A).

<sup>182</sup> See Revenue Ruling 61–146, 1961–2 CB 25.

<sup>183</sup> See IRS Notice 2002–45.

<sup>184</sup> Also see the discussion later in the preamble regarding the final PTC rules, under which amounts newly made available for an HRA plan year must be determinable within a reasonable time before the beginning of the plan year in order to be considered in determining affordability of the offer of the individual coverage HRA.

<sup>185</sup> See e.g., ERISA sections 101, 103, and 104 and PHS Act section 2715 (incorporated in Code section 9815 and ERISA section 715).

<sup>186</sup> See 78 FR 13406, 13416 (Feb. 27, 2013).

scope of the proposed and final rules, are not summarized or addressed.

#### 16. Revisions to Current PHS Act Section 2711 Rules Regarding Integration With Other Group Health Plan Coverage and Medicare

The 2015 rules under PHS Act section 2711 provide methods for integrating HRAs with coverage under another group health plan, and, in certain circumstances, with Medicare Part B and D. The proposed rules did not include a proposal to substantively change the current group health plan or Medicare integration tests under the existing PHS Act section 2711 rules. However, the proposed rules included minor proposed revisions to those rules, including changing the term “account-based plan” to “account-based group health plan” and moving defined terms to a definitions section. The proposed rules also proposed to amend the rules under PHS Act section 2711 to reflect that HRAs may be integrated with individual health insurance coverage subject to the requirements of 26 CFR 54.9802–4, 29 CFR 2590.702–2, and 45 CFR 146.123. The final rules adopt these changes as proposed, except that the final rules have been updated to reflect that individual coverage HRAs may be integrated with Medicare, for purposes of compliance with PHS Act sections 2711 and 2713, if certain conditions are satisfied.<sup>190</sup>

In addition, the proposed rules included a proposal to update the definition of EHBs set forth in paragraph (c) of the rules under PHS Act section 2711, which applies for a group health plan or health insurance issuer not required to cover EHBs. The update in the proposed rules reflected the revision to the EHB-benchmark plan selection process that was promulgated in the HHS Notice of Benefit and Payment Parameters for 2019 Final Rule (2019 Payment Notice) and that applies for plan years beginning on or after January 1, 2020.<sup>191</sup> The 2019 Payment Notice revisions provide states with additional choices with respect to the selection of benefits and promote affordable coverage through offering states additional flexibility in their selection of an EHB-benchmark plan for plan years beginning on or after January 1, 2020. The state’s existing EHB-

benchmark plan will continue to apply for any year for which a state does not select a new EHB-benchmark plan from the available EHB-benchmark plan selection options finalized in the 2019 Payment Notice.<sup>192</sup> The Departments are finalizing as proposed the update to the definition of EHB under the PHS Act section 2711 rules.

One commenter expressed concern with the change made by HHS to the definition of EHB in the 2019 Payment Notice and requested that the Departments decline to update the rules under PHS Act section 2711 to reflect the revised EHB definition. The Departments clarify that PHS Act section 2711 defines EHB by reference to PPACA section 1302(b), under which HHS has the authority to define EHB. The update to the definition of EHB in the PHS Act section 2711 rules is a technical update made to avoid applying an out-of-date definition and is the result of the change HHS finalized in the 2019 Payment Notice. Issues regarding EHBs more generally, as well as the specific changes made in the 2019 Payment Notice, are outside of the scope of this rulemaking.

#### B. Excepted Benefit HRAs

##### 1. In General

As the Departments noted in the preamble to the proposed rules, there may be scenarios in which an employer wants to offer an HRA that might not be integrated with individual health insurance coverage, non-HRA group coverage, Medicare, or TRICARE. For example, some employers may want to offer an HRA without regard to whether their employees have other coverage at all, or without regard to whether their employees have coverage that is subject to and satisfies the market requirements. Therefore, the proposed rules utilized the Departments’ discretion under Code section 9832(c)(2)(C), ERISA section 733(c)(2)(C), and PHS Act section 2791(c)(2)(C), and included an amendment to the prior rules that would recognize certain limited HRAs as excepted benefits (excepted benefit HRAs), if specific conditions were satisfied.<sup>193</sup>

As explained earlier in this preamble, the Departments have the authority and discretion to specify in rules additional limited excepted benefits that are similar to the limited benefits specified

in the statutes and that either are insured under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a plan. The proposed rules included a proposal for an excepted benefit HRA that is consistent with both this statutory framework and the Departments’ objective of expanding the availability and usability of HRAs to maximize employee welfare. Specifically, the proposed rules provided that, to be recognized as an excepted benefit, the HRA: (1) Must not be an integral part of the plan, (2) must provide benefits that are limited in amount, (3) cannot provide reimbursement for premiums for certain health insurance coverage, and (4) must be made available under the same terms to all similarly situated individuals.

A number of commenters generally expressed support for the proposed excepted benefit HRA rule as a way to expand the availability and use of HRAs. Some of the commenters who supported the proposed excepted benefit HRA rule opposed allowing the purchase of STLDI. Also, a number of commenters opposed the proposed excepted benefit HRA rule, expressing concerns that the excepted benefit HRA could incentivize individuals to obtain STLDI, cause adverse selection in the small group and individual market risk pools, and increase complexity and the potential for confusion.

The Departments considered these comments and agree that the excepted benefit HRA is a way to expand the availability and use of HRAs, thereby providing increased options for healthcare coverage to employers and employees. Therefore, the final rules recognize certain HRAs as limited excepted benefits, with some changes from the proposed rule, which are intended to address concerns raised by commenters regarding the potential for adverse selection and confusion.

A few commenters questioned the Departments’ legal authority for establishing the excepted benefit HRA, with one requesting that the proposed excepted benefit HRA rules be withdrawn. These commenters stated that the excepted benefit HRA is not similar to the other limited excepted benefits because it does not provide insurance that is limited in scope for a particular medical condition. The Departments disagree. As stated earlier in this section of the preamble, Code section 9832(c)(2)(C), ERISA section 733(c)(2)(C), and PHS Act section 2791(c)(2)(C) authorize the Secretaries of the Treasury, Labor, and HHS to issue rules establishing other, similar limited benefits as excepted benefits. Similar to

<sup>190</sup> The Departments further note that, unless the final rules conflict with the subregulatory guidance that has been issued under PHS Act section 2711, that guidance remains in effect.

<sup>191</sup> See 83 FR 16930 (April 17, 2018). The definition of EHB that applies under the PHS Act section 2711 rules for plan years beginning before January 1, 2020 is not substantively changed by the final rules.

<sup>192</sup> For more information on the revised EHB standard, refer to the preamble to the 2019 Payment Notice (83 FR 16930, 17007 (April 17, 2018)).

<sup>193</sup> The proposed rules, and the final rules, do not apply to health FSAs. For a health FSA to qualify as an excepted benefit, the rules at 26 CFR 54.9831–1(c)(3)(v), 29 CFR 2590.732(c)(3)(v), and 45 CFR 146.145(b)(3)(v) continue to apply.

the exercise of authority with respect to certain health FSAs, limited wraparound coverage,<sup>194</sup> and employee assistance programs, the Departments utilized this authority to propose rules to permit HRAs as limited excepted benefits, if certain conditions are satisfied. The Departments have determined that the conditions that apply to excepted benefit HRAs under the final rules result in such an arrangement being sufficiently limited and sufficiently similar to other limited excepted benefits. The Departments are now adopting these final rules on excepted benefit HRAs, subject to clarifications, described later in this section of the preamble.

As a general matter, some commenters expressed confusion and asked for clarification regarding the difference, if any, between the proposed excepted benefit HRA and an HRA that only reimburses expenses for excepted benefits. In IRS Notice 2015–87, Q&A–5, the Treasury Department and the IRS explained that an HRA or employer payment plan that, by its terms, reimburses (including paying directly for) premiums for individual health insurance coverage solely to the extent that the individual health insurance coverage covers excepted benefits would not fail to satisfy the market requirements because those requirements do not apply to a group health plan that is designed to provide only excepted benefits, either through reimbursement of premiums or cost sharing (referred to in this preamble as an HRA that provides only excepted benefits). Excepted benefit HRAs, on the other hand, can provide reimbursement for costs incurred related to coverage that is not limited to excepted benefits (for example, cost sharing for individual health insurance coverage). Several commenters asked the Departments to confirm that an HRA that provides only excepted benefits is not subject to the conditions that apply to an excepted benefit HRA. One commenter was concerned that if an HRA that provides only excepted benefits must satisfy the

<sup>194</sup> The Departments note that limited wraparound coverage was permitted as an excepted benefit under a temporary pilot program. Specifically, limited wraparound coverage could be offered as excepted benefits if it was first offered no earlier than January 1, 2016, and no later than December 31, 2018, and would end no later than on the later of: (1) The date that is 3 years after the date limited wraparound coverage is first offered, or (2) the date on which the last collective bargaining agreement relating to the plan terminates after the date limited wraparound coverage is first offered (determined without regard to any extension agreed to after the date limited wraparound coverage is first offered). See 26 CFR 54.9831–1(c)(3)(vii)(F), 29 CFR 2590.732(c)(3)(vii)(F), and 45 CFR 146.145(b)(3)(vii)(F).

conditions that apply to an excepted benefit HRA, the proposed rules would inadvertently reduce employers' ability to fund excepted benefits.

The final rules establish a new excepted benefit HRA under Code section 9832(c)(2)(C), ERISA section 733(c)(2)(C), and PHS Act section 2791(c)(2)(C), which can be used to reimburse certain medical care expenses incurred with respect to coverage that is not limited to other types of excepted benefits. If a plan sponsor offers an HRA that only provides reimbursement for other types of excepted benefits (for example, limited-scope vision and limited-scope dental benefits), that arrangement is, itself, already an excepted benefit and need not satisfy the criteria of the final excepted benefit HRA rules. Instead, the final rules provide that an additional type of HRA, specifically, one that reimburses benefits not limited to other types of excepted benefits, can also qualify as an excepted benefit.<sup>195</sup> Excepted benefit HRAs may reimburse medical care expenses, such as cost sharing for individual health insurance coverage or group health plan coverage that would not otherwise qualify as excepted benefits, if the conditions of the final rules are satisfied.

## 2. Otherwise Not an Integral Part of the Plan

Among other things, to be a limited excepted benefit under Code section 9831(c)(1), ERISA section 732(c)(1), and PHS Act section 2722(c)(1), benefits must: (1) Be provided under a separate policy, certificate, or contract of insurance; or (2) otherwise not be an integral part of the plan.<sup>196</sup> HRAs are self-insured group health plans and, therefore, are not insurance coverage that can be provided under a separate policy, certificate, or contract of insurance. Accordingly, to satisfy the statutory requirement to be a limited excepted benefit, among other things, an HRA must not be an integral part of the plan.

To satisfy this condition, the proposed rules specified that other group health plan coverage (other than an account-based group health plan or coverage consisting solely of excepted benefits) must be made available by the same plan sponsor for the plan year to the participants offered the excepted benefit HRA. Only individuals eligible to participate in the traditional group

<sup>195</sup> That is, the excepted benefit HRA may reimburse expenses for excepted benefits, as well as other types of medical expenses that do not qualify as excepted benefits.

<sup>196</sup> Code section 9831(c)(1), ERISA section 732(c)(1), and PHS Act section 2722(c)(1).

health plan would be eligible to participate in the excepted benefit HRA. However, while the plan sponsor would be required to make an offer of a traditional group health plan, HRA participants (and their dependents) would not be required to enroll in the traditional group health plan for the HRA to be an excepted benefit HRA. In the preamble to the proposed rules, the Departments noted that this provision is similar to the requirement that applies under the limited excepted benefits rules for health FSAs at 26 CFR 54.9831–1(c)(3)(v), 29 CFR 2590.732(c)(3)(v), and 45 CFR 146.145(b)(3)(v).

Commenters generally supported this requirement and suggested that it be retained in the final rules. Some commenters suggested that the Departments should go further and permit employers to offer an excepted benefit HRA only to individuals who are actually enrolled in a traditional group health plan.<sup>197</sup> These commenters argued that without such a requirement, healthy employees would decline their employer's traditional group health plan and only participate in the excepted benefit HRA. These commenters speculated this might lead to a less stable small group market risk pool and higher premiums for employees who remain in the traditional group health plan. One commenter was concerned that if some employers offer traditional group health plans that are exorbitantly expensive, many employees would decline to enroll and rely on their excepted benefit HRA as their only source of coverage. One commenter disagreed with the Departments' assertion that the requirement to offer a traditional group health plan satisfies the requirement that limited excepted benefits not be an integral part of the plan. Another commenter stated that individuals could be without comprehensive coverage if they do not enroll in the employer's traditional

<sup>197</sup> One commenter opposed the requirement that traditional group health plan coverage be made available to the participants offered the excepted benefit HRA, but the comment was based on the misunderstanding that the proposed conditions that apply to the excepted benefit HRA apply to an HRA that provides only excepted benefits. The commenter was concerned that an employer that did not previously offer a traditional group health plan, but did previously offer an HRA that provides only excepted benefits, might discontinue offering that HRA if the final rules were to apply to the HRA that provides only excepted benefits. As explained earlier in this preamble, the final rules do not apply to HRAs that provide only excepted benefits. Therefore, if an employer offers an HRA that provides only excepted benefits, such an arrangement would not be subject to the requirements of the final rules, including the requirement that the plan sponsor must offer a traditional group health plan.

group health plan and rely instead on an excepted benefit HRA, or a combination of the excepted benefit HRA and other excepted benefits, without understanding the limited nature of excepted benefits. The commenter also represented that there is a long history of unscrupulous promoters cobbling together different types of excepted benefits and fraudulently marketing them as major medical insurance, leaving thousands of participants and beneficiaries with unpaid claims. One commenter urged the Departments to add a requirement that employers offering an excepted benefit HRA must maintain their traditional group health plan at an equivalent level of coverage, actuarial value, and premium affordability relative to the coverage offered prior to offering the excepted benefit HRA.

The final rules do not adopt a requirement that excepted benefit HRAs be limited to employees who are enrolled in the employer's traditional group health plan or impose a maintenance of effort requirement. First, the condition that employees must be offered (but not necessarily enrolled) in the employer's traditional group health plan is similar to that for excepted benefits health FSAs, pursuant to the same statutory authority.<sup>198</sup> Second, limiting eligibility to employees enrolled in their employer's traditional group health plan would make employees covered under other primary coverage, such as a spouse's plan, ineligible for the excepted benefit HRA. Applying such a restrictive requirement would unduly limit some employees' access to excepted benefit HRAs and reduce their welfare if they choose a different primary health coverage option to best meet their needs.<sup>199</sup> Third, other factors will likely prevent most employees from relying on an excepted benefit HRA as their primary form of coverage. For example, the dollar limit imposed on excepted benefit HRAs (discussed later in this preamble) will likely make it apparent that an excepted benefit HRA does not provide adequate financial protection against unexpected health costs, even for the healthiest individuals. Moreover, as discussed later in this preamble, in general, excepted benefit HRAs must provide

<sup>198</sup> See 26 CFR 54.9831-1(c)(3)(v), 29 CFR 2590.732(c)(3)(v), and 45 CFR 146.145(b)(3)(v). See also 62 FR 67688 (Dec. 29, 1997).

<sup>199</sup> In the context of other HRA integration rules, the Departments have recognized and supported employee choice to enroll in primary coverage other than the employer's group health plan (such as a spouse's plan or Medicare), without these types of limitations. See, e.g., 26 CFR 54.9815-2711(d)(2) and (d)(5), 29 CFR 2590.715-2711(d)(2) and (d)(5), and 45 CFR 147.126(d)(2) and (d)(5).

notice of the dollar limits and other limitations on coverage under the plan. Finally, as to the concern that employers will offer traditional group health plans that are very expensive, thereby encouraging employees to enroll only in the excepted benefit HRA, the employer shared responsibility provisions of Code section 4980H (for ALEs), and employers' desire to offer affordable health coverage as a means to attract and retain talented workers, are strong incentives for employers to offer affordable, quality health coverage.

### 3. Limited in Amount

Under the Code, ERISA and the PHS Act, limited excepted benefits may include limited scope vision or dental benefits, benefits for long-term care, nursing home care, home healthcare, or community-based care, or any combination thereof and may include "such other similar, limited benefits as are specified in regulations" by the Departments.<sup>200</sup> Thus, in creating the excepted benefit HRA, the Departments had to determine what type of HRA would be sufficiently limited to qualify as a limited excepted benefit.

The Departments have applied limiting principles consistently in prior rulemakings under which discretion was exercised to establish additional types of limited excepted benefits.<sup>201</sup> For example, a health FSA is an excepted benefit only if the arrangement is structured so that the maximum benefit payable to any participant in the class for a year does not exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater, \$500 plus the amount of the participant's salary reduction election).<sup>202</sup> Additionally, limited wraparound coverage is a limited excepted benefit only if it is limited in amount, such that the cost of coverage per employee (and any covered dependents) under the limited wraparound coverage does not exceed the greater of the maximum permitted annual salary reduction contribution toward a health FSA or 15 percent of the cost of coverage under the primary plan.

The Departments recognize that limited excepted benefits that are not limited in scope by benefit type (such as limited-scope dental or limited-scope vision benefits) must be limited in amount to constitute the type of ancillary benefit contemplated by the

<sup>200</sup> Code section 9832(c)(2)(C), ERISA section 733(c)(2)(C), and PHS Act section 2791(c)(2)(C).

<sup>201</sup> See the discussion in the preamble to the proposed rules at 83 FR 54420, 54437 (Oct. 29, 2018).

<sup>202</sup> 26 CFR 54.9831-1(c)(3)(v), 29 CFR 2590.732(c)(3)(v), and 45 CFR 146.145(b)(3)(v).

statutes within the meaning of a "similar, limited benefit" under Code section 9832(c)(2), ERISA section 733(c)(2), and PHS Act section 2791(c)(2).<sup>203</sup>

Accordingly, the Departments proposed that amounts newly made available for a plan year in an excepted benefit HRA may not exceed \$1,800, indexed for inflation for plan years beginning after December 31, 2020. For this purpose, inflation was defined in the proposed rules by reference to the Chained Consumer Price Index for All Urban Consumers, unadjusted (C-CPI-U), published by DOL. Also, the Departments stated that the adjusted limit for plan years beginning in a particular calendar year would be published early in the fall of the prior calendar year.

### a. Dollar Limit on the Amount That May Be Made Newly Available During a Plan Year

Many commenters supported the proposed dollar limit as a reasonable mid-point of the different limits that would result in applying various methodologies. Several noted it was sufficient because excepted benefits are meant to provide ancillary coverage, and the proposed amount is comparable to the cost of other excepted benefits, such as stand-alone dental and vision plans. One commenter noted that \$1,800 would be a generous level of reimbursement for excepted benefits, but only a modest support to participants and beneficiaries seeking reimbursement for COBRA premiums. Another commenter asserted that it was a reasonable middle ground relative to the various alternatives that the Departments considered and discussed in the preamble to the proposed rules.<sup>204</sup> A few commenters supported the proposed dollar limit due to their opposition to allowing excepted benefit HRAs to provide reimbursement for STLDI premiums, arguing that if the limit were any higher some participants could be more likely to rely on STLDI

<sup>203</sup> See also 80 FR 13995, 13997 (March 18, 2015).

<sup>204</sup> The Departments stated in the preamble to the proposed rules that a range of options were considered, such as a limit that would mirror the cap on employer contributions for excepted benefit health FSAs, a fixed percentage of the cost of coverage under the plan sponsor's primary group health plan, and the cost of coverage under the second lowest cost silver plan in various markets. However, consistent with the principle of promoting HRA usability and availability, rather than proposing a complex test for the limit on amounts newly made available in the excepted benefit HRA, the Departments proposed a maximum of \$1,800 because it approximated the midpoint amount yielded by the various methodologies considered. 83 FR 54420, 54437 (Oct. 29, 2018).

as their primary form of coverage. In expressing their support for the proposed dollar limit, a number of commenters stated that the limit should not be any higher, due to adverse selection concerns and concerns about disincentivizing comprehensive coverage.

Other commenters requested that excepted benefit HRAs not be subject to any dollar limit because a limit would restrict participants' ability to choose the types of treatment or coverage that is best suited to their needs. Some commenters argued that the proposed dollar limit should be higher. Some of these commenters favored a higher limit for excepted benefit HRAs based on age and number of dependents to reflect that participants who are older or have dependents are likely to have higher healthcare costs. Some commenters suggested specific higher limits that, in their view, would be appropriate, such as the maximum annual permitted benefit for QSEHRAs, the maximum out-of-pocket limit for HDHPs, the annual salary reduction contribution limit for health FSAs, the greater of 15 percent of the cost of coverage under the employer's primary group health plan or the health FSA salary reduction contribution limit (which is the threshold for limited wraparound coverage),<sup>205</sup> or 15 percent of the cost of coverage under the employer's primary group health plan (which is the threshold for certain supplemental excepted benefits).<sup>206</sup> The commenters asserted that the limit should be increased for various reasons, including to enable employees to pay for premiums and cost sharing for excepted benefit policies, to approximate the limits allowed for limited wraparound coverage, to reduce administrative complexity for plan sponsors by aligning the limit with a limit that already exists, to help employees bypass insurance and pay directly for medical care, and to enable employees to pay for more expensive STLDI plans that may, in some cases, provide comprehensive, high-quality coverage. Some commenters noted that setting the limit as a percentage of the cost of the employer's primary group health plan could partially account for regional differences for healthcare services.

<sup>205</sup> See 26 CFR 54.9831-1(c)(3)(vii)(B), 29 CFR 2590.732(c)(3)(vii)(B), and 45 CFR 146.145(b)(3)(vii)(B).

<sup>206</sup> See EBSA Field Assistance Bulletin No. 2007-04 (available at <https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2007-04>); CMS Insurance Standards Bulletin 08-01 (available at [http://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa\\_08\\_01\\_508.pdf](http://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa_08_01_508.pdf)); and IRS Notice 2008-23.

One commenter stated that a dollar limit is not sufficient to cause the excepted benefit HRA to be a limited excepted benefit and also stated that the proposed dollar limit was too high, with the result that the excepted benefit HRA is not a limited excepted benefit because the dollar limit is significantly more than the premium value of the other limited excepted benefits; therefore, according to the commenter, the excepted benefit HRA is not similar to other limited excepted benefits.

The final rules do not remove or change the dollar limit for the excepted benefit HRA. The Departments agree that significantly increasing the dollar limit could encourage certain participants to rely solely on benefits reimbursed through the excepted benefit HRA and could lead to adverse selection. Also, as stated earlier in this preamble, if a benefit that is generally not otherwise limited in scope is too large, it would not constitute a "similar, limited benefit" under Code section 9832(c)(2), ERISA section 733(c)(2), and PHS Act section 2791(c)(2). These governing statutes require that these benefits be limited, which the Departments interpret to require a strict dollar limit because the excepted benefit HRA is not restricted to reimbursing specific, limited types of medical expenses.<sup>207</sup> Further, the Departments are cognizant that an excepted benefit HRA, like all excepted benefits, does not render an individual ineligible for the PTC and, therefore, a higher dollar limit on the excepted benefit HRA could result in individuals being eligible for both subsidized coverage through the Exchanges and a higher employer provided HRA benefit, which would increase the cost to the federal government. To the extent commenters advocated for a higher dollar limit in order to allow HRAs to be used to purchase excepted benefits, HRAs that provide only excepted benefits may be an alternative option because those HRAs are not subject to the excepted benefit HRA rules, including the dollar limit.

In determining the appropriate dollar limit for excepted benefit HRAs, the Departments considered other, similar limited excepted benefits. The Departments agree with commenters' assertions that the proposed limit was

<sup>207</sup> The Departments note, however, that an excepted benefit HRA is also limited, to some extent, in scope of reimbursable expenses in that it may not reimburse premiums for individual health insurance coverage (other than excepted benefits); group health coverage (other than COBRA or other continuation coverage or excepted benefits); Medicare Part A, B, C, or D; and under certain circumstances, it cannot reimburse STLDI premiums.

reasonable and rational, especially considering the relatively low cost of excepted benefits coverage, such as dental or vision coverage. While limited wraparound coverage and similar supplemental coverage may have higher overall dollar limits, they are also limited in additional ways. Limited wraparound coverage must provide meaningful benefits beyond coverage of cost sharing (such as coverage for expanded in-network medical clinics or providers, or provide benefits that are not EHBs and that are not covered by the eligible health insurance) and, in general, may only be offered to part-time employees and retirees (and their dependents), and only if the employer makes certain offers of coverage to full-time employees.<sup>208</sup> Further, similar supplemental coverage is restricted to coverage "specifically designed to fill gaps in the primary coverage."<sup>209</sup> On the other hand, employee salary reduction contributions to health FSAs, which will vary by employee and cannot exceed \$2,700 (adjusted for inflation), cannot be used to pay premiums, and generally may not be rolled over from year to year, except for a limited runout period or limited amount.<sup>210</sup> Excepted benefit HRAs are not subject to all the limitations that apply to these other limited excepted benefits; thus, a lower dollar amount is appropriate for excepted benefit HRAs.

Additionally, although the Departments recognize that healthcare expenses may be higher for participants who are older or have dependents, adopting a higher limit to account for a combination of factors like age and family size could allow an excepted benefit HRA to be too large and to resemble major medical coverage. Moreover, these factors were already considered and accounted for in developing the \$1,800 limit. Accordingly, the final rules adopt, without change, the proposed maximum that can be newly made available for a plan year of \$1,800.

#### b. Indexing for Inflation

Many commenters supported the proposed rule's approach to indexing for inflation the amount that may be made newly available to participants during a plan year, though some suggested alternative methods of indexing may be more appropriate.

<sup>208</sup> See 26 CFR 54.9831-1(c)(3)(vii)(A) and (D), 29 CFR 2590.732(c)(3)(vii)(A) and (D), and 45 CFR 146.145(b)(3)(vii)(A) and (D). See also 80 FR 13995, 13997 (March 18, 2015).

<sup>209</sup> See 26 CFR 54.9831-1(c)(5)(i)(C), 29 CFR 2590.732(c)(5)(i)(C), and 45 CFR 146.145(b)(5)(i)(C).

<sup>210</sup> IRS Notice 2005-42, 2005-1 CB 1204 and IRS Notice 2013-71, 2013-47 IRB 532.

Several commenters suggested that the chained CPI-U does not accurately reflect the increases in the cost of medical care over time because healthcare prices consistently increase at a greater rate than prices in the economy as a whole. Several commenters suggested that the appropriate measure of inflation would be the Consumer Price Index overall medical care component because it focuses on consumers' out-of-pocket medical expenses, while another suggested unchained CPI-U. Another commenter, however, suggested that the measure selected in the proposed rules would be the most appropriate measure, as other types of excepted benefits, such as limited-scope dental, limited-scope vision, and fixed indemnity plans, do not typically have cost trends (that is, inflation) similar to products that provide comprehensive medical care. One commenter expressed support for the proposed adjustment because it is consistent with the adjustment of various other amounts under the Code.

The final excepted benefit HRA rules index the annual dollar limit of \$1,800 to inflation for plan years beginning after December 31, 2020, and define inflation by reference to the C-CPI-U, as was proposed. This index strikes a reasonable balance among a number of factors, including balancing the decreasing real value of a static excepted benefit HRA annual maximum contribution amount and the ability of an employer to maintain a meaningful, yet limited, excepted benefit HRA that can carry over unused amounts and accumulate to higher account balances over time. Also, C-CPI-U is used to index most other amounts under the Code with which employers are familiar, such as the annual limit on employee salary reduction contributions to health FSAs, annual HSA contributions amounts, and annual HDHP minimum deductible amounts and maximum HDHP out-of-pocket amounts.<sup>211</sup> Therefore, this inflation adjustment should be familiar to plan sponsors. Using the same indexing method is less likely to result in confusion and will make implementation and compliance easier.

One commenter urged that the annual amount should be announced at the same time that other account-based plan limits, such as the limits for HSAs and HSA-eligible HDHPs, are announced, as employers and plan administrators need to know these amounts in advance to set their benefit levels and communicate them to employees. The Departments agree that it is essential that the annual

adjustment be made available sufficiently in advance of the upcoming plan year to allow plan sponsors to make benefit determinations. Therefore, the Departments are revising the final rules to provide that the C-CPI-U for any calendar year is the average of the C-CPI-U as of the close of the 12 month period ending on March 31 of that calendar year and that the Treasury Department and the IRS will publish the adjusted amount for plan years beginning in any calendar year no later than June 1 of the preceding calendar year, which is the same timing rule that applies for HSAs and HSA-eligible HDHPs.

#### c. Roll-Overs and Aggregation Rules

The proposed rules provided that if a participant or beneficiary in an excepted benefit HRA does not use all of the amounts made available for a plan year, and the excepted benefit HRA allows for these amounts to be carried over to later plan years, then these carryover amounts would be disregarded for purposes of determining whether the \$1,800 limit is exceeded.<sup>212</sup> One commenter specifically expressed support for this aspect of the proposed rules, and this feature is retained in the final rules.

In addition, the proposed rules provided that if the plan sponsor provides more than one HRA to a participant for the same time period, the amounts made available under all such plans would be aggregated to determine whether the \$1,800 limit has been exceeded. One commenter opposed this aspect of the rule. However, the Departments retain this provision in the final rules in order to avoid circumvention of the \$1,800 limit, which provides the statutory basis for recognizing this type of HRA as a limited excepted benefit. However, the final rules clarify that the aggregation rules do not take into account amounts made available under HRAs that reimburse only excepted benefits (including premiums for individual health insurance coverage that consists solely of excepted benefits). An HRA that reimburses only excepted benefits is exempt from the provisions of the final rules, including those provisions that apply to individual coverage HRAs and excepted benefit HRAs.

<sup>212</sup> Transfers, however, from other HRAs are not permitted. See the discussion earlier in this preamble.

#### 4. Prohibition on Reimbursement of Premiums for Certain Types of Coverage

##### a. In General

To be an excepted benefit HRA, the proposed rules provided that the HRA could not reimburse premiums for Medicare Part B or D, individual health insurance coverage, or coverage under a group health plan (other than COBRA or other group continuation coverage), except that the HRA could reimburse premiums for individual health insurance coverage or group health plan coverage that consists solely of excepted benefits. An excepted benefit HRA would be permitted to reimburse any other medical care expenses, including STLDI premiums.

Commenters generally supported the proposed requirement that an excepted benefit HRA would not be permitted to reimburse premiums for individual health insurance coverage (other than for such coverage consisting solely of excepted benefits). These commenters contended that to allow reimbursement of individual health insurance coverage premiums would undermine the basis for recognizing the HRAs as limited excepted benefits, and would enhance employers' ability to move their higher-risk employees into the individual market. The Departments agree that maintaining the prohibition on the use of the excepted benefit HRA for individual health insurance coverage premiums is one way in which the HRA is limited, in order to qualify as a limited excepted benefit, and that the prohibition mitigates the risk that excepted benefit HRAs could cause adverse selection in the individual market.

In addition, the Departments have concluded that the prohibition on the reimbursement of premiums for group health plan coverage (other than COBRA or other continuation coverage and excepted benefits) and individual health insurance coverage (other than excepted benefits), is appropriate because other final rules that are part of this rulemaking permit individual coverage HRAs and other rules allow HRAs to be integrated with non-HRA group health plan. Further, current guidance allows HRAs to reimburse premiums for Medicare Part B and D in certain circumstances and under the final rules, individual coverage HRAs that are integrated with Medicare may be allowed to reimburse premiums for Medicare Part A, B, C, or D. Therefore, an employer that wants to provide an HRA that reimburses premiums for individual health insurance coverage, Medicare Part A, B, C or D, or group health plan coverage, may do so under

<sup>211</sup> See Code sections 125(i) and 223(g).

the applicable integration rules. Accordingly, the final rules retain the proposed prohibition on reimbursing premiums for individual health insurance coverage (other than for such coverage consisting solely of excepted benefits) and group health insurance coverage (other than for such coverage consisting solely of excepted benefits and COBRA or other continuation coverage). Moreover, because the excepted benefit HRA generally is not intended to reimburse premiums that may be reimbursed under the individual coverage HRA, the final rules also provide that the excepted benefit HRA may not reimburse premiums for Medicare Part A or C, in addition to Medicare Part B and D, as provided for in the proposed rules. This approach ensures that, similar to other limited excepted benefits, excepted benefit HRAs provide limited benefits different from those typically provided by a traditional group health plan.

Some commenters requested clarification regarding the medical care expenses an excepted benefit HRA may reimburse. In particular, a few commenters requested that the Departments clarify that an excepted benefit HRA can reimburse individuals for cost sharing under individual health insurance coverage or group health plans, although excepted benefit HRAs may not be used to reimburse premiums for that coverage. Some commenters inquired whether an employer could place limits on the medical care expenses it allows to be reimbursed by the excepted benefit HRA, in addition to those limits imposed by the excepted benefit HRA rules. In particular, a few commenters asked whether an employer could choose not to provide any reimbursement of certain premiums or medical care expenses otherwise allowed under Code section 213(d).

In general, an HRA may provide for reimbursement for medical care expenses. Consistent with the current rules that apply to HRAs generally, a plan sponsor has discretion to specify which medical care expenses are eligible for reimbursement from an excepted benefit HRA it establishes, in addition to the limits under the excepted benefit HRA rules. For example, a plan sponsor may permit an excepted benefit HRA to reimburse all medical care expenses not otherwise disallowed by the excepted benefit HRA rules, it may permit reimbursements for non-premium medical care expenses only (such as cost sharing), or it may otherwise decide which particular medical care expenses will be reimbursable and which will not be reimbursable. An excepted benefit HRA

may allow for reimbursement of cost sharing under individual health insurance coverage or group health insurance coverage, although the excepted benefit HRA may not reimburse the premiums for that coverage. Further, a plan sponsor generally may, but need not, allow reimbursement of STLDI premiums or cost sharing under the excepted benefit HRA. Also, see later in this section of the preamble for a discussion of the special circumstance in which excepted benefit HRAs may not be used to reimburse STLDI premiums.

Several commenters inquired whether an excepted benefit HRA could reimburse expenses related to participation in a health care sharing ministry or a direct primary care arrangement. One commenter asked whether reimbursement could be provided for categories of excepted benefits other than “limited excepted benefits,” such as those in which benefits for medical care are secondary or incidental (for example, travel insurance). This commenter expressed concern that there could be potential conflicts under rules regarding taxable fringe benefits under the Code. Some commenters requested clarification more generally regarding whether an excepted benefit HRA may only reimburse excepted benefits that pay health benefits or all excepted benefits, with some advocating that excepted benefit HRAs be allowed to reimburse all expenses for all excepted benefits and some advocating that the excepted benefit HRA only be allowed to reimburse expenses for excepted benefits that are medical care. The Departments clarify that an HRA, including an excepted benefit HRA, generally may reimburse medical care expenses of an employee and certain of the employee’s family members (subject to the prohibition on the reimbursement of certain premiums that apply for excepted benefit HRAs).<sup>213</sup> Neither the proposed nor the final rules make any changes to the rules under Code section 213. Thus, any issues arising under Code section 213, and any guidance requested by commenters to address those issues, are beyond the scope of this rulemaking. The Treasury Department and the IRS, however,

<sup>213</sup> See Notice 2002–45 which states “[a]n HRA does not qualify for the exclusion under [Code section] 105(b) if any person has the right to receive cash or any other taxable or non-taxable benefit under the arrangement other than the reimbursement of medical care expenses. If any person has such a right under an arrangement currently or for any future year, all distributions to all persons made from the arrangement in the current tax year are included in gross income, even amounts paid to reimburse medical care expenses.”

appreciate the comments and anticipate addressing some of these issues in future rulemaking or guidance.

One commenter stated that excepted benefit HRAs should not be permitted to reimburse COBRA premiums because COBRA generally is more expensive than other coverage options and the Departments should not incentivize individuals to elect COBRA when more affordable coverage options may be available. Another commenter opposed allowing reimbursement for COBRA premiums because COBRA generally provides comprehensive coverage and, to the extent an HRA can be used to reimburse such coverage, it should not be considered to be providing limited benefits within the meaning of the statutes.

The Departments decline to prohibit reimbursement for COBRA premiums under excepted benefit HRAs in the final rules. Excepted benefit HRA participants or beneficiaries may choose to elect COBRA or other group continuation coverage, even if other more affordable coverage options are available. For example, they may want to ensure they are still able to see their preferred doctors or maintain coverage for certain prescription drugs. Furthermore, nothing in the final rules requires an employer to make an excepted benefit HRA available for the reimbursement of COBRA (or other group continuation coverage) premiums. The Departments also do not agree that an HRA that provides reimbursement for COBRA (or other group continuation coverage) premiums would not be providing limited benefits, consistent with Code section 9832(c)(2)(C), ERISA section 733(c)(2)(C), and PHS Act section 2791(c)(2)(C). As explained earlier in this preamble, the restriction on annual contributions to the excepted benefit HRA ensures this HRA is limited.

#### b. Reimbursement of STLDI Premiums

Many commenters requested that excepted benefit HRAs not be permitted to provide reimbursement of STLDI premiums. These commenters expressed concern that some participants may use excepted benefit HRA funds to purchase STLDI policies without understanding that STLDI might not provide comprehensive coverage and is not subject to the same federal consumer protections that apply to PPACA-compliant coverage. Some commenters expressed concerns that individuals with STLDI could be exposed to serious financial risk and others expressed concerns about specific benefits or conditions not generally covered by STLDI. One commenter represented that

in some states, individuals with an excepted benefit HRA and STLDI coverage would not satisfy state law requirements to maintain comprehensive coverage and would, therefore, incur state income tax penalties. A few commenters stated that they believed that permitting reimbursement for STLDI premiums would mean that the excepted benefit HRA would not be providing a limited benefit because STLDI policies typically cover at least some of the same benefits as individual health insurance coverage and because Congress exempted STLDI from the market requirements by distinguishing it from individual health insurance coverage rather than making it an excepted benefit. Other commenters were concerned that this rule would incentivize small employers to offer an excepted benefit HRA to purchase STLDI, instead of a QSEHRA to purchase individual health insurance coverage.

Several commenters also claimed that permitting excepted benefit HRAs to reimburse STLDI premiums would lead to market segmentation, potentially negatively affecting the small group market. These commenters argued that healthier, lower-cost individuals who do not have preexisting conditions and who believe they do not need comprehensive benefits would enroll in STLDI, rather than in more comprehensive group or individual coverage. In the opinion of these commenters, this scenario is more likely to occur in the fully-insured small group market, where premiums do not vary based on an individual employer's claims experience.<sup>214</sup> In contrast, large employers whose plans are experience-rated, or employers that offer self-insured plans, likely would not offer an excepted benefit HRA that could be used to reimburse STLDI premiums because, according to these commenters, healthy employees foregoing coverage under the employer's traditional group health plan could result in direct negative financial consequences on the cost of maintaining that plan; thus, the employer would have strong incentives not to offer an excepted benefit HRA that could be used to purchase STLDI. One commenter noted that the benefit of allowing HRAs to be used for STLDI is outweighed by the risks to the individual and small group markets. Other commenters supported making STLDI more available generally to

consumers, citing choice and flexibility, as well as affordability.

The final rules generally do not prohibit reimbursement of STLDI premiums by excepted benefit HRAs. Employees at small firms are increasingly turning down an offer of health coverage.<sup>215</sup> Low-wage workers at small firms are especially likely to turn down such coverage when offered, particularly as a given premium is a larger share of income for a low-wage employee.<sup>216</sup> Thus, low-wage workers at smaller firms who are turning down the employer offer of coverage are potentially likely to benefit from permitting the excepted benefit HRA to reimburse STLDI premiums. To the extent that people who would use the excepted benefit HRA to purchase STLDI would otherwise have been uninsured and, therefore, would not have been part of the small group single risk pool, the small group market is unaffected by the introduction of an excepted benefit HRA that may be used to purchase STLDI. Moreover, the impact of any adverse selection is likely to be small because the small group market is much larger than the STLDI market. Thus, any potential expansion of the number of healthier-than-average STLDI enrollees will have a smaller proportional impact on expected claims in the small group market.

While the final rules do not prohibit reimbursement of STLDI premiums by excepted benefit HRAs, the final rules include a special rule in response to commenters' concerns about the potential for adverse selection in the small group markets, as discussed later in this preamble.<sup>217</sup> Further, because individuals offered an excepted benefit HRA must be offered a traditional group health plan, individuals with an excepted benefit HRA who are considering STLDI will likely be deciding between STLDI and the traditional group health plan, rather than individual health insurance coverage, premiums for which may not

be reimbursed by an excepted benefit HRA. Therefore, adverse selection in the individual market is mitigated.

STLDI may not be suitable coverage for all individuals in all circumstances and in many instances it might not provide coverage that is as comprehensive as individual health insurance coverage. However, STLDI can be a viable health insurance option for many people in many circumstances. Also, no individual is required to enroll in STLDI; rather, it is simply an additional (and in some circumstances, more affordable), option that may be available to them. With respect to concerns that some excepted benefit HRA participants may not understand the limited nature of STLDI, a notice is required to be prominently displayed in STLDI contracts and enrollment application materials advising consumers of the differences between STLDI and other health insurance coverage. Among other things, the notice must state that the coverage: (1) Is not required to comply with certain federal market requirements for health insurance; (2) may exclude or limit coverage for preexisting conditions; (3) may not include coverage for hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services; and (4) may have lifetime or annual dollar limits on health benefits.<sup>218</sup>

The Departments disagree with commenters' assertions that permitting excepted benefit HRAs to reimburse STLDI would not be providing limited excepted benefits because STLDI is not an excepted benefit and often covers some of the same benefits as individual health insurance coverage. Nothing in these final rules would designate STLDI as a limited excepted benefit. Rather, it is the HRAs that must satisfy certain conditions to be recognized as limited excepted benefits, and the HRAs must be limited as to amount and are substantially limited as to the types of premiums they may reimburse. Further, STLDI coverage often provides much more limited benefits than coverage that is subject to the market requirements. Taking all of this into account, the Departments have determined that excepted benefit HRAs are sufficiently limited to constitute a limited excepted benefit, notwithstanding that employers may generally elect to permit HRA reimbursement of STLDI premiums.

One commenter noted that the excepted benefit HRA rules do not preempt state regulation of STLDI and

<sup>215</sup> In 1999, 17 percent of workers eligible for employer coverage at small firms (those with 3 to 199 workers) turned down the offer of employer coverage. By 2011, this share had climbed to 22 percent, and in 2018 it was 27 percent. See Kaiser Family Foundation, "Employer Health Benefits 2018 Annual Survey," Figure 3.1, available at <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018>.

<sup>216</sup> *Id.*

<sup>217</sup> To the extent an excepted benefit HRA reimburses premiums for STLDI, the insurance, which is not individual health insurance coverage, will not be eligible for the safe harbor under 29 CFR 2510.3-1(l). Accordingly, to the extent offered in connection with a group health plan, the benefits could be subject to those provisions of ERISA that apply to excepted benefits (for example, ERISA parts 1, 4, and 5).

<sup>218</sup> See 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103.

<sup>214</sup> See PHS Act section 2701 and PPACA section 1312(c). See also 45 CFR 147.102 and 45 CFR 156.80.

so do not inhibit a state from prohibiting the sale of STLDI. The Departments agree with the commenter that nothing in the final rules affects state regulation of STLDI.

#### 5. Uniform Availability

To prevent an excepted benefit HRA from intentionally or unintentionally, directly or indirectly, steering participants or dependents with adverse health factors away from the sponsor's traditional group health plan, the proposed rules provided that an excepted benefit HRA must be made available under the same terms to all similarly situated individuals, regardless of any health factor.<sup>219</sup> The Departments proposed and are finalizing this condition to prevent discrimination based on health status and to preclude opportunities for an employer to offer a more generous excepted benefit HRA to individuals with an adverse health factor, such as an illness or a disability, as an incentive not to enroll in the plan sponsor's traditional group health plan.<sup>220</sup> Consistent with the approach outlined in the proposed rules, under the final rules, an excepted benefit HRA may not, for example, be offered only to employees who have cancer or fail a physical examination, just as the excepted benefit HRA may not be offered only to employees who are cancer-free or who pass a physical examination. Similarly, an employer may not make greater amounts available in an excepted benefit HRA for employees who have cancer or who fail a physical examination, just as an employer may not make greater amounts available in an excepted benefit HRA for employees who are cancer-free or who pass a physical examination.

Commenters generally supported this requirement and asserted that it is necessary to prevent discrimination based on health status. Two commenters sought confirmation that an excepted benefit HRA would not violate the uniform availability requirement if it were made available to only certain individuals, such as pre-Medicare eligible retirees who decline coverage under the former employer's traditional group health plan and purchase coverage through the individual market, so long as those eligibility conditions are not based on a health factor. In the Departments' view, a plan design that permits enrollment in an excepted benefit HRA only if coverage is declined

under the traditional group health plan is inconsistent with the uniform availability requirement and with the basic premise that an excepted benefit HRA must be ancillary to the employer's traditional group health plan. HHS further notes that structuring the offering or design of a group health plan based on pre-Medicare status would generally run afoul of the Medicare nondiscrimination provisions described earlier in this preamble.<sup>221</sup> Therefore, an employer may not condition enrollment in an excepted benefit HRA on declining to enroll in the traditional group health plan.

As noted earlier in this preamble, Code section 9831(a) and ERISA section 732(a) generally provide that chapter 100 of the Code and part 7 of ERISA, respectively, do not apply to plans, including HRAs, with fewer than two participants who are current employees on the first day of the plan year (including retiree-only plans that cover fewer than two participants who are current employees).<sup>222</sup> Therefore, a retiree-only HRA is not subject to the market requirements and would not need to qualify as an excepted benefit in order to avoid the application of PHS Act sections 2711 and 2713. However, a retiree-only HRA that does not qualify as an excepted benefit would qualify as MEC,<sup>223</sup> and, therefore, a retiree who accepted such an HRA could not claim the PTC.<sup>224</sup>

One commenter suggested that the Departments should issue additional guidance and resources about the definition of similarly situated individuals to ensure that this requirement is properly implemented. In response to these comments, the final rules define similarly situated individuals by reference to the definition found in the HIPAA nondiscrimination rules, as was proposed.<sup>225</sup> Those rules generally provide that group health plans may,

subject to an anti-abuse provision for discrimination directed at individuals, treat groups of participants as distinct groups if the distinction is based on a bona fide employment-based classification consistent with the employer's usual business practice. Whether an employment-based classification is bona fide is determined based on all the relevant facts and circumstances, including whether the employer uses the classification for purposes independent of qualification for health coverage (such as, determining eligibility for other employee benefits or determining other terms of employment). Examples in the HIPAA nondiscrimination rules of classifications that may be bona fide, based on all the relevant facts and circumstances, include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, current employee versus former employee status, and different occupations. Under the anti-abuse provision, however, a distinction between groups of individuals is not permitted if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In addition, a plan may, subject to certain anti-abuse provisions for discrimination directed at individuals, treat beneficiaries as distinct groups based on the bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage; the relationship to the participant; marital status; with respect to children of a participant, age or student status; and other factors if the factor is not a health factor. Finally, the HIPAA nondiscrimination rules generally allow group health plans to treat participants and beneficiaries as distinct groups. Additional guidance on similarly situated individuals is available on DOL's website.<sup>226</sup> The final rules define similarly situated individuals by reference to the definition in the HIPAA

<sup>221</sup> SSA sections 1862(b)(1)(A)(i)(I), (b)(1)(B)(i), and (b)(1)(C)(i).

<sup>222</sup> While title XXVII of the PHS Act, as amended by PPACA, no longer contains a parallel provision at PHS Act section 2721(a), HHS has explained that it will not enforce the requirements of title XXVII of the PHS Act with respect to nonfederal governmental retiree-only plans and generally encourages states to adopt a similar approach with respect to retiree-only plans offered by issuers. See 75 FR 34538, 34540 (June 17, 2010).

<sup>223</sup> 26 CFR 1.5000A-2(c).

<sup>224</sup> 26 CFR 1.36B-2(c)(3). Note that a former employee is only rendered ineligible for the PTC if the former employee enrolls in employer-sponsored coverage; an offer of coverage (even if it is affordable and provides MV) does not preclude a former employee from claiming the PTC. See 26 CFR 1.36B-2(c)(3)(iv).

<sup>225</sup> See 26 CFR 54.9802-1(d), 29 CFR 2590.702(d), and 45 CFR 146.121(d).

<sup>219</sup> See Code section 9802(a)(1), ERISA section 702(a)(1) and PHS Act 2705(a)(1). See also 26 CFR 54.9802-1(a)(1) and (d), 29 CFR 2590.702(a)(1) and (d), and 45 CFR 146.121(a)(1) and (d).

<sup>220</sup> See 83 FR 54420, 54438 (Oct. 29, 2018).

<sup>226</sup> See Compliance Assistance Guide—Health Benefits Coverage Under Federal Law, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide.pdf>; Self-Compliance Tool for Part 7 of ERISA: Health Care-Related Provisions, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a.pdf>; and FAQs on HIPAA Portability and Nondiscrimination Requirements for Employers and Advisers, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/hipaa-compliance.pdf>.

nondiscrimination rules, which are also designed to prevent discrimination in group health plans based on health status. These standards are already familiar to stakeholders and therefore use of the existing definition will reduce complexity and the potential burden of having to use a different definition.

#### 6. Coordination With HSAs

Commenters asked for clarification regarding the circumstances in which participation in an excepted benefit HRA might preclude an individual from being eligible for an HSA. These commenters expressed concern that, because HSA eligibility is restricted if an individual has certain other types of health coverage, a loss of HSA eligibility could occur for some individuals enrolled in excepted benefit HRAs.

As explained earlier in this preamble, among the requirements for an individual to qualify as an eligible individual under Code section 223(c)(1) for purposes of HSA eligibility is that the individual must be covered under an HDHP and have no disqualifying health coverage. If an individual fails to satisfy the requirements to be an eligible individual, then contributions to an HSA are disallowed. The Treasury Department and the IRS have provided some guidance on the interaction between HRAs and the requirements of Code section 223 in Revenue Ruling 2004-45 and IRS Notice 2008-59. More specifically, as explained earlier in this preamble, in Revenue Ruling 2004-45, the Treasury Department and the IRS clarified that an otherwise eligible individual (that is, an individual with coverage under an HDHP and no disqualifying coverage) remains an eligible individual for purposes of making contributions to an HSA for periods during which the individual is covered by a limited-purpose HRA, a post-deductible HRA, or combinations of these arrangements. Subsequently, Q&A-1 of IRS Notice 2008-59 stated that a limited-purpose HRA that is also available to pay premiums for health coverage does not disqualify an eligible individual from contributing to an HSA, provided the individual does not use the HRA to, or otherwise, obtain coverage that is not HSA-compatible.

This prior guidance applies to all HRAs, including excepted benefit HRAs.<sup>227</sup> Therefore, for example, an

<sup>227</sup> To be an eligible individual under Code section 223(c)(1), an individual may not be covered by a health plan that is not an HDHP, except for certain coverage which is disregarded, as enumerated in Code section 223(c)(1)(B). Code section 223(c)(1)(B) does not disregard all excepted benefits, and an excepted benefit HRA is not disregarded coverage. Therefore, an excepted

individual covered by an excepted benefit HRA that is available to pay premiums for STLDI is an eligible individual for purposes of making contributions to an HSA, assuming the HRA is used to purchase STLDI that qualifies as an HDHP (and so, for example, the STLDI does not pay benefits prior to satisfying the minimum required deductible),<sup>228</sup> and the individual has no disqualifying coverage.

#### 7. Notice Requirements

Several commenters suggested that the Departments impose certain notice requirements for excepted benefit HRAs in the final rules. Commenters stated that the required notice should be similar to the notice required for individual coverage HRAs, or should, at a minimum, inform participants and beneficiaries of the annual dollar limit for benefits under the excepted benefit HRA, other terms and conditions of the excepted benefit HRA, and participants' and beneficiaries' rights under the excepted benefit HRA.

However, the Departments note that for private-sector, employment-based plans, other long-standing notice requirements under Part 1 of ERISA already apply. ERISA-covered plans, including excepted benefit HRAs, must provide an SPD, summaries of material modifications, and summaries of material reductions in covered services or benefits.<sup>229</sup> Under ERISA sections 102 and 104 and their implementing regulations, an excepted benefit HRA's SPD must include, for example, the conditions pertaining to eligibility to receive benefits; a description or summary of the benefits; the circumstances that may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (for example, by exercise of subrogation or reimbursement rights) of any benefits; and the procedures governing claims for benefits under the excepted benefit HRA. Excepted benefit HRAs that are ERISA-covered plans are subject to additional disclosure requirements to provide instruments under which the excepted benefit HRA is established or operated and information relevant to a

benefit HRA must be HSA-compatible under the relevant Code section 223 guidance in order to allow an otherwise eligible individual to remain an eligible individual under Code section 223.

<sup>228</sup> See Code section 223(c)(2). See also Notice 2008-59, Q&A-14, which provides that to be an HDHP a plan must provide significant benefits, and if a plan only provides benefits for hospitalization or in-patient care, the plan would not qualify as an HDHP.

<sup>229</sup> See ERISA sections 102 and 104. See also 29 CFR 2520.104b-2 and 2520.104b-3(a) and (d)(3).

participant's adverse benefit determination upon request.<sup>230</sup>

Under these disclosure provisions, excepted benefit HRAs that are ERISA-covered plans should generally provide information on eligibility to receive benefits, annual or lifetime caps or other limits on benefits under the plan, and a description or summary of the benefits. Accordingly, for excepted benefit HRAs that are subject to ERISA, the final rules include a cross reference to existing ERISA notice provisions in order to ensure that excepted benefit HRA plan sponsors are aware of their obligations under those provisions. However, the final rules do not include any additional notice requirements for ERISA-covered plans.

In response to commenters' concerns, HHS intends to propose in future rulemaking a notice requirement with respect to non-federal governmental plan excepted benefit HRAs. HHS anticipates proposing that a non-federal governmental plan excepted benefit HRA would be required to provide a notice that states conditions pertaining to eligibility to receive benefits, annual or lifetime caps or other limits on benefits under the excepted benefit HRA, and a description of, or summary of, the benefits consistent with the requirements of 29 CFR 2520.102-3(j)(2) and (3). HHS anticipates that, under the proposal, this notice would be required to be provided in a time and manner consistent with the requirements of 29 CFR 2520.104b-2(a).

#### 8. Special Rule To Address the Potential Impact on the Small Group Market of the Reimbursement of STLDI Premiums Through Excepted Benefit HRAs

As discussed earlier in this preamble, the final rules include a special rule in response to comments regarding the potential for adverse selection in the small group market if small, insured employers also sponsor excepted benefit HRAs that reimburse STLDI premiums. Specifically, the final rules provide that the Departments may restrict excepted benefit HRAs from reimbursing STLDI premiums, for certain employers in a state, if five criteria are satisfied.

First, the restriction applies only to excepted benefit HRAs offered by small employers, as defined in PHS Act section 2791(e)(4), to respond to concerns by commenters about adverse selection in the small group market. Second, the restriction applies only in situations in which the other group health plan coverage offered by the

<sup>230</sup> See, e.g., ERISA sections 104(b), 502(c), and 503. See also 29 CFR 2520.104b-1 and 2560.503-1.

small employer is either fully-insured or partially-insured. This focus on insured coverage again is designed to narrowly address the potential for adverse selection by small, insured employers that was identified by commenters. Third, the restriction applies only if the Secretary of HHS makes a finding, in consultation with the Secretaries of Labor and the Treasury, that the reimbursement of premiums for STLDI by excepted benefit HRAs in a state has caused significant harm to the small group market in the state that is the principal place of business of the small employer.

Fourth, this finding may be made only after submission of a written recommendation by the applicable state regulatory authority of such state, in the form and manner specified by HHS. The written recommendation must include evidence that the reimbursement of STLDI premiums by excepted benefit HRAs established by insured or partially-insured small employers in the state has caused significant harm to the state's small group market, including on small group market premiums. The evidence may include the State Insurance Commissioner's documented overall assessment of the small group market in the state. It may also include representations made by small group market issuers that an increase in the purchase of STLDI coverage by employees of small employers has caused issuers to increase premiums for small group market insurance, due to the issuers' reasonable belief about adverse selection. HHS will evaluate each recommendation on a case-by-case basis. Factors that HHS may consider in determining whether significant harm had occurred include, but are not limited to, the impact on issuers' presence in the small group market, whether there has been more than a de minimis increase in premiums in the small group market, enrollment declines in the small group market related to individuals purchasing STLDI, and changes to the health of the small group market risk pool.

Finally, the restriction (or discontinuance of the restriction) must be imposed by publication of a notice by the Secretary of HHS in the **Federal Register** and will be effective prospectively only, and with a reasonable time for plan sponsors to comply.

#### 9. Other Comments on Excepted Benefit HRAs and Comments Outside the Scope of This Rulemaking

Some commenters raised issues that relate to types of excepted benefits other than excepted benefit HRAs. For

example, several commenters requested that the Departments extend the pilot program for limited wraparound coverage.<sup>231</sup> One commenter requested that the Departments amend the criteria for health FSAs to incorporate the excepted benefit HRA, instead of adding a new excepted benefit HRA, to avoid the appearance of too many limited excepted benefits. Other commenters requested that the Departments address questions regarding fixed indemnity and hospital indemnity insurance. However, the proposed excepted benefit rules were limited to establishing criteria for certain HRAs to qualify as excepted benefits and, therefore, those comments are outside the scope of this rulemaking.

Notwithstanding that fact, the Departments do not intend to extend the pilot program for limited wraparound coverage, due to minimal take up and overlap with various other benefit options, including the new excepted benefit HRA, which, like the limited wraparound coverage excepted benefit, can be used for cost sharing under and expenses for services not covered by individual health insurance coverage, while not causing covered individuals to be ineligible for the PTC.

One commenter suggested that the excepted benefit HRA should only be allowed to be offered by an employer that has not previously offered health coverage, which the commenter appears to have suggested due to a concern about employers offering an excepted benefit HRA instead of comprehensive coverage. The Departments decline to limit excepted benefit HRAs in this way as the excepted benefit HRA is intended to provide flexibility and additional healthcare options to all employers and their employees. However, to the extent the commenter is concerned about plan sponsors no longer offering traditional group health plans, the Departments reiterate that in order to offer the excepted benefit HRA, a plan sponsor must also offer those eligible for the HRA a traditional group health plan.

Some commenters expressed confusion regarding the interaction of the excepted benefit HRA and the employer shared responsibility provisions under Code section 4980H. The Departments note for the sake of clarity, as explained earlier in this preamble, that coverage that consists solely of excepted benefits is not MEC.<sup>232</sup> Therefore, the offer of an excepted benefit by an employer is not considered to be an offer of MEC under an eligible employer-sponsored plan for

purposes of Code section 4980H. Although an employer will not avoid potential liability for a payment under Code section 4980H by virtue of an offer of an excepted benefit, including an excepted benefit HRA, the traditional group health plan that is required to be offered in order to offer the excepted benefit HRA would constitute an offer of MEC under an eligible employer-sponsored plan.<sup>233</sup>

One commenter inquired whether an individual enrolled in an excepted benefit HRA would have a special enrollment right in the employer's traditional group health plan if the individual had enrolled in STLDI and then coverage under the STLDI was rescinded because the individual became sick. The Departments clarify that under the special enrollment rules for group health plans, in general, an employee or dependent is eligible for special enrollment if they are otherwise eligible for the benefit package; when coverage under the plan was previously offered, the employee had group health plan or health insurance coverage; and then the employee loses eligibility for other coverage.<sup>234</sup> STLDI is health insurance coverage and, therefore, loss of eligibility for STLDI will create a special enrollment opportunity to enroll in a group health plan, if the employee otherwise satisfies the special enrollment opportunity requirements. However, under the special enrollment rules for individual market coverage, loss of eligibility for STLDI will not trigger an SEP in the individual market.<sup>235</sup>

Other comments not responsive to the provisions and topics addressed by the proposed rules, or otherwise beyond the scope of the proposed and final rules, are not addressed.

#### C. Interaction Between Individual Coverage HRAs and Excepted Benefit HRAs

Under the final rules, as under the proposed rules, a plan sponsor is permitted to offer an individual coverage HRA to a class of employees so long as it does not also offer a traditional group health plan to the same class of employees, subject to

<sup>233</sup> See Code section 4980H(a)(1) and (b)(1). See also 26 CFR 54.4980H-1(a)(14).

<sup>234</sup> See Code section 9801(f), ERISA section 701(f), and PHS Act section 2704(f). See also 26 CFR 54.9801-6(a)(2)(i) and (3)(i), 29 CFR 2590.701-6(a)(2)(i) and (3)(i), and 45 CFR 146.117(a)(2)(i) and (3)(i).

<sup>235</sup> See 45 CFR 155.420(d)(1)(i), which provides an SEP in the individual market only for loss of coverage that constitutes MEC. See also 45 CFR 147.104(b)(2) and 83 FR 38212, 38225 (Aug. 3, 2018) (stating that STLDI “. . . is not individual health insurance coverage, nor is it MEC.”).

<sup>231</sup> See 26 CFR 54.9831-1(c)(3)(vii), 29 CFR 2590.732(c)(3)(vii), and 45 CFR 146.145(b)(3)(vii).

<sup>232</sup> See Code section 5000A(f)(3).

additional applicable conditions discussed elsewhere in this preamble. However, a plan sponsor may only offer an excepted benefit HRA if traditional group health plan coverage is also made available to the employees who are eligible to participate in the excepted benefit HRA. Thus, a plan sponsor cannot offer both an individual coverage HRA and an excepted benefit HRA to any employee.<sup>236</sup>

### III. Overview of Final Rules Regarding the Premium Tax Credit—Department of the Treasury and the IRS

#### A. In General

Consistent with the objectives in Executive Order 13813 to expand the use of HRAs, the proposed rules included an amendment to the rules under Code section 36B to provide guidance for individuals who are offered or covered by an individual coverage HRA and who otherwise may be eligible for the PTC. As explained earlier in this preamble, an employee who is offered coverage under an eligible employer-sponsored plan, and an individual who may enroll in the coverage because of a relationship to the employee (a related individual), are not eligible for a PTC for any month the eligible employer-sponsored plan is affordable and provides MV.<sup>237</sup> Further, an employee or related individual who enrolls in an eligible employer-sponsored plan for a month is ineligible for a PTC for that month regardless of whether the coverage is affordable or provides MV.<sup>238</sup>

Because an HRA is a self-insured group health plan, under existing rules, an individual who is covered by an individual coverage HRA is ineligible for the PTC.<sup>239</sup> However, guidance was needed regarding the PTC eligibility of an individual who is offered, but opts out of, an individual coverage HRA, and, therefore, the Treasury Department and the IRS issued the proposed PTC rules.

Consistent with the rule for traditional group health plans under

Code section 36B and the existing rules thereunder, the proposed rules provided that an employee and a related individual offered an individual coverage HRA (a related HRA individual) would not be eligible for a PTC for any month the individual coverage HRA is affordable. Relatedly, the proposed rules provided that an affordable individual coverage HRA would be deemed to provide MV. Therefore, under the proposed rules, if an employee and a related HRA individual are offered an individual coverage HRA that is affordable, the employee and related HRA individual are ineligible for a PTC even if the employee opts out of the individual coverage HRA. However, an employee and a related HRA individual offered an individual coverage HRA that is not affordable will be eligible for the PTC (assuming they are otherwise eligible) if the employee opts out of the individual coverage HRA.

Commenters generally acknowledged that guidance was needed, and some commenters agreed with the proposed rules relating to the effect of an individual coverage HRA offer on an individual's PTC eligibility. However, a number of commenters expressed concern that the proposed rules would adversely affect lower-paid employees and their ability to obtain adequate subsidies for their healthcare coverage. The commenters pointed out that the PTC generally is more valuable than the individual coverage HRA would be for lower-paid employees. These commenters suggested that the individual coverage HRA would subsidize the cost of coverage for higher paid employees while making coverage more expensive, and likely out of reach, for the lower-paid employees who would have been eligible for a PTC but for the offer of an individual coverage HRA. Some commenters expressed a concern that the complexity of the rules would make it difficult for employees to make optimal decisions about their coverage and whether to opt out of the individual coverage HRA, with some noting a concern that employees may mistakenly opt out of an affordable individual coverage HRA because they believe that the opt-out preserves their PTC eligibility, only to find out that they have lost both PTC eligibility and the right to reimbursements under the individual coverage HRA. Some commenters expressed concern that employers might inadvertently offer an individual coverage HRA that leaves employees worse off than they would have been had the employer not offered the HRA, whether or not the employees

opt out of the arrangement. The Departments note that this concern, however, is mitigated by the fact that employers seek to maximize overall employee welfare in order to recruit and retain talented workers.

To address these concerns, some commenters suggested that employees who are otherwise eligible for the PTC should be allowed both the PTC and the individual coverage HRA offered to them by their employers. Other commenters suggested a rule to allow employees to choose between an individual coverage HRA and the PTC. Under this suggested rule, an employee would be able to opt out of the individual coverage HRA and receive the PTC in situations in which the PTC would provide a more generous subsidy than the individual coverage HRA. Employees would have this choice regardless of whether the individual coverage HRA was affordable or provided MV.

The final rules retain the rule as proposed that an employee and a related HRA individual are not eligible for a PTC for any month the employee is offered an individual coverage HRA that is affordable, even if the employee opts out of the arrangement. An individual coverage HRA is an eligible employer-sponsored plan for purposes of Code section 36B. Code section 36B(c)(2)(B) and 26 CFR 1.36B-2(a)(2) provide that an employee and a related individual who are offered coverage under an eligible employer-sponsored plan are not eligible for a PTC for any month that the eligible employer-sponsored coverage is affordable and provides MV. Under these provisions, an individual generally is ineligible for a PTC for a month in which the individual had an opportunity to enroll in affordable, MV employer-sponsored coverage, regardless of whether the individual actually chose to enroll. Therefore, Code section 36B and the applicable rules do not allow individuals to choose between an offer of employer-sponsored coverage that is affordable and that provides MV or Exchange coverage with a PTC. Furthermore, many of the concerns raised by commenters also apply to traditional group health plans; for example, lower-income individuals may be better off with the PTC than a traditional group health plan. Thus, consistent with the rules for traditional group health plans, the final rules retain the rule that a PTC is not allowed for any month in which the individual coverage HRA is affordable.

As to the suggestion by commenters that individuals should be allowed to both enroll in the individual coverage HRA and claim the PTC if otherwise

<sup>236</sup> The Departments note that an employer may not provide a QSEHRA to any employee if it offers any employee a group health plan. Accordingly, an employer may not provide a QSEHRA to any employee if it offers any employee an individual coverage HRA (which is a group health plan) or an excepted benefit HRA (which is a group health plan and which requires an offer of a traditional group health plan). See Code section 9831(d)(3)(B)(ii).

<sup>237</sup> Code section 36B and 26 CFR 1.36B-2(c)(3)(i).

<sup>238</sup> 26 CFR 1.36B-2(c)(3)(vii)(A).

<sup>239</sup> See the discussion earlier in this preamble of the related requirement under the final integration rules that plan sponsors provide participants with an annual opportunity to opt-out of and waive future reimbursements under an individual coverage HRA.

eligible, this is precluded by Code section 36B(c)(2)(C)(iii). Under that Code section, and as noted earlier in this preamble, an individual who is covered for one or more months by a group health plan, including an individual coverage HRA, is ineligible for the PTC for his or her Exchange coverage for those months. Therefore, the final PTC rules do not adopt this suggestion.

The Treasury Department and the IRS agree with commenters that some lower-paid employees may be adversely affected by an employer's offer of an individual coverage HRA because the PTC, if available, could provide a larger subsidy for the employee's Exchange coverage as compared to the individual coverage HRA. However, this dynamic already exists under current rules, as an individual may be required to pay a greater portion of his or her household income for a traditional group health plan than the individual would, in the absence of an offer of employer-sponsored coverage, have to pay for Exchange coverage with a PTC. Under Code section 36B(b)(3)(A) and current PTC rules, an individual's contribution amount for 2019 Exchange coverage may be as little as 2.08 percent of household income for an individual who claims the PTC whereas the same individual may have to pay up to 9.86 percent of household income for coverage offered by the individual's employer and still be considered to have an affordable offer and therefore ineligible for the PTC. Nevertheless, an employee in this situation is not permitted to forego the employer coverage and choose the Exchange coverage with a PTC to take advantage of the smaller contribution amount. Under the final rules, the same treatment applies to offers of an individual coverage HRA: That is, individuals are not allowed to forego an individual coverage HRA that is affordable (and thus deemed to provide MV) and instead choose the Exchange coverage with a PTC.

The Departments also appreciate the concerns expressed by commenters regarding the burden on employees to properly determine whether the HRA they have been offered is affordable and provides MV and whether they should opt out of the individual coverage HRA. These concerns are the primary reason that the Departments proposed to require employers that offer individual coverage HRAs to provide a written notice to each participant. The final rules strengthen the notice requirement and the Departments are providing model notice language regarding the PTC, separate from, but

contemporaneous with, the final rules. Further, the Departments will work closely with the State Exchanges to ensure that Exchanges' applications and other relevant materials are updated to assist individuals with an individual coverage HRA offer who are applying for, or considering applying for, individual health insurance coverage, in determining whether they are eligible for APTC.

Lastly, the Treasury Department and the IRS note that under the final rules, an individual coverage HRA may be integrated with Medicare, if certain conditions are satisfied. Individuals who are enrolled in Medicare for one or more months during the calendar year are not eligible for the PTC for their Exchange coverage for those months.<sup>240</sup> Therefore, the final PTC rules regarding when an offer of an individual coverage HRA is considered affordable are not relevant for individuals enrolled in Medicare. Those individuals are ineligible for the PTC without regard to whether they are offered or covered by an individual coverage HRA.<sup>241</sup>

#### *B. Use of Lowest Cost Silver Plan To Determine Affordability of an Individual Coverage HRA*

The proposed rules provided that an individual coverage HRA is affordable for an employee and a related HRA individual for a month if the employee's required HRA contribution does not exceed  $\frac{1}{12}$  of the product of the employee's household income and the required contribution percentage (defined in 26 CFR 1.36B-2(c)(3)(v)(C)). The proposed rules defined an employee's required HRA contribution as the excess of: (1) The monthly premium for the lowest cost silver plan for self-only coverage available to the employee through the Exchange for the rating area in which the employee

resides; over (2) the monthly self-only HRA amount provided by the employee's employer.<sup>242</sup> The monthly self-only HRA amount was proposed to be the self-only HRA amount newly made available to the employee under the individual coverage HRA for the plan year, divided by the number of months in the plan year the individual coverage HRA is available to the employee.

In the preamble to the proposed rules, the Treasury Department and the IRS explained that the lowest cost silver plan was chosen because, in the individual market, the lowest cost silver plan is the lowest cost Exchange plan for which the plan's share of the total allowed costs of benefits provided under the plan is certain to be at least 60 percent of such costs, as required by Code section 36B(c)(2)(C)(ii) for a plan to provide MV. In selecting the lowest cost plan for which it is certain that the plan's share of the total allowed costs of benefits provided under the plan will be at least 60 percent of such costs, the proposed rules sought to most closely approximate the PTC eligibility rules that apply to offers of eligible-employer sponsored coverage that is not an HRA.<sup>243</sup> The proposed rules also provided that an individual coverage HRA that is affordable is treated as providing MV, because the plan used to determine affordability will always provide MV and so an employee who is offered an affordable individual coverage HRA has the ability to purchase affordable coverage that provides MV. In the preamble to the proposed rules, the Treasury Department and the IRS requested comments on whether the lowest cost silver plan is the appropriate metal-level plan to use to determine affordability of an individual coverage HRA for PTC eligibility purposes.

A number of commenters advocated for retaining the proposed rule's use of the lowest cost silver plan as the

<sup>240</sup> See Code section 36B(c)(2)(B) and 26 CFR 1.36B-2(a)(2). An individual generally is eligible for Medicare if the individual meets the criteria for coverage under the program as of the first day of the first full month the individual may receive benefits under the program. See 26 CFR 1.36B-2(c)(2)(i). However, an individual who meets the criteria for eligibility for Medicare must complete the requirements necessary to receive benefits. See 26 CFR 1.36B-2(c)(2)(ii). An individual who fails by the last day of the third full calendar month following the event that establishes eligibility for Medicare to complete the requirements to obtain that coverage is treated as eligible for Medicare as of the first day of the fourth calendar month following the event that establishes eligibility. *Id.*

<sup>241</sup> The Treasury Department and the IRS are considering whether clarification is needed regarding how to determine whether an offer of an individual coverage HRA to an employee enrolled in Medicare is considered affordable and to provide MV for purposes of Code section 4980H. The Treasury Department and the IRS anticipate addressing that issue in guidance in the near term.

<sup>242</sup> If the employer offers an HRA that provides for a single dollar amount regardless of whether an employee has self-only or other-than-self-only coverage, the monthly maximum amount available to the employee is used to determine affordability. The monthly maximum amount was proposed to be the maximum amount available to the employee divided by the number of months in the plan year the individual coverage HRA is available to the employee.

<sup>243</sup> With regard to an offer of eligible employer-sponsored coverage that is not an HRA, an individual is eligible for the PTC for his or her Exchange coverage only if the employee's required contribution, which is the portion of the annual premium that would be paid for the lowest cost self-only MV coverage offered by the employer to the employee, exceeds a certain percentage of the employee's household income. See Code section 36B(c)(2)(C).

appropriate plan to determine affordability and MV of an individual coverage HRA for PTC eligibility. These commenters stated that although the lowest cost silver plan generally would have an actuarial value that is higher than is required to provide MV under a traditional group health plan, a bronze-level plan would not always be sufficient to provide MV.<sup>244</sup> Therefore, the commenters found the use of the lowest cost silver plan to be a reasonable approximation of the PTC eligibility rules that apply to offers of traditional group health plans.

Some commenters suggested using a gold-level plan to determine affordability, contending that the coverage benefits provided by a gold-level plan more closely resemble the coverage benefits under a traditional group health plan. According to these commenters, using a gold-level plan for the affordability determination would ensure that an employee who is offered an individual coverage HRA would not pay more for health coverage that provides fewer benefits than the employee would have paid for under either a traditional group health plan or Exchange coverage with a PTC.

Other commenters suggested that a bronze-level plan should be used for determining affordability of an individual coverage HRA, arguing that a bronze-level plan is comparable to coverage under a traditional group health plan which provides MV because a bronze-level plan generally has an actuarial value of 60 percent. According to these commenters, using a silver-level plan to determine affordability and MV for PTC eligibility would provide employees (and related HRA individuals) with greater coverage benefits than required under traditional group health plans.

A plurality of the commenters on the issue of the appropriate affordability plan suggested that the second lowest cost silver plan (SLCSP) should be used to determine the affordability of an individual coverage HRA. These commenters generally pointed to administrative ease and the affordability rules for QSEHRAs as the reasons for modifying the proposed rule. Under Code section 36B, a taxpayer who is eligible for the PTC computes his or her PTC amount using the premiums for the SLCSP available to the taxpayer. Therefore, the commenters asserted that

information concerning the premiums for a taxpayer's applicable SLCSP is already readily available to taxpayers and providing this information to taxpayers for their individual coverage HRA affordability determinations would not require additional Exchange resources. In addition, in light of the fact that the SLCSP is already used for certain PTC purposes, the commenters expressed concern that using premiums for the lowest cost silver plan instead of the SLCSP could lead to confusion and miscalculations. Commenters also noted that the premiums for the SLCSP are used to determine affordability for QSEHRAs. Some commenters expressed concern that using the lowest cost silver plan for affordability would result in three different affordability calculations depending on whether an employee was offered a traditional group health plan, a QSEHRA, or an individual coverage HRA. However, some commenters opposed the use of the SLCSP, contending that the higher premiums for a SLCSP, which may not always provide greater benefits than the lowest cost silver plan, do not warrant modifying the proposed rule's use of the lowest cost silver plan to determine affordability of an individual coverage HRA.

After consideration of the comments, the final rules adopt as proposed the use of the lowest cost silver plan for self-only coverage available through the Exchange in the rating area in which the employee resides to determine whether an individual coverage HRA is affordable. As explained in the preamble to the proposed rules, using the lowest cost silver plan to determine the affordability of an individual coverage HRA is consistent with, and most closely approximates, the rules that apply to an offer of a traditional group health plan, under which an offer is affordable if the employee's required contribution for the lowest cost, self-only MV coverage offered by the employer to the employee does not exceed a specified percentage of the employee's household income. Further, using the lowest cost silver plan, which will not have an actuarial value lower than 66 percent, to determine affordability of an individual coverage HRA ensures that the plan used to determine affordability will always provide MV. As a result, a determination that an individual coverage HRA is affordable, using this standard, is sufficient to ensure that an employee who is offered an affordable individual coverage HRA has the ability to purchase affordable coverage that provides MV. Therefore, the Treasury

Department and the IRS are also adopting as proposed the rule that an individual coverage HRA that is affordable is treated as providing MV.

The final rules result in consistent treatment for purposes of Code section 36B for employees offered an individual coverage HRA and employees offered a traditional group health plan. In both instances, the employees may be allowed the PTC if they decline the offer and the coverage is either unaffordable or does not provide MV. Further, in both instances, the employee's required contribution is based on the amount the employee must pay for self-only coverage that provides MV because under the final rules affordability is determined based on the lowest cost silver plan offered in the Exchange for the rating area in which the employee resides (which, by definition, will always provide MV). If the amount the employee must pay is more than the product of the required contribution percentage and the employee's household income, the employee may be allowed the PTC. As such, the final rules are consistent with the affordability and MV rules that apply to offers of traditional group health plans.

Although commenters suggested using a bronze-level or gold-level plan for the affordability determination, the final rules do not adopt either of those suggestions. Using a bronze-level plan could result in individuals being determined ineligible for the PTC based on the cost of a plan that does not provide MV under Code section 36B(c)(2)(C)(ii) (because a bronze plan may have an actuarial value as low as 56 percent). While use of a gold-level plan (which generally has an actuarial value no lower than 76 percent) would ensure that the plan used to determine affordability provides MV, it would be inconsistent with, and require the use of, a plan with a higher actuarial value than in the rules that apply for a traditional group health plan.

The final rules do not adopt the suggestion that the SLCSP plan be used for the affordability determination. The Treasury Department and the IRS acknowledge that the SLCSP applies for other PTC purposes, including calculation of the PTC amount and the determination of affordability of a QSEHRA. However, affordability for a traditional group health plan is based on the amount an employee would pay for a plan for which the share of the total allowed costs of benefits provided under the plan is at least 60 percent of such costs and the lowest cost silver plan, not the SLCSP, is the plan that most closely approximates that rule and provides consistency with these same

<sup>244</sup> In the individual market, a bronze plan may have an actuarial value of 56 percent, which would not ensure the plan's share of the total allowed costs of benefits provided under the plan is at least 60 percent of such costs, as required by Code section 36B(c)(2)(C)(ii) for a plan to provide MV. See 45 CFR 156.140.

rules as applied to traditional group health plans under Code section 36B. Consequently, the final rules provide a rule that is comparable to the affordability and MV rules that apply for traditional group health plans.

As to the concerns expressed by commenters regarding the potential for confusion for individuals due to the different health coverage arrangements that exist and the different PTC eligibility rules that apply, see earlier in this preamble for a discussion of the steps the Departments are taking to address those concerns, including providing a model notice that will explain the PTC consequences of an individual coverage HRA.

### C. Other Issues Under the PTC Rules

The proposed rules provided that the affordability of an individual coverage HRA for a related HRA individual would be based on the cost of self-only, not family, coverage available to the employee through the Exchange for the rating area in which the employee resides. One commenter stated that affordability of an individual coverage HRA should be based on the cost of Exchange coverage for all members of the employee's family offered the individual coverage HRA, not just the self-only cost. The final rules do not adopt this suggestion. Under 26 CFR 1.36B-2(c)(3)(v)(A)(2), an eligible employer-sponsored plan is affordable for a related individual if the portion of the annual premium the employee must pay for self-only coverage does not exceed a percentage of the employee's household income. Similarly, under Code section 36B(c)(4), the affordability of a QSEHRA for a spouse or dependent of an employee is based on the cost of self-only Exchange coverage to the employee. Consequently, the final rules are consistent with the existing rules for other types of employer coverage in providing that affordability of an individual coverage HRA for employees and related HRA individuals is based on the cost of self-only coverage.

One commenter stated that because of the likelihood of confusion in the early years on the part of taxpayers whose employers offer individual coverage HRAs, the IRS should waive the requirement that taxpayers increase their tax liability for excess APTC (the excess of a taxpayer's APTC over his or her allowed PTC) resulting from an offer of an affordable individual coverage HRA. Under Code section 36B(f)(2), a taxpayer must increase his or her tax liability for a taxable year by the excess of the APTC paid on the taxpayer's behalf over the PTC the taxpayer is allowed for the year, subject to a

limitation for taxpayers with household income less than 400 percent of the applicable federal poverty line for the taxpayer's family size. The Treasury Department and the IRS do not have the authority to suspend this statutory rule. Thus, the final rules do not adopt this suggestion. The Departments understand, however, that there is potential for taxpayer confusion about individual coverage HRAs and have taken measures to ensure that taxpayers are aware of the PTC implications of accepting or opting out of an individual coverage HRA. In particular, as described earlier in this preamble, the final integration rules require that an individual coverage HRA provide eligible participants with a written notice setting forth certain information about the individual coverage HRA, including the potential availability of PTC if they opt out of the HRA and the PTC eligibility consequences if they accept the HRA. Individuals applying for Exchange coverage will provide information about the individual coverage HRA they have been offered to the Exchange during the application process, which will help prevent the improper payment of APTC.

A few commenters raised issues regarding the application of the PTC rules to individual coverage HRAs that are negotiated pursuant to a CBA, with the commenters asking for special rules to account for the fact that CBAs are often negotiated over multiple years, including that the affordability status that is determined as of the effective date of a CBA should apply for all years covered by the CBA. The final rules do not adopt the suggestion that special rules should apply to employees covered by CBAs. The existing rules under Code section 36B do not include special rules for determining the affordability of traditional group health plans for employees covered by CBAs. In addition, such special rules would likely result in undue complexities for Exchanges and others. Thus, employees covered by CBAs must determine affordability consistent with the rules that apply to individuals not covered by such agreements.

A number of comments were received expressing concerns about the effective date for the final rules generally, but many with a specific focus on issues related to implementing the final PTC rules by 2020. These comments are addressed later in this preamble.

Also, commenters expressed concern about the availability of resources for verifying eligibility for APTC for individuals who are offered an individual coverage HRA. While Exchanges are required to verify certain

eligibility requirements that affect Exchange enrollees' APTC eligibility with electronic data sources, commenters stated that electronic data sources are not available to allow State Exchanges to verify APTC eligibility based on an offer of an individual coverage HRA. Commenters urged the Departments to dedicate additional funding to the State Exchanges for electronic verification of information about individual coverage HRA offers that consumers will be required to provide to Exchanges. In response to these comments, the Departments note that Congress generally appropriates funding for the federal government. The Departments do not generally have the authority to determine additional uses of funds beyond those established by Congress, including with respect to additional funding for State Exchanges.

One commenter asked that the Treasury Department and the IRS confirm which premium applies in determining the affordability of an individual coverage HRA if more than one premium is available for the lowest cost silver plan, for example, because there is one rate for tobacco users and one rate for non-tobacco users. Existing rules at 26 CFR 1.36B-3(e) provide that, in determining a taxpayer's SLSCP premium, a monthly premium may not include any adjustments for tobacco use. Consequently, in response to the commenter, the final rules provide that if there is a silver-level plan that has one rate for tobacco users and one rate for non-tobacco users, the rate for non-tobacco users will apply to determine affordability of the individual coverage HRA.

In addition, in the context of a traditional group health plan, existing rules at 26 CFR 1.36B-2(c)(3)(v)(A)(4) provide that nondiscriminatory wellness program incentives<sup>245</sup> that affect premiums are treated as earned in determining an employee's required contribution for purposes of affordability to the extent the incentives relate exclusively to tobacco use. The rules further provide that wellness program incentives that do not relate to tobacco use or that include a component unrelated to tobacco use are treated as not earned for this purpose. Consequently, the Treasury Department and the IRS are clarifying in these final rules that similar rules apply for purposes of determining the affordability of an individual coverage HRA. Thus, if a wellness program incentive is allowed in the individual

<sup>245</sup> For this purpose, the term "wellness program incentive" has the same meaning as the term "reward" in 26 CFR 54.9802-1(f)(1)(i).

market, the lowest cost silver plan premium will be determined without regard to any premium discount or rebate under that program unless the wellness program incentive relates exclusively to tobacco use.

The final rules also address a situation in which the silver-level QHP used to determine a taxpayer's lowest cost silver plan at enrollment later terminates or closes to enrollment during the plan year. Specifically, the final rules provide that, in such a case, the silver-level QHP that is used to determine a taxpayer's lowest cost silver plan will not cease to be the taxpayer's lowest cost silver plan solely because the plan later terminates or closes to enrollment. However, a taxpayer's lowest cost silver plan used to determine affordability could change during the tax year under other circumstances, such as if the taxpayer moves into a different rating area.

With respect to which HRA amounts are taken into account in determining affordability, the proposed rules provided that only amounts that are newly made available and that are determinable within a reasonable period of time before the beginning of the plan year of the HRA are considered. The proposed rules further provided that amounts made available from a prior plan year that carry over to the current plan year are not taken into account. The final rules retain these provisions and also provide that, similarly, amounts made available under an HRA to account for amounts remaining in a different HRA the employer previously provided to the employee and under which the employee is no longer covered are not taken into account for purposes of determining affordability. This clarification is generally intended to address the situation in which an employee moves between classes of employees and, as a result, moves between different HRAs, as discussed earlier in this preamble.

One commenter asked the Treasury Department and the IRS to clarify the application of the PTC rules to an employee opting out of, or accepting, an individual coverage HRA with a non-calendar year plan year.<sup>246</sup> As noted

<sup>246</sup> An employee who opts out of a non-calendar year individual coverage HRA, like an employee who opts out of a non-calendar year traditional group health plan, may qualify for an individual market SEP based on the employee's enrollment in a non-calendar year plan that is ending, regardless of whether he or she has the option to renew, per 45 CFR 155.420(d)(1)(ii). The employee may, therefore, choose to change his or her individual health insurance plan, though his or her plan options may be restricted based on 45 CFR 155.420(a)(4)(iii). Regardless of whether an employee changes his or her plan, an employee

earlier in this preamble, the final integration rules clarify that individual coverage HRAs must provide participants with one advance opportunity to opt into, or out of, the individual coverage HRA for each plan year, but generally may not provide participants multiple opportunities to opt into, or out of, the individual coverage HRA over the course of the plan year. In addition, the final PTC rules provide specific rules to determine affordability of an individual coverage HRA for each employment period that is less than a full calendar year or for the portions of the plan year of an individual coverage HRA that fall in different taxable years of a taxpayer. Although affordability of an individual coverage HRA and thus eligibility for PTC generally are determined on a monthly basis, the opt-out rules and the part-year affordability rules work in conjunction with the employee safe harbor to provide a taxpayer with an affordability determination that generally will apply for the entire plan year of the individual coverage HRA, barring any change in circumstance of the taxpayer. For example, if a taxpayer opts out of an individual coverage HRA that begins on July 1, 2020, and an Exchange determines that the HRA is unaffordable and the taxpayer is eligible for APTC, the employee safe harbor in the final rules provides that the HRA generally will be treated as unaffordable for the entire plan year of the HRA (from July 1, 2020–June 30, 2021). If the taxpayer decides to forego both APTC and the individual coverage HRA and pay the enrollment premium out-of-pocket, the taxpayer still may claim PTC on a tax return for the months the individual coverage HRA was unaffordable if the taxpayer otherwise is eligible for PTC.<sup>247</sup>

#### *D. Employer Shared Responsibility Provisions Under Code Section 4980H*

As part of implementing the objectives of Executive Order 13813, the

who is enrolled in Exchange coverage and opts out of an HRA when permitted to do so may apply to the Exchange for a redetermination of APTC eligibility.

<sup>247</sup> The proposed rules also clarified how the generally applicable employer-sponsored coverage PTC eligibility rules apply to individual coverage HRAs. The Treasury Department and the IRS are finalizing those rules as proposed. Further, existing guidance addresses when amounts newly made available under an HRA count toward the affordability or MV of another group health plan offered by the same employer. See 26 CFR 1.36B-2(c)(3)(v)(A)(5) and 26 CFR 1.36B-6(c)(4). See also IRS Notice 2015-87, Q&A-7. As under the proposed rules, the final rules do not make substantive revisions to those rules but do make clarifying updates to 26 CFR 1.36B-2(c)(3)(v)(A)(5), mainly to incorporate a reference to more recent guidance.

Treasury Department and the IRS are considering how Code section 4980H applies to an employer offering an individual coverage HRA.

Only ALEs are subject to Code section 4980H.<sup>248</sup> For an employer that is an ALE, the employer may owe a payment for a month under Code section 4980H(a) or Code section 4980H(b) or neither. In general, an ALE will owe a payment under Code section 4980H(a) if it fails to offer an eligible employer-sponsored plan to at least 95 percent of its full-time employees and their dependents and at least one full-time employee is allowed the PTC for the month.<sup>249</sup> An ALE that offers an eligible employer-sponsored plan to at least 95 percent of its full-time employees and their dependents (and therefore is not liable for a payment under Code section 4980H(a)) may be liable for a payment under Code section 4980H(b) if at least one full-time employee is allowed the PTC, which may occur if the eligible employer-sponsored plan offered is not affordable or does not provide MV, or if the employee was not offered coverage.

On November 19, 2018, the Treasury Department and the IRS released Notice 2018-88 which addressed the application of Code section 4980H to ALEs offering individual coverage HRAs. In order to provide clarity to stakeholders, Notice 2018-88 explained how Code section 4980H would apply to an ALE that offers an individual coverage HRA, described potential additional affordability safe harbors, requested comments, and provided examples.

The Treasury Department and the IRS intend to propose rules under Code section 4980H on the issues addressed in Notice 2018-88, taking into account the comments received. To the extent comments were received on the proposed integration rules specific to the application of Code section 4980H to employers offering individual coverage HRAs, those comments will be addressed in the preamble to the proposed rules under Code section 4980H.

<sup>248</sup> The explanation of Code section 4980H provided here is a summary. For a complete explanation of the rules, including for definitions of terms used in this summary, see 26 CFR 54.4980H-1, *et seq.* (79 FR 8544 (Feb. 12, 2014)).

<sup>249</sup> Note that if an ALE offered coverage to all but five of its full-time employees (and their dependents), and five is greater than 5 percent of the employer's full-time employees, the employer will not owe an employer shared responsibility payment under Code section 4980H(a). See 26 CFR 54.4980H-4(a).

#### IV. Overview of the Final Rules Regarding Individual Health Insurance Coverage and ERISA Plan Status

##### A. In General

The proposed rules included an amendment to DOL rules defining the ERISA terms “employee welfare benefit plan,” “welfare plan,” and, derivatively “group health plan,” so that these terms would not include individual health insurance coverage, the premiums of which are reimbursed by an HRA and certain other arrangements, under certain conditions. As explained in the preamble to the proposed rules, the objective in proposing this clarification was to provide clarity and assurance to employees; employers, employee organizations, and other plan sponsors; health insurance issuers; state insurance regulators; and other stakeholders. Specifically, the objective was to provide assurance that the insurance policies sold as individual health insurance coverage (that is, policies generally subject to comprehensive federal and state individual market rules for minimum and uniform coverage, standardized rating requirements, guaranteed availability, and guaranteed renewability) would not be treated as part of an HRA or certain other arrangements for purposes of ERISA if certain conditions were satisfied.<sup>250</sup> Specifically, DOL proposed an amendment to 29 CFR 2510.3–1 on the definition of “employee welfare benefit plan” in ERISA section 3(1).<sup>251</sup> This proposed amendment would apply to individual health insurance coverage purchased through individual coverage HRAs. It would also apply to individual health insurance coverage purchased through certain other arrangements that reimburse participants for the purchase of individual health insurance coverage that are not subject to the market requirements (including QSEHRAs and HRAs that have fewer than two participants who are current employees on the first day of the plan year). Further, this proposed amendment would apply to an arrangement under which an employer allows employees to pay the portion of the premium for off-

Exchange individual health insurance coverage that is not covered by the HRA with which the coverage is integrated by using a salary reduction arrangement under a cafeteria plan (supplemental salary reduction arrangement).<sup>252</sup>

ERISA section 3(1) broadly defines ERISA-covered welfare plans to include “any plan, fund, or program” that is “established or maintained by an employer or employee organization” for the provision of health benefits “through the purchase of insurance or otherwise.” At the same time, however, provisions in the PHS Act generally treat individual health insurance and group health insurance as mutually exclusive categories.<sup>253</sup> If individual health insurance coverage were considered to be a group health plan or part of a group health plan, the individual health insurance coverage typically would violate some of the group market requirements (for example, the single risk pool requirement for the small group market; the rating rules for the small group market; or the separate medical loss ratio requirements for large group insurance coverage, which is lower than that for individual or small group insurance).<sup>254</sup> As explained in the preamble to the proposed rules, treatment of such individual health insurance coverage as subject to both individual market and group market requirements thus would likely result in conflicting requirements, uncertainty and confusion which could inhibit or, in some instances, even preclude, the ability to integrate HRAs with individual health insurance coverage as contemplated by other provisions in the proposed rules.<sup>255</sup> Accordingly, DOL concluded that the ERISA status of this type of individual health insurance

coverage should be clarified. Under the proposed rules, the individual health insurance coverage that is paid for by the HRA<sup>256</sup> is not covered by ERISA Title I if all of the conditions of the safe harbor are satisfied. The conditions in the safe harbor incorporate criteria well-recognized under similar ERISA safe harbor rules and under case law, where similar arrangements are considered to be exempt from ERISA Title I.

Under the proposed rules, the status under ERISA of an HRA, QSEHRA, or supplemental salary reduction arrangement would remain unaffected. Rather, the proposed rules clarified that individual health insurance coverage selected by the employee in the individual market and reimbursed by such a plan is not part of a group health plan, is not health insurance coverage offered in connection with a group health plan, and is not a part of any employee welfare benefit plan for purposes of ERISA Title I, provided all the following conditions are satisfied:

1. The purchase of any individual health insurance coverage is completely voluntary for employees.<sup>257</sup>
2. The employer, employee organization, or other plan sponsor does not select or endorse any particular issuer or insurance coverage.
3. Reimbursement for non-group health insurance premiums is limited solely to individual health insurance coverage.
4. The employer, employee organization, or other plan sponsor receives no consideration in the form of cash or otherwise in connection with the employee’s selection or renewal of any individual health insurance coverage.<sup>258</sup>

<sup>252</sup> While the proposed rule under 29 CFR 2510.3–1(l) included in the term “supplemental salary reduction arrangement” cafeteria plan salary reduction arrangements paying premium amounts not covered by a QSEHRA, these final rules do not. See Code section 9831(d)(3)(B)(ii) and IRS Notice 2017–67, Q&A–55 (employer may allow employee to pay the excess of a health insurance premium over the amount paid by the QSEHRA with an after-tax payroll deduction (in contrast to a pre-tax salary reduction)).

<sup>253</sup> See ERISA section 733(b)(4) and PHS Act sections 2791(b)(4), (5), and (e)(1). See also 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103.

<sup>254</sup> See PPACA section 1312 (which defines each issuer’s enrollees in the individual market to be members of a single risk pool, and each issuer’s enrollees in the small group market to be members of a separate single risk pool, unless a state has opted to merge the risk pools), PHS Act section 2701 (which sets forth maximum age rating ratios in the individual and small group markets), and PHS Act section 2718 (which sets forth medical loss ratio requirements that differ based on market).

<sup>255</sup> 83 FR 54420, 54441 (Oct. 29, 2018).

<sup>256</sup> For simplicity and readability, the discussion in this section IV of the preamble generally refers simply to HRAs, although it is intended to also capture other account-based group health plans, QSEHRAs and supplemental salary reduction arrangements. If the term HRA is intended to refer only to HRAs in this section IV, it will be clear from context. Moreover, the title of paragraph (l) of the DOL final rule is amended to refer to a “Safe harbor for health reimbursement arrangements (HRAs) and certain other arrangements that reimburse individual health insurance coverage,” to better reflect the regulatory text that follows.

<sup>257</sup> The fact that a plan sponsor requires the coverage to be purchased as a condition for participation in an HRA or supplemental salary reduction arrangement does not make the purchase involuntary. This issue should not arise in the context of a QSEHRA because in that case, although individuals must be enrolled in MEC, employers may not require employees to enroll in individual health insurance coverage.

<sup>258</sup> The limitation on employers, employee organizations, and other plan sponsors receiving consideration from an issuer or person affiliated with an issuer in connection with any participant’s purchase or renewal of individual health insurance coverage was not intended to change any ERISA requirements governing the circumstances under

<sup>250</sup> 83 FR 54420, 54440 (Oct. 29, 2018). For examples of other circumstances under which DOL has determined an arrangement is not a plan within the meaning of ERISA, see 29 CFR 2510.3–1(j), 29 CFR 2510.3–2(f), and 29 CFR 2509.99–1. See also DOL Field Assistance Bulletins No. 2004–01 and No. 2006–02.

<sup>251</sup> In light of the fact that “group health plan” is defined derivatively in ERISA section 733(a)(1), in relevant part, as an “employee welfare benefit plan to the extent that the plan provides medical care . . . directly or through insurance, reimbursement, or otherwise[.]” DOL has concluded that a separate rule relating to the definition of group health plan is not required.

5. Each plan participant is notified annually that the individual health insurance coverage is not subject to ERISA.

Current rules issued by the Departments define “group health insurance coverage” as health insurance coverage offered in connection with a group health plan.<sup>259</sup> The proposed rules included an amendment to clarify that—subject to certain conditions—individual health insurance coverage is not group health insurance coverage (or “health insurance offered in connection with a group health plan”). This amendment was intended to ensure consistency and avoid any potential conflicting interpretations regarding individual health insurance coverage. Accordingly, if the conditions in 29 CFR 2510.3–1(1) were satisfied, the individual health insurance coverage would not be “health insurance coverage offered in connection with a group health plan” for purposes of ERISA, the PHS Act, the Code, and PPACA, even though the premiums are reimbursed by an HRA.<sup>260</sup>

After consideration of the comments, the conditions set forth in the proposed amendment to 29 CFR 2510.3–1, and the proposed amendment to the Departments’ rules defining “group health insurance coverage,” are being finalized without significant change, but with minor clarifications in response to comments.

#### B. Safe Harbor

The preamble to the proposed rules referred to the proposed amendment as a clarification. Some commenters asked DOL to clarify whether the conditions established in the proposed amendment would be considered a safe harbor, or absolute requirements for plan sponsors. These commenters asserted that it was unclear and expressed concern about the potential unintended consequences of non-compliance and confusion if all individual health insurance coverage reimbursed under an arrangement that did not satisfy the proposed criteria of the rule was treated as being subject to ERISA. Examples highlighted by commenters include how requirements under other federal laws such as HIPAA, the Paul Wellstone and Pete

which plans, including HRAs, may reimburse employers, employee organizations and other plan sponsors for certain expenses associated with administration of the plan.

<sup>259</sup> 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103.

<sup>260</sup> Note that the clarification with respect to the meaning of group health insurance coverage is not relevant for QSEHRAs because QSEHRAs generally are not group health plans. See Code section 9831(d)(1), ERISA section 733(a)(1), and PHS Act section 2791(a)(1).

Domenici Mental Health Parity and Addiction Equity Act of 2008, and PPACA would apply to the coverage (including the single risk pool requirement, the rating rules for the small group market, or the medical loss ratio requirements, as well as the PPACA section 9010 health insurance fee), whether health insurance issuers could be considered plan fiduciaries, and whether participants could bring legal actions against health insurance issuers under ERISA’s private right of action provisions. They also stated that factors outside of a plan sponsor’s control could result in the employer not satisfying the conditions of the rules. As one example, a commenter suggested that an insurance broker could endorse an insurance product in the context of a private exchange without the employer’s knowledge, possibly resulting in a failure to satisfy the condition that the plan sponsor not select or endorse any particular issuer or insurance coverage.<sup>261</sup> These commenters suggested that flexibility would be appropriate to account for plan sponsors that make reasonable, good faith efforts to comply with the conditions in the proposed amendment but make de minimis errors.

As noted earlier in this section of the preamble, DOL has set forth several safe harbors in other rules and guidance under which DOL has determined an arrangement is not a plan within the meaning of ERISA.<sup>262</sup> These safe harbors are intended to clearly define circumstances in which a workplace arrangement falls outside of the scope of a plan under ERISA without necessarily specifying all the circumstances under which a workplace arrangement could avoid ERISA plan status. Here, too, DOL intended the proposed rules to constitute a safe harbor, as reflected in language in the proposed amendment providing that an ERISA plan “shall not include” individual health insurance coverage. The final rules make clear that the rule is a safe harbor.

The conditions of the various regulatory safe harbors noted earlier in this preamble are highly sensitive to the particular type of plan at issue, and the particular legal and factual context associated with that type of plan. Accordingly, DOL cautions that the

<sup>261</sup> DOL notes that “private exchange” is a term that was not specifically defined in any public comments and is similarly undefined in this preamble. It is generally meant to refer to a tool or web-based platform that facilitates individuals’ enrollment in the coverage of their choice. The term does not include any entity that meets the definition of an “Exchange” in 45 CFR 155.20.

<sup>262</sup> See 29 CFR 2510.3–1(j), 29 CFR 2510.3–2(f), and 29 CFR 2509.99–1. See also DOL Field Assistance Bulletins No. 2004–01 and No. 2006–02.

particular conditions of the safe harbor provided here are not directly relevant to other types of plan arrangements, such as retirement plans, life insurance plans, or disability plans. In particular, the employer’s funding of a benefit arrangement, in most circumstances, is sufficient to preclude the grant of a safe harbor. In the particular context of the individual health insurance policies at issue here, however, DOL has concluded that employer funding is not disqualifying based on its conclusion that Congress generally intended that individual and group health insurance coverage be regulated as mutually exclusive categories. In this unique context, DOL has concluded that employer funding, by itself, is an insufficient basis for treating the individual health insurance policy, as opposed to the HRA, as part of an ERISA-covered plan.

#### C. An Employer, Employee Organization, or Other Plan Sponsor May Not Select or Endorse Any Particular Issuer or Insurance Coverage

Paragraph 1)(2) of the proposed amendment required that the employer, employee organization, or other plan sponsor may not select or endorse any particular issuer or insurance coverage. The proposed rules clarified that an HRA plan sponsor would not be considered to have endorsed a particular issuer or insurance coverage if, for example, the plan sponsor offered general contact information regarding availability of health insurance in a state (such as providing information regarding *HealthCare.gov* or contact information for a state insurance commissioner’s office) or providing general health insurance educational information (such as the uniform glossary of health coverage and medical terms available at: <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf>).

Some commenters asked DOL to provide additional guidance on what types of activities would or would not constitute endorsement. These commenters stated that it would be important to provide HRA plan sponsors with flexibility to permit them to help employees shop for coverage, especially because many might be unfamiliar with the processes associated with obtaining health insurance in the individual market. Several commenters asked whether there would be circumstances in which a plan sponsor could connect participants or beneficiaries with an insurance agent or

broker without running afoul of the prohibition on endorsement. A few commenters asked whether, or under what circumstances, an HRA could be offered in connection with a private exchange where participants could make a selection from a set of coverage options. One commenter stated that without an ability to use a private exchange model, most employers will be reluctant to offer an individual coverage HRA over a traditional group health plan, thereby undermining the purpose of the proposed rules to expand use and availability of HRAs. One commenter stated that DOL should incentivize the use of private exchanges that would provide price and quality transparency as well as navigational support for plan participants shopping for individual health insurance coverage, and possibly even require that private exchanges offer QHPs. Another commenter urged DOL to ensure that private exchanges could not be used in a manner that harms the risk pools or that is anti-competitive and promotes one issuer over another. This commenter suggested that the final rules specify that an employer cannot use an individual coverage HRA in conjunction with a plan purchased through a private exchange unless the private exchange is designed in such a way as not to constitute selection or endorsement by the employer.

A plan sponsor may provide assistance to participants and beneficiaries in shopping for individual health insurance coverage without being considered to endorse any particular coverage if that assistance is unbiased, neutral, uniformly available, and does not steer participants and beneficiaries towards a particular health insurance issuer or coverage. For example, an HRA plan sponsor could accommodate requests from insurance brokers to speak with employees or distribute informational materials at their worksite, so long as such accommodations are granted on an equal basis and also without any preference for brokers that represent a particular firm or have a relationship with a certain health insurance issuer.

DOL agrees with commenters that the use of private exchanges may be a helpful tool in shopping for coverage. However, DOL declines to adopt suggestions regarding adding incentives or requirements with respect to transparency standards, navigational support, or offering QHPs because any such rules are beyond the scope of this rulemaking.

Moreover, a private exchange may be designed in a way that satisfies the conditions of 29 CFR 2510.3–1(l), in

which case individual health insurance coverage purchased through the private exchange would not be considered group health plan coverage. Alternatively, a private exchange could be designed in a way that limits employees' choice of issuer, or promotes certain issuers or coverage options over others. In that case, coverage offered through the private exchange would not satisfy the prohibition on endorsement in the safe harbor. The final rules provide a new option for employers to offer individual coverage HRAs together with private exchanges that work with all individual market insurance issuers in a neutral and unbiased fashion, and maintain the individual insurance nature of the individual health insurance coverage.

For example, under the final rules, an employer could maintain (or contract with) a tool or web-based platform that displays information about all coverage options in a state and facilitates enrollment. However, to be eligible for the safe harbor, the platform would be required to present all available coverage options in a way that is entirely neutral. The platform could not be designed or operated in a way that limits users' ability to select a coverage option that would otherwise be available to them or that promotes one option over another (for example, with "recommended" or "starred" listings), or the prohibition on endorsement would not be satisfied. However, an otherwise neutral platform that allows users to select certain criteria (such as a platform that allows participants to search for an HDHP or plans that contained specific providers in their network) and search for coverage options that fulfilled these criteria would not be considered to be an endorsement by the employer of any particular coverage, and would not violate this requirement of the final rule.

#### *D. Reimbursement for Non-Group Health Insurance Premiums Must Be Limited Solely to Individual Health Insurance Coverage*

Paragraph (l)(3) of the proposed amendment would require that reimbursement for non-group health insurance premiums must be limited solely to individual health insurance coverage, as defined in 29 CFR 2590.701–2.<sup>263</sup> DOL included this

<sup>263</sup> While the HRA's reimbursement of non-group health insurance premiums is limited solely to individual health insurance coverage that does not consist solely of excepted benefits, the HRA may reimburse Medicare premiums for Medicare beneficiaries as permitted under 29 CFR 2590.702–2 without causing the reimbursement of individual

condition in order to limit the application of the proposed safe harbor to determining whether insurance policies sold as individual health insurance coverage would be treated as part of an employee welfare benefit plan subject to ERISA.

Several commenters asked DOL to clarify whether arrangements that provide reimbursement for individual health insurance coverage that consists solely of excepted benefits (for example, standalone limited-scope dental benefits) could be considered to satisfy the proposed safe harbor. For the reasons explained earlier in this section of the preamble, in DOL's view, the proposed safe harbor was a necessary clarification for the types of individual health insurance coverage that might be reimbursed by an individual coverage HRA or QSEHRA. However, coverage that is sold in the individual market that provides only excepted benefits is not subject to the market requirements and does not present the same concerns about incompatible individual and group market regulatory regimes. Thus, the proposed safe harbor was not intended to address excepted benefit policies sold in the individual market. The final rules include additional language to make this clearer.

In the preamble to the proposed rules, DOL also invited comments regarding which forms of payment are appropriately treated as "reimbursement" to participants for this purpose. DOL asked whether, for example, "reimbursement" should be interpreted to include direct payments, individual or aggregate, by the employer, employee organization, or other plan sponsor to the insurance company.

Commenters generally favored an expansive interpretation of the types of payments that should be treated as reimbursements. These commenters argued that permitting employers to pay health insurance issuers directly would promote administrative simplicity, and would enable plan sponsors to substantiate that participants and beneficiaries are enrolled in individual health insurance coverage, as the final integration rules require. Some commenters asserted that "reimbursement" should be interpreted in a manner consistent with current industry practices for account-based plans, which permit the transfer of employer funds to debit cards that can be used to pay for certain qualified medical expenses. One commenter also stated that it should not matter whether

health insurance coverage premiums for other individuals to fall outside the safe harbor.

employer funds paid from an HRA go directly to a participant or a health insurance issuer because the economic substance of the transaction is the same—that is, the funds are being used to discharge an employee's premium payment obligations.

DOL agrees with these commenters and, under the final rules, “reimbursement” may include employee-initiated payments made through use of financial instruments, such as pre-paid debit cards, as well as direct payments, individual or aggregate, by the employer, employee organization, or other plan sponsor to the health insurance issuer.<sup>264</sup> However, DOL cautions that plan sponsors should take care to ensure that payment practices do not violate the prohibition on endorsements by effectively limiting participants' and beneficiaries' ability to select certain coverage options or favoring certain issuers or coverage options. For example, if a plan sponsor were to establish procedures for sending direct payments to health insurance issuers, but those procedures excluded certain health insurance issuers, or placed additional burdens on HRA participants if they chose health insurance coverage offered by some health insurance issuers, rather than others, the procedure would be considered an endorsement, and the criteria of the safe harbor would not be satisfied.

*E. The Employer, Employee Organization, or Other Plan Sponsor Receives No Consideration in Connection With the Employee's Selection or Renewal of Any Individual Health Insurance Coverage*

Paragraph (l)(4) of the proposed amendment would require that an employer, employee organization, or other plan sponsor receive no consideration in the form of cash or otherwise in connection with the employee's selection or renewal of any individual health insurance coverage. Commenters requested more specific guidance on how a plan may comply with this condition.

As stated in the preamble to the proposed rules, this limitation in the DOL safe harbor rule for HRAs was focused on employers, employee organizations, and other plan sponsors

receiving consideration, including from an issuer or person affiliated with an issuer in connection with any participant's purchase or renewal of individual health insurance coverage. The preamble to the proposed rules also explained that the provision was not intended to change any ERISA requirements governing the circumstances under which ERISA plans, including HRAs, may reimburse employers, employee organizations and other plan sponsors for certain expenses associated with administration of the plan.<sup>265</sup>

The requirement in the DOL final rule is different from the “no compensation” criteria established in the safe harbor rules regarding certain group or group-type insurance programs established at 29 CFR 2510.3–1(j)(4) and individual retirement accounts (IRAs) established at 29 CFR 2510.3–2(d)(iv). In the case of those rules, there is no ERISA plan, and the rules limit permissible compensation that an employer can receive, including from third parties, to reasonable compensation, excluding any profit, for administrative services actually rendered in connection with forwarding employee contributions to the insurer or IRA provider through payroll deductions or dues checkoffs.

In the context of the DOL final rule, the HRA is generally an ERISA-covered plan and the issue is the extent to which the plan sponsor of the HRA could receive payments from the HRA or third parties. As noted above, the preamble to the proposed rules explained that the rule was not intended to change any ERISA requirements governing the circumstances under which ERISA plans, including HRAs, may reimburse employers, employee organizations and other plan sponsors for expenses associated with administration of a plan. Thus, in the case of plan assets being used for HRA related payments, reimbursement could not be made for expenses associated with settlor functions and activities.<sup>266</sup> The fiduciary prohibitions in ERISA section 406(a) and 406(b) also would apply in such cases, so that any reimbursements would need to be permissible under ERISA section 408(b)(2) and 29 CFR 2550.408b–2(e). Subparagraph (e)(3) of those rules states: “If a fiduciary provides services to a plan without the receipt of compensation or other consideration (other than reimbursement of direct expenses properly and actually incurred in the performance of such services within the meaning of 2550.408c–2(b)(3)), the

provision of such services does not, in and of itself, constitute an act described in section 406(b) of the Act.” ERISA section 408(c) and 29 CFR 2550.408c–2 place additional restrictions on compensation for services in the case of a fiduciary who is already receiving full-time pay from an employer or employee organization sponsoring the plan. However, in the case of an unfunded HRA, with payments from the HRA made solely out of an employer's general assets, there would not be any plan assets; thus, there could be no payments to the employer from plan assets. Moreover, in the case of such an unfunded HRA, it seems extremely unlikely that an employer would apply debits to the notional employee accounts that are part of the HRA to “reimburse” itself from the HRA for expenses associated with sponsoring the HRA. Finally, in DOL's view, receipt of compensation from third parties to cover the cost of operating the HRA would be prohibited payments in connection with the employee's selection or renewal of any individual health insurance coverage, and, therefore, not permissible under paragraph (l)(4) of the final rules. Accordingly, such receipt of compensation would not be permissible under paragraph (l)(4) of the final rules.

*F. Each Plan Participant Must Be Notified Annually That the Individual Health Insurance Coverage Is Not Subject to ERISA*

Paragraph (l)(5) of the proposed amendment included a requirement that plans provide an annual notice to participants stating that individual health insurance coverage funded through an HRA is not subject to the requirements of ERISA. For an individual coverage HRA, the notice must satisfy the requirements set forth in the final integration rules at 29 CFR 2590.702–2(c)(6), discussed earlier in this preamble. For a QSEHRA or an HRA that is not subject to 29 CFR 2590.702–2(c)(6) (such as a retiree-only HRA), the proposal set forth model language to satisfy the condition.<sup>267</sup> The preamble to the proposed rules also explained that a supplemental salary reduction arrangement need not provide the required notice; instead, the notice

<sup>264</sup> Any direct payment should include an affirmative act by the employee requesting that the employer or plan administrator make the payment, as part of the enrollment process or otherwise. For example, as part of the insurance enrollment process, the employee might direct the employer or plan administrator to begin making monthly premium payments for so long as the employee remains enrolled in the individual health insurance coverage and remains eligible for HRA benefits.

<sup>265</sup> 83 FR 54420, 54442 (Oct. 29, 2018).

<sup>266</sup> See DOL Advisory Opinion 2001–01A.

<sup>267</sup> As stated in the preamble to the proposed rules, in DOL's view, the SPD for the HRA, QSEHRA, or other ERISA plan would fail to satisfy the style, format, and content requirements in 29 CFR 2520.102–3 unless it contained a discussion of the status of the HRA or QSEHRA and the individual health insurance coverage under ERISA sufficient to apprise the HRA or QSEHRA plan participants and beneficiaries of their rights and obligations under the plan and ERISA Title I. 83 FR 54420 at 54441 (Oct. 29, 2018).

could be provided by the HRA that the salary reduction arrangement supplements.<sup>268</sup> DOL invited comment on whether it would be helpful to issue additional rules or guidance addressing the application of ERISA reporting and disclosure requirements to HRAs integrated with such non-ERISA individual health insurance coverage (for example, SPD content and Form 5500 annual reporting requirements).

Commenters requested that DOL confirm that HRAs are subject to the reporting and disclosure requirements of ERISA, such as the SBC or (for plans of applicable size) the Form 5500 Annual Report. These commenters said that reporting and disclosure should be revised to allow state regulators and Exchanges to gather necessary information about the use of HRAs. One commenter also urged DOL to ensure that these requirements did not discourage employers from offering individual coverage HRAs to their employees by preserving, for example, any exemptions from filing reports for small businesses, or allowing the filing of simpler reports, such as the Form 5500-SF. Another commenter urged DOL to review the current required information, notices and disclosures that plan sponsors must convey to plan participants and beneficiaries and to simplify, combine or eliminate unnecessary or redundant material.

After considering the comments and feedback received from stakeholders, DOL has determined that adding additional new, potentially redundant<sup>269</sup> disclosure requirements beyond the scope of the proposed rules is not necessary. For example, individual coverage HRAs are group health plans and must, therefore, provide participants with an SBC.<sup>270</sup> ERISA also contains comprehensive reporting requirements that apply to group health plans, such as HRAs,<sup>271</sup> and DOL has determined that adding or changing those reporting requirements with respect to HRAs is not necessary at this time. In certain situations, DOL has provided for exemptions or reporting exemptions and simplified disclosure requirements.<sup>272</sup> Provided they satisfy

the requirements under applicable DOL rules, HRAs and their administrators remain eligible for this relief.

#### G. Comments Outside the Scope

Some commenters raised issues relating to the separate safe harbor for certain group or group-type insurance programs at 29 CFR 2510.3-1(j).<sup>273</sup> Several commenters asked DOL to clarify whether other types of coverage, such as health care sharing ministries, might be considered part of an employee welfare benefit plan subject to ERISA if they were paid for through an HRA, QSEHRA, or supplemental salary reduction arrangement. The safe harbor is intended to provide assurance to stakeholders that insurance policies sold as individual health insurance coverage, and that are generally subject to comprehensive federal (and state) individual market rules, would not be treated as part of an employee welfare benefit plan subject to ERISA so long as the conditions of the safe harbor are satisfied. DOL has concluded that the safe harbor is appropriate because of the significant differences in legal requirements that would apply to health insurance coverage based on whether it is considered individual health insurance or group coverage. However, the safe harbor was not intended to address all circumstances in which health insurance coverage may be treated as part of an employee welfare benefit plan subject to ERISA. DOL may provide additional clarification in the future regarding other types of coverage.<sup>274</sup>

### V. Overview of Final Rules Regarding Individual Market Special Enrollment Periods—Department of Health and Human Services

#### A. In General

With the ability to integrate HRAs with individual health insurance coverage, many employees may need access to individual health insurance coverage, or may want to change to other individual health insurance

coverage in order to maximize the use of their individual coverage HRA. Therefore, HHS proposed a new SEP to allow employees and their dependents to enroll in individual health insurance coverage, or to change from one individual health insurance plan to another, outside of the individual market annual open enrollment period if they gain access to an individual coverage HRA.

In addition, because employees and dependents with a QSEHRA generally must be enrolled in MEC,<sup>275</sup> and one category of MEC is individual health insurance coverage, the proposed rules also applied the new SEP to individuals who are provided QSEHRAs.<sup>276</sup> Because the proposed rules allowed for HRAs to be integrated with individual health insurance coverage both on- and off-Exchange (and because individuals with QSEHRAs may enroll in individual health insurance coverage on- or off-Exchange), the proposed rules included this new SEP in the limited open enrollment periods available off-Exchange, in accordance with current rules at 45 CFR 147.104(b)(2).<sup>277</sup>

After considering the comments, HHS is adopting the proposed SEP parameters in these final rules, with some changes and clarifications in response to comments, as explained in more detail later in this section of the preamble.

#### 1. SEP Triggering Event and Availability

The proposed rules included a new paragraph 45 CFR 155.420(d)(14) that would establish an SEP for when an employee or his or her dependent(s) gains access to and enrolls in an individual coverage HRA or is provided a QSEHRA, so that he or she may enroll in or change his or her enrollment in individual health insurance coverage. The proposed rules also offered the existing option for advanced availability to those enrolling through the new SEP. That is, per 45 CFR 155.420(c)(2), qualifying individuals would have the option to apply for coverage and select

and 2590.715-2715(a)(1)(iii); and 45 CFR 147.200(a)(1)(iii).

<sup>273</sup> This safe harbor does not relate to HRAs, QSEHRAs, or other arrangements that constitute an employee welfare plan that provides reimbursement for premiums for individual health insurance coverage because it is limited to arrangements without employer contributions.

<sup>274</sup> As noted earlier in this preamble, an HRA generally may reimburse expenses for medical care, as defined under Code section 213(d), of an employee and certain of the employee's family members. Neither the proposed rules nor the final rules make any changes to the rules under Code section 213. Thus, any issues arising under Code section 213, and any guidance requested by commenters to address those issues, are beyond the scope of this rulemaking.

<sup>275</sup> Generally, payments from a QSEHRA to reimburse an eligible employee's medical care expenses are not includable in the employee's gross income if the employee has coverage that provides MEC as defined in Code section 5000A(f), which includes individual health insurance coverage.

<sup>276</sup> This preamble refers to a QSEHRA being "provided" as opposed to being "offered" because employees and dependents cannot opt out of a QSEHRA.

<sup>277</sup> The Departments note that the new SEP would not apply to individuals who gain access to an excepted benefit HRA, as those individuals are not required to be enrolled in individual health insurance coverage, and those HRAs are generally prohibited from reimbursing premiums for individual health insurance coverage.

<sup>268</sup> 83 FR 54420, 54441 (Oct. 29, 2018).

<sup>269</sup> See e.g., 29 CFR 2520.104b-2 and 2520.104b-3(a) and (d)(3).

<sup>270</sup> See PHS Act section 2715. See also 26 CFR 54.9815-2715, 29 CFR 2590.715-2715, and 45 CFR 147.200.

<sup>271</sup> See e.g., ERISA sections 101, 103, and 104; and PHS Act section 2715A (incorporated in Code section 9815 and ERISA section 715).

<sup>272</sup> See ERISA sections 104(a)(3) and PHS Act section 2715 (incorporated in Code section 9815 and ERISA section 715). See also 26 CFR 54.9815-2715(a)(1)(iii); 29 CFR 2520.104-20, 2520.104-44,

a plan within 60 days before or after their SEP triggering event.

Many commenters supported providing an SEP to allow individuals who newly gain access to an individual coverage HRA or who are newly provided a QSEHRA to enroll in or change their health insurance coverage. One commenter asked for clarification that individuals who are already enrolled in individual health insurance coverage would be eligible for the SEP if they newly gain access to an individual coverage HRA. The final rules clarify that employees and dependents may qualify for the new SEP regardless of whether they are currently enrolled in individual health insurance coverage, in order to allow all individuals who newly gain access to an individual coverage HRA or who are newly provided a QSEHRA the flexibility to take this into account when choosing an individual health insurance plan for themselves, and, if applicable, for their families.

Additionally, the final rules include changes to the SEP triggering event at 45 CFR 155.420(d)(14) to reflect that employees and their dependents who had access to, but who were not enrolled in, an employer's individual coverage HRA during all or at the end of the preceding plan year may use the new SEP if they may newly enroll in an individual coverage HRA at the beginning of the subsequent HRA plan year. Similarly, employees and their dependents who at one time had an individual coverage HRA or a QSEHRA, but then had another type of health coverage (including but not limited to a different individual coverage HRA or a different QSEHRA), and are again newly offered an individual coverage HRA or newly provided a QSEHRA from the same employer (for example, because they moved from one class of employees to another, or because they were re-hired by a former employer), may qualify for this SEP, as they may need an opportunity to enroll in individual health insurance coverage, regardless of whether they were previously offered or enrolled in an individual coverage HRA or previously provided a QSEHRA by the same employer.

In many cases like these, employees also will be eligible for an SEP due to a loss of MEC in accordance with 45 CFR 155.420(d)(1)—for example, due to a loss of coverage sponsored by a previous employer or other coverage that they may have had during that time, such as coverage from a spouse's employer. However, some employees and dependents may not be eligible for another SEP, such as those who did not previously have other coverage, or who

previously chose to enroll in coverage that was not MEC, such as STLDI. The final rules, therefore, provide that the SEP at 45 CFR 155.420(d)(14) is available when a qualified individual, enrollee, or dependent newly gains access to an individual coverage HRA or is newly provided a QSEHRA, regardless of whether they were previously offered or enrolled in an individual coverage HRA or previously provided a QSEHRA, so long as the individual is not covered by the HRA or QSEHRA on the day immediately prior to the triggering event (that is, for an individual coverage HRA, the first day on which coverage under the individual coverage HRA can become effective or for a QSEHRA, the first day on which coverage under the QSEHRA is effective). In other words, the new SEP will be available to individuals who have not previously been offered an individual coverage HRA or provided a QSEHRA, as well as those who had access to the individual coverage HRA or were provided a QSEHRA during a prior plan year(s) or earlier during the current plan year, but are not currently covered by the individual coverage HRA or the QSEHRA.

In order to clarify the specific date on which the coverage effective date and availability are based, as discussed later in this preamble, the final rules specify that the SEP triggering event at 45 CFR 155.420(d)(14) is the first day on which coverage for the individual under the individual coverage HRA can take effect or the first day on which coverage for the individual under the QSEHRA takes effect, as applicable. The Departments anticipate that the first day on which an individual coverage HRA can become effective or the date on which a QSEHRA is effective will generally be the first day of the plan year. In either case, the triggering event is the first day of the plan year. However, an individual coverage HRA may offer more than one effective date option to accommodate an individual who, under the final integration rules, is not required to be sent the notice setting forth the terms of the HRA at least 90 days before the beginning of the individual coverage HRA plan year, as required by 26 CFR 54.9802-4(c)(6), 29 CFR 2590.702-2(c)(6), and 45 CFR 146.123(c)(6) (for example, an individual who is newly hired and therefore newly offered the individual coverage HRA in the middle of the plan year).<sup>278</sup> For individuals

<sup>278</sup> Because employees may not enroll in an individual coverage HRA if they are not enrolled in individual health insurance coverage, the Departments anticipate that some employers may want to provide employees who are not eligible to participate in the individual coverage HRA at least

who are newly hired or who otherwise newly gain access to an individual coverage HRA during the plan year, the triggering event is the first day on which the individual coverage HRA can take effect for those who enroll in individual health insurance coverage that itself takes effect no later than that date.<sup>279</sup> This is the case even for the individuals or dependents who do not actually enroll in the individual coverage HRA until a later date.

For example, assume an employer hires a new employee on June 15 and offers an individual coverage HRA to the employee that may take effect on either (1) July 1, if the employee is enrolled in individual health insurance coverage that takes effect no later than that date; or (2) August 1, if the employee enrolls in individual health insurance coverage that will take effect no later than that date. In this case, the employee's triggering event is July 1 because that is the first day on which coverage under the individual coverage HRA can take effect.

Several commenters supported applying the advanced availability rules at 45 CFR 155.420(c)(2) to the proposed new SEP in order to allow qualified individuals, enrollees, and dependents to enroll in or change to a different individual health insurance plan in advance of when their individual coverage HRA or QSEHRA would begin. As discussed earlier in this preamble in response to comments on the final integration rules, many commenters supported the requirement that individuals covered by an individual coverage HRA must be enrolled in individual health insurance coverage and that the HRA must implement reasonable procedures to substantiate that participants and dependents will be enrolled in individual health insurance coverage for the plan year, or for the portion of the plan year during which the individual is covered by the HRA, as applicable. Several commenters noted the importance that individuals be enrolled in individual health insurance coverage by the time that their individual coverage HRA takes effect to ensure that they have health

90 days prior to the start of the HRA plan year with flexibility regarding the start date of their individual coverage HRA, so that the employees have sufficient time to enroll in individual health insurance coverage after receiving the notice.

<sup>279</sup> For individuals who are newly hired or who otherwise become newly eligible for a QSEHRA, the triggering event is the first day on which coverage under the QSEHRA is effective. However, a QSEHRA may not reimburse any incurred medical care expense until the participant substantiates that he or she (and the individuals whose expenses are being reimbursed) has MEC for the month during which the expense was incurred.

insurance coverage that complies with PHS Act sections 2711 and 2713 at all times during which they are covered by the individual coverage HRA. In order to avoid effectively forfeiting their HRA because they are not enrolled in individual health insurance coverage on the day that their individual coverage HRA can take effect, employees and dependents generally will need to make an individual health insurance plan selection before that date.

The final SEP rules include several changes in response to these comments. First, the proposed rules stated that the SEP applies to an individual who “gains access to and enrolls in” an individual coverage HRA or QSEHRA. The final SEP rules remove the phrase “and enrolls in” to clarify that currently being covered by the individual coverage HRA or QSEHRA is not necessary to trigger the SEP. This change is intended to better align with the requirement that participants and any dependents must be enrolled in individual health insurance coverage that will take effect no later than the date their individual coverage HRA takes effect, by ensuring that individuals will be able to enroll in individual health insurance coverage using the new SEP prior to the first day that their individual coverage HRA may take effect.

The final SEP rules also include changes to the advanced availability rules to ensure that, whenever possible, employees and their dependents are enrolled in individual health insurance coverage (which is generally a requirement for those with an individual coverage HRA and an option for satisfying the requirement to enroll in MEC for those with a QSEHRA) by the time coverage under their individual coverage HRA may take effect or that their QSEHRA takes effect. Specifically, the final rules include a new paragraph at 45 CFR 155.420(c)(3) to provide that a qualified individual, enrollee, or his or her dependent who is described in paragraph (d)(14) has 60 days before the triggering event to select a QHP, unless the HRA or QSEHRA was not required to provide the notice setting forth its terms to such qualified individual or enrollee at least 90 days before the first day of the plan year, as specified in 26 CFR 54.9802-4(c)(6), 29 CFR 2590.702-2(c)(6) and 45 CFR 146.123(c)(6) or Code section 9831(d)(4), as applicable, and therefore the qualified individual, enrollee, or his or her dependent(s) may not have received sufficient advance notice of eligibility for the individual coverage HRA or QSEHRA to enroll in individual health insurance coverage that takes effect by the time their individual coverage HRA may take

effect or their QSEHRA takes effect, in which case the qualified individual, enrollee, or his or her dependent(s) has 60 days before or after the triggering event to select a QHP.

In other words, qualified individuals and enrollees to whom employers must send a notice setting forth the terms of the individual coverage HRA at least 90 days before the first day of the individual coverage HRA plan year, and, if applicable, their dependents, must enroll in individual health insurance coverage within 60 days before the date the individual coverage HRA may take effect, which would be the first day of the individual coverage plan year. Similarly, employees, and, if applicable, their dependents, who will be provided a QSEHRA, and whose employer is required to send them a written notice at least 90 days before the beginning of the plan year, have 60 days prior to the first day of the QSEHRA plan year to enroll in individual health insurance coverage. This change will help ensure that the individual coverage HRA can comply with the annual coverage substantiation requirement by the time that an individual's or family member's individual coverage HRA takes effect, or that the QSEHRA satisfies the requirement that individuals who are provided the QSEHRA and who intend to satisfy their requirement to have MEC by enrolling in individual health insurance coverage have MEC. It will also reduce gaps in coverage by helping ensure that individuals and dependents who will be eligible for an individual coverage HRA and are notified at least 90 days before the beginning of the individual coverage HRA plan year are covered by individual health insurance coverage for the full HRA plan year and do not inadvertently forfeit their HRA.

In contrast, because individual coverage HRAs and QSEHRAs must only provide notice by the day that an individual coverage HRA may take effect or that a QSEHRA takes effect for employees who newly become eligible for an individual coverage HRA or are newly provided a QSEHRA less than 90 days prior to the beginning of the individual coverage HRA or QSEHRA plan year (or during the plan year), these employees are unlikely to receive this notice as far in advance of their SEP triggering event. Therefore, these employees may need time after their triggering event to select an individual health insurance plan for themselves, and, if applicable, for their dependent(s). To accommodate these employees and their dependents, the final SEP rules provide them with up to 60 days before or after their triggering

event to enroll in individual health insurance coverage. Under this rule combined with the coverage effective date rules discussed in the next section of this preamble, newly hired employees and their dependents may enroll in individual health insurance coverage that does not take effect until up to 3 months after the earliest date that their individual coverage HRA may take effect, or up to 3 months after the date coverage begins under their QSEHRA.<sup>280</sup> For example, an employee who starts work on July 25, and whose individual coverage HRA may take effect on August 1 (or whose QSEHRA does take effect on August 1), will have until September 30—60 days following the triggering event date—to enroll in an individual health insurance plan. If the employee enrolls on September 30, then his or her individual health insurance coverage will take effect on October 1.<sup>281</sup> The Departments encourage employers to work with employees who do not receive substantial advance notice of their individual coverage HRA to help them understand the latest date by which they must enroll themselves, and, if applicable, their dependents, in individual health insurance coverage to avoid effectively forfeiting their individual coverage HRA.

## 2. Coverage Effective Dates

The proposed rules added a new paragraph at 45 CFR 155.420(b)(2)(vi) to

<sup>280</sup> The Departments note that nothing in the final SEP rules eliminates the requirement that individual coverage HRAs comply with the final integration rules. Individual coverage HRAs must be designed in accordance with all the applicable rules, including the final integration rules and the final SEP rules.

<sup>281</sup> Additionally, partial year individual coverage HRA or QSEHRA coverage may occur due to employees gaining new dependents during the plan year. 45 CFR 155.420(c)(1) provides qualified individuals who gain a new dependent due to the birth or adoption of a child, or due to a child support or other court order, and therefore qualify for the SEP at 45 CFR 155.420(d)(2)(i), with 60 days to enroll their new dependent in individual health insurance coverage. As provided at 45 CFR 155.420(b)(2)(i), this coverage takes effect retroactively to the child's date of birth or adoption, or the date of the child support or other court order, or, at the option of the Exchange, the qualified individual may request that it take effect prospectively. To the extent the HIPAA special enrollment rules or other rules require group health plans to make such coverage available under such circumstances, either retroactively or prospectively, employers should ensure that employees understand how much time they have to enroll their new dependent in their individual coverage HRA, especially if they will have less than the 60 days post-SEP triggering event that they have to enroll their new dependent in individual health insurance coverage. See Code section 9801(f) and 26 CFR 54.9801-6; ERISA section 701(f) and 29 CFR 2590.701-6; and PHS Act section 2704(f) and 45 CFR 146.117. The Departments note that QSEHRAs are not subject to the HIPAA special enrollment rules. See Code section 9831(d)(1).

provide that if plan selection is made before the day of the triggering event, then the coverage effective date is either the first day of the first month following the SEP triggering event, or, if the triggering event is on the first day of a month, the date of the triggering event. Under the proposed rules, if plan selection is made on or after the day of the triggering event, coverage would take effect the first day of the month following the date of plan selection. For example, under the proposed rules, if an individual newly gains access to an individual coverage HRA or is provided a QSEHRA for a plan year starting April 1 and enters April 1 in their application for individual health insurance coverage as their HRA or QSEHRA effective date, then so long as the individual selects an individual health insurance plan before April 1, the effective date of their new individual health insurance coverage will be April 1.

Several commenters supported providing a coverage effective date of the first day of the first month following the individual's plan selection and SEP triggering event. One commenter agreed that a first-of-the-month effective date was appropriate, but also stated that this may require issuers to allow an additional premium payment during an employee's first month of employment.<sup>282</sup>

The final rules include coverage effective dates for this SEP as proposed, with some edits to incorporate the changes at 45 CFR 155.420(d)(14) and for clarity. Additionally, with regard to timing of premium payments for individual health insurance coverage, HHS notes that in other contexts individual market plans on- and off-Exchange regularly receive enrollment information within the same timeframe that will apply for the new SEP's coverage effective date rules. For example, under current rules, if a qualified individual or dependent is going to lose MEC on March 31 and enrolls in coverage during March, his or her coverage effective date is April 1. Therefore, issuers that already participate in the individual health insurance market will be accustomed to setting premium payment deadlines for enrollees in this situation.

<sup>282</sup> Under 45 CFR 155.400(e)(1)(ii), if an individual has a coverage effective date of April 1, for example, then the issuer could set a premium payment deadline as early as April 1, but may, instead, adopt a policy setting a later due date (either 30 days after the enrollment transaction was received, or 30 days after the policy start date, whichever is later). Therefore, the new enrollee might have a similar deadline for his or her initial payment that he or she has for his or her subsequent payment.

### 3. Special Enrollment Period Verification

Several commenters expressed support for verifying SEP eligibility for employees newly enrolling in individual health insurance coverage based on the new SEP, and one commenter requested additional guidance on how the verification would be administered. HHS confirms that Exchanges that use the Federal *HealthCare.gov* platform will require these individuals to submit documentation to confirm their SEP eligibility prior to effectuating their enrollment in individual health insurance coverage through the Exchange. More information on the process for submitting documents to verify SEP eligibility is available on *HealthCare.gov*, and HHS will provide additional guidance on how the FFEs and State Exchanges on the Federal platform will confirm eligibility for the new SEP.

#### *B. Individuals Re-Enrolling in Individual Coverage HRA or Being Provided a QSEHRA From the Prior Plan Year*

The proposed rules requested comments on whether an employee who is enrolled in an individual coverage HRA or provided a QSEHRA should be eligible for the SEP at 45 CFR 155.420(d)(14) annually, at the beginning of each new plan year of the individual coverage HRA or QSEHRA, particularly if the new plan year is not aligned with the calendar year. The proposed rules noted that such annual availability would allow employees to change to new individual health insurance coverage in response to updated information about their individual coverage HRA or QSEHRA for each of their plan years, even if their individual coverage HRA or QSEHRA plan year is not based on a calendar year cycle. HHS notes that employees and dependents enrolled in an individual coverage HRA or provided a QSEHRA that has a calendar year plan year would have this option; that is, they would be able to change their individual health insurance plan in response to updated information about their individual coverage HRA or QSEHRA during the individual market open enrollment period.

Some commenters supported providing the new SEP annually for employees and dependents enrolled in an individual coverage HRA or provided a QSEHRA and whose individual coverage HRA or QSEHRA has a non-calendar year plan year, in order to allow employees to enroll in or change

to a new plan in response to updated information about their individual coverage HRA or QSEHRA each plan year. Several commenters emphasized the importance of providing employees and their dependents with the opportunity to re-evaluate their individual health insurance coverage options at the same time that their individual coverage HRA or QSEHRA is likely to change, with one commenter suggesting that employers should not be permitted to make changes to their individual coverage HRA unless employees may also make changes to their individual health insurance coverage during the calendar year. Another commenter suggested that providing the new SEP annually would offer convenience for employees and employers who choose to begin their individual coverage HRA plan year on a date other than January 1.

However, some commenters opposed providing the new SEP on an annual basis due to concerns that allowing consumers to regularly change plans during the calendar year would harm the individual market risk pool. One commenter generally opposed providing the new SEP annually, but specified that if HHS chooses to do so, it should only be available to employees and dependents whose employer changes their individual coverage HRA contribution in excess of a certain amount, such as \$100, and that this change be verified to prevent employees who do not qualify for the SEP from accessing it for reasons related to a health condition. To ensure that the SEP would not be available on an annual basis, one commenter suggested offering the SEP only after an employee becomes eligible for an individual coverage HRA following a period of at least 60 days during which they were not eligible for an HRA from the same employer.

Other commenters opposed offering the new SEP annually based on concerns that employees who changed individual health insurance coverage during the calendar year would be harmed because their deductibles and other accumulators would reset twice per year: Once after the calendar year individual coverage open enrollment period, and then again after their SEP. One commenter suggested that this could negate the potential advantage to the employee of changing plans to take advantage of an update to their individual coverage HRA or QSEHRA.

Several commenters suggested that to mitigate this challenge, employers should provide individual coverage HRAs on a calendar-year basis to align updates that they make to their individual coverage HRA with the

individual market open enrollment period, with one commenter recommending that the Departments require employers to do so. One commenter suggested that the final rules should permit employers to begin offering individual coverage HRAs at any time during the calendar year, and the Departments could then require these employers to transition to offering individual coverage HRAs based on a calendar plan year within a reasonable period of time, such as 5 years.

HHS determined that employees who are enrolled in an individual coverage HRA or who are provided a QSEHRA should have the option to re-evaluate their individual health insurance coverage options for each new individual coverage HRA or QSEHRA plan year, regardless of whether the HRA or QSEHRA is offered or provided (as applicable) on a calendar plan year basis. However, the final rules provide that the new SEP will not be available on an annual basis at the beginning of a new individual coverage HRA or QSEHRA plan year to individuals who are already enrolled in an individual coverage HRA or who are already provided a QSEHRA. This is because employees offered an individual coverage HRA or provided a QSEHRA with a calendar year plan year may re-evaluate their individual health insurance coverage options and change their individual health insurance plan, if they wish to do so, during the annual individual market open enrollment period. Further, individuals with an individual coverage HRA or QSEHRA with a non-calendar year plan year will have an opportunity through an existing SEP to re-evaluate their coverage options.

More specifically, because HRAs are group health plans, employees enrolled in an individual coverage HRA with a non-calendar year plan year may qualify for an SEP on an annual basis pursuant to existing rules at 45 CFR 155.420(d)(1)(ii) (the non-calendar year plan year SEP). This SEP applies to qualified individuals and dependents enrolled in a group health plan or an individual health insurance plan with a non-calendar year plan year, even if the qualified individual or his or her dependent has the option to renew the coverage. In addition, while Cures Act section 18001(c) provides that the term "group health plan" generally does not include a QSEHRA,<sup>283</sup> HHS will treat a QSEHRA with a non-calendar year plan year as a group health plan for the

limited purpose of the non-calendar year plan year SEP, and intends to codify this interpretation in future rulemaking. For the non-calendar year plan year SEP, the triggering event is the last day of the plan year.

HHS has determined that the availability of the non-calendar year plan year SEP achieves an appropriate balance between providing employers with flexibility to offer an individual coverage HRA or provide a QSEHRA on a 12-month cycle that meets their needs and allowing employees and their dependents the flexibility to re-assess their individual health insurance coverage options at the same time that the terms of their individual coverage HRA or QSEHRA may change. Additionally, per 45 CFR 155.420(a)(4), the non-calendar year plan year SEP is subject to plan category limitations for Exchange enrollees, which HHS has determined will mitigate commenters' concerns about the potential risks to individual market stability that providing employees with the flexibility to choose a different plan annually, outside of the annual individual market open enrollment period, could pose. Employers that want to ensure their employees have the ability to change to a different individual health insurance policy each individual coverage HRA or QSEHRA plan year without being subject to plan category limitations, and consider potential changes to their individual coverage HRA or to their QSEHRA at the same time that their costs for individual health insurance coverage may also change, can align their individual coverage HRA or QSEHRA plan year with the calendar year. HHS will incorporate messaging into the *HealthCare.gov* application for Exchange individual health insurance coverage and other technical assistance materials to help employees understand that changing individual health insurance coverage during the calendar year will reset their deductibles and other accumulators. HHS encourages State Exchanges to adopt similar messaging.

### C. Plan Category Limitations

To allow employees and their dependents the flexibility to adequately respond to newly gaining access to an individual coverage HRA or newly being provided a QSEHRA, the proposed rules included an amendment to 45 CFR 155.420(a)(4)(iii) to exclude Exchange enrollees who would qualify for the new SEP from plan category limitations.<sup>284</sup> Therefore, under the

proposed rules, individuals eligible for the new SEP who are currently enrolled in individual health insurance coverage on an Exchange would be able to select any available Exchange plan without regard to the metal level of their current coverage.

Several commenters expressed support for the proposal to exempt the new SEP from plan category limitations, noting the importance of providing access to individual health insurance coverage or flexibility to change their current individual health insurance plan to employees and dependents who qualify for this new SEP.

HHS agrees with commenters about the importance of providing access to individual health insurance coverage or flexibility to change their current individual health insurance plan to employees and dependents who qualify for the new SEP, and is, therefore, finalizing the amendment to 45 CFR 155.420(a)(4)(iii) to exempt individuals eligible for the new SEP from plan category limitations. However, see the discussion earlier in this section of the preamble regarding the application of plan category limitations to individuals to whom the non-calendar year plan year SEP applies.

### VI. Applicability Dates

The proposed integration rules and proposed excepted benefit HRA rules, as well as the proposed DOL clarification and the proposed clarification by the Departments regarding the meaning of "group health insurance coverage," were proposed to apply to group health plans and health insurance issuers for plan years beginning on or after January 1, 2020. The proposed PTC rules were proposed to apply for taxable years beginning on or after January 1, 2020, and the proposed SEP rules were proposed to apply January 1, 2020. The proposed rules also provided that taxpayers and others could not rely on the proposed rules. The Departments solicited comments on the proposed applicability date.

Some commenters requested that the Departments either provide an earlier applicability date or maintain the proposed general applicability date of January 2020. Some urged finalization by the end of the first quarter of 2019 to account for the 2020 rate setting schedule and to allow for implementation by 2020.

Many commenters expressed concern that issuers, state insurance regulators, the Exchanges, and employers would not be prepared for implementation of the final rules by 2020 and requested various applicability date delays, including a 2021 applicability date, an

<sup>283</sup> A QSEHRA continues to be treated as a group health plan under the PHS Act for purpose of Part C Title XI of the Social Security Act.

<sup>284</sup> 45 CFR 155.420(a)(4) does not apply to SEPs in the individual market off-Exchange.

applicability date of 12 or 18 months following finalization of the rule, and an indefinite delay to allow further time to study the market. These commenters focused on the significance of the changes made by the proposed rules and the anticipated complexity of implementation. Several State Exchanges submitted comments urging the Departments to delay the applicability date for several plan years or until further support for states is available. These commenters stated that it would be very difficult, and in some instances impossible, to implement the system changes required by the proposed integration, PTC, and SEP rules for the 2020 plan year. One commenter suggested that individual coverage HRAs be implemented on a small scale for only certain employers and employees or only for a very limited time period, such as 2 years. Another commenter requested that the Departments postpone finalization of the integration rules until the Departments develop a federally-hosted electronic data source to verify individual coverage HRA offer information required to determine APTC eligibility.

The Departments considered the comments and the concerns raised by various State Exchanges, issuers, employers and other stakeholders related to the ability of the Exchanges to fully implement changes related to the final rules in time for open enrollment for the 2020 plan year. In particular, the Departments acknowledge the crucial role that the Exchanges have in implementation and operationalization of the final rules, and the Departments will work closely with the Exchanges on implementation. The Departments recognize that Exchanges may be unable to fully implement changes related to the final rules in time for open enrollment for the 2020 plan year. However, prior to full implementation, the Departments will work with the Exchanges on their strategies to provide information to consumers about affordability of individual coverage HRAs and eligibility for APTC, including how employees can access individual health insurance coverage through the Exchanges and determine whether they should use APTC. Ongoing technical assistance will be provided related to the development of Exchanges' tools and functionality to support employers and employees with understanding HRA affordability determinations and their impact on APTC eligibility, as well as the SEP for those with an offer of an individual coverage HRA. HHS has already

discussed with State Exchanges what changes would likely be necessary if the rule were finalized as proposed to assist with planning, as well as what kind of assistance would be most helpful during implementation. Specific assistance could include sharing technical and educational documentation from FFE implementation that can be leveraged to support State Exchange efforts. In addition, the Departments will provide assistance to Exchanges in developing information and tools that could be provided to employers and employees to help ensure smooth implementation before the full system changes are complete. This could include State Exchanges providing employees with information on how they can calculate HRA affordability and the impact on APTC in the absence of system changes that can make those calculations for the employee.

The Departments have also considered that many individuals covered by an individual coverage HRA will prefer to select off-Exchange individual health insurance plans because salary reductions through a cafeteria plan may be used to pay premiums for off-Exchange coverage, if the employer so allows, and may not be used to pay premiums for Exchange coverage. To the extent a significant proportion of employees with individual coverage HRAs purchase individual health insurance coverage off the Exchange, concerns about burden on the Exchanges, and concerns regarding the effects of timely operationalization of the PTC rules, are mitigated.

The Departments have also worked to release the final rules as early in 2019 as possible, in recognition of the implementation timing issues raised. With regard to the concerns expressed about the interaction of the release of the final rules with rate filing for 2020, the Departments note that the proposed rules were published in October 2018, to provide sufficient notice of the Departments' proposals in advance of the 2020 plan year. While these final rules adopt some changes in response to comments, they are substantially similar to the proposed rules. Even though the proposed rules provided that taxpayers and others may not rely on the proposed rules, the Departments understand that issuers began considering the potential impact of the rules on rates well in advance of the final rules. Further, issuers generally will have an opportunity to make changes in response to the final rules before the rate filing deadlines for the 2020 plan year.

The Departments also note, and considered, that plan sponsors may

choose if and when to offer an individual coverage HRA (or an excepted benefit HRA) and may do so any time on or after the applicability date. The Departments intend to provide the guidance necessary for plan sponsors to offer individual coverage HRAs and excepted benefit HRAs for the 2020 plan year, but the Departments also expect that plan sponsors will take the time they need to evaluate the final rules and to take advantage of these new coverage options if and when is best for their workforce.

The Departments have also considered that Executive Order 13813, issued in October 2017, set forth HRA expansion as an Administration priority "in the near term," in order to provide Americans with more options for financing their healthcare. Taking all of these considerations into account, the Departments have determined that it is appropriate to finalize the applicability date, as proposed.

Relatedly, one commenter requested that a "no inference" standard be the benchmark for reliance prior to 2020 with regard to individual coverage HRAs, which the Departments understand to be a request that the Departments not take enforcement against HRAs that failed to comply with the market requirements prior to 2020, under the rules and guidance in effect prior to 2020. The Departments see no basis to provide such a rule and, therefore, the final rules do not include a "no inference" standard for reliance prior to the applicability date.

Finally, HHS clarifies that, while the new SEP generally provides advanced availability to allow eligible individuals to enroll in individual health insurance coverage up to 60 days prior to the first day of coverage under their HRA, employees who are offered an individual coverage HRA with a plan year that begins early in 2020 will not have the full 60 day advanced availability period to select individual health insurance coverage using an SEP because the new SEP rules take effect on January 1, 2020. Therefore, plan sponsors offering an individual coverage HRA with a plan year that begins on January 1, 2020 should help eligible employees understand that they must enroll in individual health insurance coverage during the open enrollment period, November 1, 2019 through December 15, 2019, for individual health insurance coverage that takes effect on January 1, 2020.

## VII. Economic Impact and Paperwork Burden

### A. Summary

The final rules remove the current prohibition on integrating HRAs with individual health insurance coverage, if certain conditions are satisfied. The final rules also set forth conditions under which certain HRAs will be recognized as limited excepted benefits. In addition, the Treasury Department and the IRS are finalizing rules regarding PTC eligibility for individuals offered an individual coverage HRA. Further, DOL is finalizing a safe-harbor clarification to provide assurance that the individual health insurance coverage the premiums of which are reimbursed by an HRA, a QSEHRA or a supplemental salary reduction arrangement does not become part of an ERISA plan, if certain safe harbor conditions are satisfied, and the Departments are finalizing a related clarification to the definition of group health insurance coverage. Finally, HHS is finalizing rules to provide an SEP in the individual market for individuals who newly gain access to an individual coverage HRA or who are newly provided a QSEHRA.

The Departments have examined the effects of the final rules as required by Executive Order 13563 (76 FR 3821, January 21, 2011, Improving Regulation and Regulatory Review); Executive Order 12866 (58 FR 51735, October 4, 1993, Regulatory Planning and Review); the Regulatory Flexibility Act (September 19, 1980, Pub. L. 96–354); section 1102(b) of the Social Security Act (42 U.S.C. 1102(b)); section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995, Pub. L. 104–4); Executive Order 13132 (64 FR 43255, August 10, 1999, Federalism); the Congressional Review Act (5 U.S.C. 804(2)); and Executive Order 13771 (82 FR 9339, February 3, 2017, Reducing Regulation and Controlling Regulatory Costs).

### B. Executive Orders 12866 and 13563

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 is supplemental to and reaffirms the principles, structures, and definitions governing regulatory review as established in Executive Order 12866.

Section 3(f) of Executive Order 12866 defines a “significant regulatory action”

as an action that is likely to result in a rule: (1) Having an annual effect on the economy of \$100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis must be prepared for major rules with economically significant effects (for example, \$100 million or more in any one year), and a “significant” regulatory action is subject to review by the Office of Management and Budget (OMB). The Departments anticipate that this regulatory action is likely to have economic impacts of \$100 million or more in at least one year, and thus meets the definition of a “significant rule” under Executive Order 12866. Therefore, the Departments have provided an assessment of the potential costs, benefits, and transfers associated with the final rules. In accordance with the provisions of Executive Order 12866, the final rules were reviewed by OMB.

#### 1. Need for Regulatory Action

This regulatory action is taken, in part, in light of Executive Order 13813 directing the Departments to consider proposing regulations or revising guidance to expand the flexibility and use of HRAs. In addition, this regulatory action is taken because, since the time that the Departments previously prohibited integration with individual health insurance coverage by regulation, the Departments have observed that many employers, especially small employers, continue to struggle to offer health insurance coverage to their employees. There has been a continued decline in the percentage of small firms offering health coverage<sup>285</sup> as well as a

<sup>285</sup> Between 2010 and 2018, there has been a significant decline in the number of small firms offering coverage. For firms with 3 to 9 workers, the decline has been from 59 percent to 47 percent, for firms with 10 to 24 workers, the decline has been from 76 percent to 64 percent, and for firms with 25 to 49 workers, the decline has been from 92 percent to 71 percent. See Kaiser Family Foundation, “Employer Health Benefits 2018

decline in the percentage of workers at small firms receiving health insurance coverage from their employer.<sup>286</sup> Moreover, 80 percent of firms that offer coverage only provide a single option,<sup>287</sup> and economic research demonstrates that there is a significant benefit of additional choice for employees.<sup>288</sup> Further, this regulatory action is being taken at this time because the Departments have had additional time to consider whether, and what type of, conditions would be sufficient to mitigate the risk of adverse selection and health factor discrimination that might otherwise result from allowing HRAs to be integrated with individual health insurance coverage, and the Departments expect that the conditions adopted in the final rules will significantly mitigate the risk of adverse selection. The final rules are intended to increase the usability of HRAs to provide more Americans, including employees who work at small businesses, with more healthcare options and to increase overall coverage. These changes will facilitate the development and operation of a healthcare system that provides high-quality care at affordable prices for the American people by increasing consumer choice for employees and promoting competition in healthcare markets by providing additional options for employers and employees.

The Departments are of the view that the benefits of the final rules will substantially outweigh the costs of the rules. The final rules will increase flexibility and choices of health coverage options for employers and employees. The use of individual coverage HRAs could potentially reduce healthcare spending, particularly less efficient spending,<sup>289</sup> and ultimately

Annual Survey”, Figure 2.2, at <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018>.

<sup>286</sup> Between 2010 and 2018, there has been a significant decline in the number of workers covered by their firm’s health benefits. For firms with 3 to 24 workers, the decline has been from 44 percent to 30 percent and for firms with 25 to 49 workers, the decline has been from 59 percent to 44 percent. *Id.*, Figure 3.9.

<sup>287</sup> *Id.*, Figure 4.1

<sup>288</sup> An analysis of choices made in the large group market found that offering multiple plan choices (at large group prices) was as valuable to the median consumer as a 13 percent premium reduction. See Dafny, Leemore, Kate Ho and Mauricio Varela, “Let Them Have Choice: Gains from Shifting Away from Employer-Sponsored Health Insurance and Toward an Individual Exchange,” *American Economic Journal: Economic Policy*, 2013, 5(1):32–58.

<sup>289</sup> By less efficient healthcare spending, the Departments generally mean spending that is of low value from the consumer’s perspective, relative to the cost. The cost includes out-of-pocket spending

result in increased taxable wages for workers currently in firms that offer traditional group health plans. The final rules are also expected to increase the number of low- and moderate-wage

workers (and their family members) with health insurance coverage.

2. Summary of Impacts of Individual Coverage HRAs

The expected benefits, costs and transfers of the final rules are

summarized in Table 1 and discussed in detail later in this section of the preamble.

TABLE 1—ACCOUNTING TABLE

Benefits:

Qualitative:

- Gain of health insurance and potentially improved financial or health outcomes for some employees who are newly offered or newly accept benefits.
- Increased choice and flexibility for employees and employers around compensation arrangements, potentially resulting in more efficient use of healthcare and more efficient labor markets (including higher taxable wages).
- Decreased administrative costs for some employers who no longer offer traditional group health plans for some, or all, employees.

Costs:

Qualitative:

- Loss of health insurance and potentially poorer financial or health outcomes for some individuals who experience premium increases.
- Less comprehensive coverage and fewer health benefits for some individuals with individual health insurance coverage as compared to traditional group health plan coverage.
- Increased administrative costs for employers, employees, and government agencies to learn about and/or use a new health benefits option.

Transfers	Estimate (billion)	Year dollar	Discount rate (percent)	Period covered
Annualized Monetized (\$/year) .....	\$4.5	2020	7	2020–2029
(Net tax revenue loss) .....	4.9	2020	3	2020–2029
Quantitative: <sup>290</sup>				
<ul style="list-style-type: none"> <li>• Reduced tax revenue as a result of new individual coverage HRAs offered by employers previously offering no health benefits, less reduced PTC from employees in such firms..</li> <li>• Increase in average individual market premiums of about 1 percent and resulting increase in PTC..</li> <li>• Small decrease in per capita Medicare premiums and increase in net Medicare outlays..</li> </ul>				
Qualitative:				
<ul style="list-style-type: none"> <li>• Increased out-of-pocket costs for some employees who move from traditional group health plans to individual health insurance coverage and decreased costs for other employees who move from traditional group health plans to individual health insurance coverage (<i>i.e.</i>, transfers from reduced within-firm cross-subsidization)..</li> <li>• Reduced tax revenue as a result of new excepted benefit HRA..</li> </ul>				

In all cases, the counterfactual baseline for analysis is current law. That is, the analysis assumes as the baseline statutes enacted and regulations that are final as of date of issuance of the final rules.

Benefits

*Gain of health insurance coverage.* Some individuals could experience a gain in health insurance coverage, greater financial security and potentially improved health outcomes, if employees

are newly offered and accept individual coverage HRAs. As explained in greater detail in the Transfers section later in this section of the preamble, the Departments estimate that, on net, the number of insured persons will increase by about 800,000 by 2029, due to the final rules. Most of these newly insured individuals are expected to be low- and moderate-income workers in firms that currently do not offer a traditional group health plan.

Some commenters agreed that the allowance of individual coverage HRAs creates new options for small employers who have otherwise been unable to offer health insurance coverage. Some commenters mentioned that some segments of their workforce might particularly benefit. One commenter suggested that large employers might newly provide individual coverage HRAs to part-time or seasonal/ temporary workers while maintaining

such as copayments and deductibles plus amounts paid by the health plan.

<sup>290</sup> The monetized estimates are of the net tax revenue loss, including reduced income and payroll tax revenue from employees who would receive individual coverage HRAs and would not otherwise have a tax exclusion for a traditional group health plan, reduced PTC from individuals who would

receive individual coverage HRAs and would otherwise receive PTC, and increased PTC due to the increase in Exchange premiums; plus the increased Medicare outlays net of increased total premiums paid. As noted in the text later in this section of the preamble, the quantitative estimates are subject to considerable uncertainty. For example, the rule could cause tax revenue to

increase if the adoption of individual coverage HRAs leads to reduced healthcare spending and higher taxable wages. Or the rule could result in larger premium increases in the individual market, or in premium decreases, if the rule results in more substantial changes in the health of the individual market risk pool.

traditional benefits for their full-time employees.

*Increased choice and flexibility for employees and employers.* As a result of the final rules, employees will be able to purchase insurance with a tax subsidy by use of an individual coverage HRA, without being locked into a specific plan or selection of plans chosen by their employer. As explained later in this section of the preamble, a relatively small number of employees could have fewer choices of plans in the individual market than the number of group health plan choices previously provided by their employer, and some might be unable to find a new individual health insurance plan that covers their preferred healthcare providers. However, small firms are more likely to offer individual coverage HRAs than large firms and small firms that offer a traditional group health plan typically offer a single option. Therefore, employees at the vast majority of firms are likely to have more options through an individual coverage HRA than through a traditional group plan. The expansion of enrollment in the individual market due to the final rules could also induce additional insurers to provide individual market coverage. The Departments are of the view that on net, the final rules will significantly increase choice and flexibility for employees. Employers also will benefit from having another choice of a tax-preferred health benefit to offer their employees, giving them another tool to attract and retain workers.

Current compensation arrangements can result in less efficient labor markets and inefficient healthcare spending. Employees within a firm (or employees within certain classes of employees within a firm) are generally offered the same set of health benefits. As a result, some employees receive a greater share of compensation in the form of benefits than they would prefer, while others receive less. An individual coverage HRA will allow employees to choose coverage that better suits their preferences, allowing those who want a less comprehensive plan to select one and pay less, while allowing those who want a more comprehensive plan to pay more. In addition, some employers offer plans with a wide choice of providers, reflecting the diverse preferences and healthcare needs of their employees. While a broader network contains certain benefits, it also weakens the ability of employers and issuers to negotiate lower provider prices or otherwise manage employee care. In contrast, in the individual market insurers have an incentive to keep

premiums low relative to the SLCSP, which is used to determine the PTC. Hence, insurers are more likely to have a narrower choice of providers in order to negotiate lower prices.

By expanding the ability of consumers to choose coverage that fits their preferences, the final rules will reduce these inefficiencies in labor markets and healthcare spending. Some employees who will be offered individual coverage HRAs under the final rules might choose plans with lower premiums and higher deductibles and copayments (all of which could potentially be paid out of the HRA) and narrower provider networks than they would choose if offered a traditional group health plan. Employees facing higher cost sharing could become more cost-conscious consumers of healthcare. Narrower provider networks could strengthen the ability of purchasers (through their insurers) to negotiate lower provider prices. Both effects could lead to reduced healthcare spending, which could in turn lead to reductions in amounts made available under individual coverage HRAs and corresponding increases in taxable wages. However, these benefits are uncertain and would take some time to occur.<sup>291</sup> Moreover, the provision of a new health benefit that can be used to pay cost-sharing as well as premiums and that is available to employees who were previously uninsured or enrolled in unsubsidized coverage would be expected to increase, rather than decrease, healthcare utilization by some consumers.

Individual coverage HRAs provide flexibility for small employers in particular that might have little expertise or skill in choosing traditional group health plans or in administering coverage effectively for employees. However, some small employers can already obtain lower-cost coverage in the small group market or through AHPs than they could otherwise provide on

<sup>291</sup> The individual coverage HRA provides an income and payroll tax exclusion that is available only to workers and, unlike the PTC, benefits workers at all income levels, including workers with incomes in excess of 400 percent of the federal poverty level. Thus, it is possible that the final rules could encourage individuals to join the labor force or to work more hours or seek higher-paying employment, generating further economic benefits. In addition, the final rules could increase labor force mobility (*i.e.*, encourage workers to move more freely to employers where their productivity is highest), because workers enrolled in individual health insurance coverage could find it easier to retain their coverage when they change jobs. However, these effects are highly uncertain, are likely to be relatively small, and might take some time to occur. Labor supply changes are not reflected in the revenue estimates provided in the transfers section later in this section of the preamble.

their own. Small employers that are not ALEs can also forego offering health benefits and allow their employees to obtain individual health insurance coverage, often with PTC subsidization, without liability under Code section 4980H. Qualified small employers can also pursue establishment of QSEHRAs. Thus, small employers whose employees have particularly high healthcare costs or small employers that have little skill or interest in administering health benefits might use these other options to control costs even in the absence of the final rules. If so, the increased efficiency gain from providing an additional incentive for small employers to drop traditional group health plans in favor of individual coverage HRAs could be modest.

Some commenters agreed that the proposed rules would enable employers to offer more affordable health coverage alternatives to employees. Some commenters expressed general support for allowing employers to move to a defined contribution approach for health insurance coverage. The Departments agree that a defined contribution approach is more flexible for employers because it is easier for employers to plan for the future. Furthermore a defined contribution approach reduces the risk that an employer's healthcare costs increase due to factors outside an employer's control.

*Reduced administrative costs for some employers.* Employers that offer an individual coverage HRA rather than a traditional group health plan could experience reduced administrative costs. For example, such employers will no longer need to choose health insurance plans or self-insured health benefits for their employees and manage those plans. Some of these costs will be borne by HRA recipients. However, overall costs may be lower, particularly for small employers and their employees, as loading fees (that is, premiums in excess of expected insurance claims) appear to be quite high for small firms that provide traditional group coverage.<sup>292</sup>

<sup>292</sup> One study using data for 1997 through 2001 finds that firms with 50 or fewer employees face loading fees of 42 percent of premiums, whereas firms with more than 10,000 employees pay loading fees of just 4 percent. The authors note that these estimates are roughly consistent with the findings of earlier research. The authors caution that the introduction of Exchanges and medical loss ratio requirements provided for under PPACA should reduce loading fees for small firms, but conclude that loading factors for small firms might still be quite high. See Karaca-Mandic, Pinar, Jean M. Abraham and Charles E. Phelps, "How Do Health Insurance Fees Vary by Group Size? Implications

Some commenters stated that the proposed rules would be simpler to administer than traditional group health plans, thereby reducing administrative cost for employers. One commenter noted that while the costs of administering an individual coverage HRA could be lower than the cost of administering a traditional group health plan, the difference is not likely to be large. The Departments are of the view that it is possible that there will be modest reductions in administrative costs for employers who offer an individual coverage HRA rather than a traditional group health plan.

#### Costs

*Loss of health insurance coverage.* The Departments recognize that some individuals could experience a loss in health insurance coverage and that some of these people might experience worse financial or health outcomes as a result of the final rules.<sup>293</sup> Loss of coverage could occur if employers drop traditional group health plans and if some previously covered employees do not accept the individual coverage HRA and fail to obtain their own coverage. Loss of coverage also could occur if the addition of new enrollees to the individual market causes premiums to rise, resulting in dropping of coverage by current individual market enrollees. Finally, loss of coverage could occur if employees who are currently purchasing coverage in the Exchange with the PTC become ineligible for the PTC by an offer of (or coverage under) an individual coverage HRA and experience increases in out-of-pocket premiums.

In addition, while most employers that currently offer traditional group health plans offer only one type of plan, some employers offer more choices.<sup>294</sup>

for Healthcare Reform,” *International Journal of Health Care Finance and Economics* (2011) 11: 181–207.

<sup>293</sup> The Departments note however that increased insurance coverage does not necessarily result in better physical health. For example, Baicker et al. found that increased Medicaid coverage in Oregon “generated no significant improvements in measured physical health outcomes in the first two years, but it did increase use of health care services, raise rates of diabetes detection and management, lower rates of depression, and reduce financial strain.” See Baicker, K., S. Taubman, H. Allen, M. Bernstein, J. Gruber, J. Newhouse, E. Schneider, B. Wright, A. Zaslavsky, and A. Finkelstein. 2013. “The Oregon Experiment: Effects of Medicaid on Clinical Outcomes.” *New England Journal of Medicine* 368: 1713–22. <http://www.nejm.org/doi/full/10.1056/NEJMsa1212321>; and survey of the literature in Chapter 6 of *Economic Report of the President*, February 2018, [https://www.whitehouse.gov/wp-content/uploads/2018/02/ERP\\_2018\\_Final-FINAL.pdf](https://www.whitehouse.gov/wp-content/uploads/2018/02/ERP_2018_Final-FINAL.pdf).

<sup>294</sup> Among firms that offer traditional group coverage, an estimated 81 percent of firms with 3

As a result, a relatively small number of employees could have fewer choices of plans in the individual market than the number of group health plan choices previously provided by their employer, and some might be unable to find new individual health insurance coverage that covers their preferred healthcare providers. The Departments requested comments on this finding and the extent to which the proposed rules could reduce employee choice or cause some individuals to become uninsured.

Some commenters stated that the proposed rules would lead to adverse selection, increased premiums and overall destabilization of the individual market, causing some to become uninsured. (Adverse selection and resulting premium increases are discussed in greater detail in the Transfers section of this preamble.) Several commenters expressed concern that the offer of an individual coverage HRA could eliminate consumers’ eligibility for the PTC, increasing the cost of coverage. Some commenters suggested that some of these consumers would become uninsured. One commenter noted that this problem would be magnified for families, since affordability is determined by comparing the HRA employer contribution amount to the cost of a self-only plan, rather than to a family plan. Several commenters suggested that increased administrative costs and confusion would cause some employees who are offered an individual coverage HRA to fail to enroll and become uninsured.

The Departments acknowledge these concerns, but, as discussed later in this section of the preamble, estimate that the number of individuals with insurance coverage will be increased, rather than decreased, by adoption of the final rules. One reason for this is that the individual coverage HRA contribution that is offered will render an individual ineligible for the PTC only if it is of a sufficient size to make the offer affordable for the employee (and, in the case of ALEs, employers must make amounts available under an individual coverage HRA sufficient for the offer to be considered affordable in order to avoid liability under Code section 4980H). Thus, even if employees do transition from receiving PTC to receiving an offer of an individual coverage HRA, they are not necessarily

to 199 employees offer only one type of plan, whereas 42 percent larger firms offer one plan, 45 percent offer two and 13 percent offer three or more plans. See Kaiser Family Foundation Employer Health Benefits 2018 Annual Survey, Figure 4.1, at <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018>.

expected to become uninsured. In addition, the final rules require employers to notify employees of the effect of individual coverage HRA offers and enrollment on PTC eligibility and require employees to substantiate enrollment in individual health insurance coverage in order to receive reimbursement from an individual coverage HRA, reducing the likelihood that confusion will lead to loss of insurance coverage.

*Less comprehensive coverage, fewer benefits.* Some commenters suggested that some individuals with individual coverage HRAs, and, therefore, individual health insurance coverage, could experience a reduction in the comprehensiveness or affordability of healthcare benefits. For example, commenters noted that an employee might not be able to afford a policy with as high an actuarial value as their current traditional group health plan, or might be limited to narrower networks of providers in the individual market. Another commenter noted that patients may newly have limited choices, particularly among physician specialty care providers. Another commenter said that some employees could have fewer choices of plans in the individual market than the number of group health plan choices previously provided by their employer, or might be unable to find new individual health insurance coverage that covers their preferred healthcare providers. Another commenter stated that the proposed rules would result in poorer financial and health outcomes.

The Departments recognize that some individuals who choose health plans with less comprehensive benefits or higher out-of-pocket payments could experience adverse health or financial outcomes. However, this is unlikely because an individual coverage HRA must be integrated with individual health insurance coverage, which generally is required to provide coverage of all essential health benefits and at least 60 percent actuarial value (subject to a de minimis variation). Moreover, to the extent that commenters’ assertions about narrower networks and higher cost sharing in the individual market are accurate, the Departments note that higher cost sharing and narrower networks could also be beneficial in that they encourage consumers to be more cost-conscious, reducing unnecessary and potentially counterproductive health care utilization, and thereby reducing premiums. Such premium decreases could, in turn, lead to increased wages across employees in a firm. For example, an employee might currently

have access to only one 80 percent actuarial value traditional group health plan with a relatively broad network, but under an individual coverage HRA will have access to a choice of plans, with actuarial values generally ranging from 60 to 80 percent or higher. If he or she chooses a 60 or 70 percent actuarial value plan, he or she will have a greater incentive to be cost-conscious and will likely spend less on healthcare, leaving more resources for other forms of consumption or saving.

*Increased administrative costs.* In the impact analysis of the proposed rules, the Departments noted that the proposed rules could increase some administrative costs for employers, employees, and government entities.

Under the final rules, all employers will have a new health benefits option about which to learn. Employers who offer individual coverage HRAs but did not offer employer-sponsored health benefits before will face increased costs of administering a health benefit. In addition, all employers that offer individual coverage HRAs will be required to establish reasonable procedures to substantiate that individuals covered by the HRA are enrolled in individual health insurance coverage or Medicare; to provide a notice to all employees who are eligible for the HRA explaining the PTC eligibility consequences of the HRA offer and acceptance and other information; and to comply with various other generally applicable group health plan requirements, such as maintaining a plan document and complying with various reporting requirements. Employers offering individual coverage HRAs will need to establish systems to reimburse premiums and employee out-of-pocket medical care expenses, or hire third-party administrators to do so. In addition, to the extent an employer is subject to Code section 4980H, the employer will need to learn about the final PTC regulations and any other related guidance under Code section 4980H that the Treasury Department and the IRS may issue. As noted earlier in this preamble, administrative costs associated with individual coverage HRAs could be lower than costs for traditional group health plans for some employers. The Departments expect that third-party administrators and other benefit experts will work to minimize these costs for employers. Because offering an individual coverage HRA is voluntary, ultimately, employers that offer this benefit will do so only because they experience a net benefit from doing so.

As to increased administrative burden and costs for employees, employees

who previously enrolled in a traditional group health plan and who now receive an individual coverage HRA will need to shop for and choose their own insurance and learn new procedures for accessing their HRA benefits. In addition, employees who receive an individual coverage HRA will need to substantiate enrollment in individual health insurance coverage once per plan year and in connection with each request for reimbursement.

Further, Exchange enrollees might experience increased compliance burdens, to the extent that they must become familiar with the circumstances in which an offer of an individual coverage HRA precludes them from claiming the PTC. For employees who previously did not receive an offer of a traditional group health plan, this may require learning some of the PTC eligibility rules, and for employees who previously received an offer of a traditional group health plan, this may require learning new or different rules for PTC eligibility. Specifically, an employee who is offered a traditional group health plan is not eligible to claim the PTC for his or her Exchange coverage unless the premium of the lowest cost employer plan providing MV for self-only coverage less the employer contribution for self-only coverage exceeds 9.5 percent (indexed for inflation after 2014) of the employee's household income (assuming the employee meets various other PTC eligibility requirements). In contrast, under the final PTC rules, an employee who is offered an individual coverage HRA will not be eligible to claim the PTC for his or her Exchange coverage unless the premium of the lowest cost silver plan for self-only coverage offered by the Exchange for the rating area in which the employee resides less the individual coverage HRA contribution amount exceeds 9.5 percent (indexed for inflation after 2014) of the employee's household income (assuming the employee meets various other PTC eligibility requirements). However, the Departments note that the final rules will require HRA plan sponsors to furnish a notice to participants providing some of the information necessary for an individual to determine if the offer of the HRA could render them ineligible for the PTC.

In addition, if an enrollee in Exchange coverage is eligible for the PTC, the amount of the PTC is based, in part, on the premium for the SLCSPP for the coverage unit offered in the Exchange for the rating area in which the employee resides. As noted earlier, the final PTC rules use the premium for the

self-only lowest cost silver plan available to an employee in the Exchange for the rating area in which they reside solely for purposes of determining their individual coverage HRA affordability and the resulting impact on PTC eligibility. Therefore, Exchange enrollees may need to understand which silver level plan premium applies to them for APTC eligibility purposes and which silver level plan premium applies to their PTC calculation.

Similarly, the FFEs and State Exchanges will incur one-time costs to incorporate the SEP and the PTC eligibility rules for individuals with an individual coverage HRA offer into their instructions for enrollees and Exchange employees, as well as in application system logic and automated calculations. HHS estimates that one-time costs to account for individual coverage HRAs for the FFEs will be approximately \$3.9 million. HHS further estimates that the FFE call center, eligibility support contractors verifying SEP and application data, and other customer support functions will incur additional annual costs of approximately \$56 million in 2020 to \$243 million by 2022 to serve the expanded Exchange population. Assuming that State Exchanges will incur costs similar to the FFEs, total one-time costs incurred by the 12 State Exchanges will be approximately \$46.8 million. Total additional ongoing costs incurred by the call centers, eligibility support contractors verifying SEP and application data, and other customer support functions for the 12 State Exchanges will be approximately \$20 million in 2020 to \$85 million by 2022.

Under the final rules, the IRS also will need to add information regarding employees offered individual coverage HRAs to instructions for IRS forms for taxpayers, employee training materials, and calculation programs.

In response to the Departments' request for comments on the extent to which employer administrative costs would be increased or decreased by the rule, some commenters stated that complying with the individual coverage HRA rules would be burdensome. Several commenters expressed particular concern about the ongoing substantiation requirement.

Some commenters noted that the proposed rules would create consumer confusion. Another commenter noted that recent cutbacks in funding for outreach and assistance in the individual market could exacerbate the confusion. One commenter stated that most Americans need a large amount of professional support when making

sound health insurance purchasing decisions and they also need a degree of help to manage their medical claims and coverage during the plan year, particularly in the face of any complex medical issue.

The Departments requested comments on the implementation and ongoing costs to State Exchanges of individual coverage HRAs, and several stakeholders expressed concerns about these increased administrative costs. Although commenters did not quantify the costs, one State Exchange said it estimates a significant expense given the scope and complexity of the proposal. Costs identified include administering a new SEP; making IT changes involving new definitions and explanation texts; user testing; adding a table for the lowest cost silver plan; delaying implementation of other functions; administering appeals; and adding additional staffing for administration, training and oversight such as for increased call center activity and increased complexity. Another Exchange noted the need to update Exchange eligibility software to account for new forms for HRAs, new rules affecting PTC eligibility and new SEPs. Several states requested that the effective date of the final rules be delayed until State Exchanges have had sufficient time to implement the new requirements.

As noted earlier in this preamble, the Departments have included in the final rules some provisions to mitigate these concerns and associated costs. For example, to ensure that employees who are eligible to receive an individual coverage HRA understand the potential effect on PTC eligibility, employers must provide a written notice to eligible participants. To mitigate burden on employers, the Departments are providing model language contemporaneously on certain aspects of the notice, including model language describing the PTC consequences. In addition, ongoing technical assistance will be provided to State Exchanges related to system development activities that will support employers and employees with HRA affordability determinations and the impact on APTC eligibility, as well as the SEP for those with an offer of an individual coverage HRA. HHS has already discussed with State Exchanges what changes would likely be necessary if the rule were finalized as proposed to assist with planning, as well as what kind of assistance would be most helpful during implementation. Specific assistance could include sharing technical and educational documentation from FFE implementation that can be leveraged to

support State Exchange efforts. This assistance could help State Exchanges implement changes related to the individual coverage HRA more quickly and with less overall cost. The Departments will also provide assistance to Exchanges in developing information and tools that could be provided to employers and employees to help ensure smooth implementation before the full system changes are complete. This could include State Exchanges providing employees with information on how they can calculate HRA affordability and the impact on APTC in the absence of system changes that can make those calculations for the employee.

#### Transfers

The Treasury Department performed microsimulation modeling to evaluate the coverage changes and transfers that are likely to be induced by the final rules. The Treasury Department's model of health insurance coverage assumes that workers are paid the marginal product of their labor. Employers are assumed to be indifferent between paying wages and paying compensation in the form of benefits (as both expenses are deductible in computing employers' taxable incomes). The model therefore assumes that total compensation paid by a given firm is fixed, and the employer allocates this compensation between wages and benefits based on the aggregated preferences of their employees. As a result, employees bear the full cost of employer-sponsored health coverage (net of the value of any tax exclusion), in the form of reduced wages and the employee share of premiums.<sup>295</sup>

The Treasury Department's model assumes that employees' preferences regarding the type of health coverage (or no coverage) are determined by their expected healthcare expenses and the after-tax cost of employer-sponsored insurance, Exchange coverage with the PTC, or Exchange or other individual health insurance coverage integrated with an individual coverage HRA, and the quality of different types of coverage

<sup>295</sup> Note that the wage reduction for an employee who is offered a health benefit may be greater or less than the expected cost of coverage for that particular employee. Because employees are generally paid the same regardless of age, health status, family size or acceptance of benefits, the model assumes that each employee bears the same share of the cost of the firm's coverage. The model allows for some limited variation of the wage reduction by wage class and educational status. All costs and benefits of coverage are taken into account and assumed to accrue to employees, including all income and employer and employee payroll tax exclusions and the avoidance of the employer shared responsibility payment under Code section 4980H by firms that offer coverage.

(including actuarial value).<sup>296</sup> The tax preference for the individual coverage HRA is the same as that for a traditional group health plan, and this estimate assumes that employers will contribute the same amount towards an individual coverage HRA as they would contribute for a traditional group health plan.<sup>297</sup> Therefore, an employee will prefer an individual coverage HRA to a traditional group health plan if the price of individual health insurance coverage is lower than the price of traditional group health plan coverage, as long as the value of the higher quality of the traditional group health plan coverage (if any) does not outweigh the lower cost of individual health insurance coverage. The cost of individual health insurance coverage for an employee could be lower than the cost of the firm's traditional group health plan if the individual health insurance coverage is less generous, if the individual health insurance coverage risk pool is healthier than the firm's risk pool, or if the cost of individual health insurance coverage to a particular employee is lower than the cost of the firm's coverage (because, for example, the employee is younger than the average-age worker in the firm).<sup>298</sup>

<sup>296</sup> Expected healthcare expenses by type of coverage, age, family size and other characteristics are estimated using the Medical Expenditure Panel Survey—Household Component (MEPS-HC). These predictions are then statistically matched to the Treasury Department tax data. The MEPS-HC is conducted by the United States Census Bureau for the Agency for Healthcare Research and Quality (AHRQ), Department of Health and Human Services.

<sup>297</sup> It is possible that employers that switch from offering traditional group health plans to offering individual coverage HRAs will contribute less to individual coverage HRAs than they pay for group coverage, and increase taxable wages by a corresponding amount. This could happen because there is greater transparency around health care costs with an individual coverage HRA than with a traditional group health plan, and greater awareness of the cost will likely lower worker demand for health insurance benefits relative to wages. On the other hand, it is not clear why an employer that (based on the incomes and preferences of its workforce) wants to substitute contributions to health benefits for wages would not do so today, in the absence of the availability of individual coverage HRAs, particularly because the final rules generally require that individual coverage HRAs be offered on the same terms to all employees in a class of employees, as described earlier in this preamble.

<sup>298</sup> The Treasury Department model assumes that both the employee and employer shares of premiums for traditional group health plan coverage are fully tax exempt. In modeling the choice between an individual coverage HRA and traditional group health plan coverage, the Treasury Department assumes that the total amount currently paid for traditional group health plan coverage will continue to be tax preferred. If this amount exceeds the individual health insurance coverage premium, the excess is assumed to be used for copayments and deductibles. However, the Treasury Department

Continued

When evaluating the choice between an individual coverage HRA and the PTC for Exchange coverage, the available coverage is assumed to be the same but the tax preferences are different. Hence, an employee will prefer the individual coverage HRA if the value of the income and payroll tax exclusion (including both the employee and employer portion of payroll tax) is greater than the value of the PTC. In modeling this decision, the Departments assume that premiums paid by the employee are tax preferred through the reimbursement of premiums from the individual coverage HRA, with any additional premiums (up to the amount that would have been paid under a traditional group health plan) paid through a salary reduction arrangement.<sup>299</sup>

In the Treasury Department's model, employees are aggregated into firms, based on tax data.<sup>300</sup> The expected health expenses of employees in the firm determine the cost of employer-sponsored insurance for the firm.<sup>301</sup> Employees effectively vote for their preferred coverage, and each employer's offered benefit is determined by the preferences of the majority of employees. Employees then decide whether to accept any offered coverage, and the resulting enrollment in traditional or individual health insurance coverage determines the risk pools and therefore premiums for both employer coverage and individual

does not increase the amount that is tax preferred in the case where the individual health insurance coverage premium exceeds the traditional group health plan premium.

<sup>299</sup> The assumption that coverage subsidized by the PTC is the same as coverage subsidized by an individual coverage HRA may be incorrect to the extent that coverage on an Exchange differs from off-Exchange individual health insurance coverage. In addition, the assumption that the full premium for an employee with or without an individual coverage HRA is tax preferred may be incorrect if the employer does not offer a salary reduction arrangement, if the employee does not elect the salary reduction, or if the employee chooses on-Exchange rather than off-Exchange coverage. Salary reduction arrangements may not be used to pay premiums for Exchange coverage.

<sup>300</sup> A crucial component of the model is the use of Form W-2, Wage and Tax Statement, filed by employers to report wages and other benefits of employees. Forms W-2 with the same employer identification number are grouped together to represent the employees of the firm.

<sup>301</sup> Some small firms—generally those with sicker than average employees—are able to purchase community rated coverage in the small group market at lower cost than they could obtain by self-insuring or would pay if they had to purchase coverage in the underwritten large-group market. Firm coverage costs are over-estimated in the Treasury Department's model for these firms. As a result, the Treasury Department model likely over-estimates the extent to which small firms will adopt individual coverage HRAs instead of traditional group health plan coverage and the premium increase from this rule.

health insurance coverage. The Treasury Department's model, thus, predicts enrollment and premiums in each type of coverage.

*Transitions from traditional group health plans to individual coverage HRAs.* Based on microsimulation modeling, the Departments expect that the final rules will cause some participants (and their dependents) to move from traditional group health plans to individual coverage HRAs. As previously noted, the estimates assume that for this group of firms and employees, employer contributions to individual coverage HRAs are the same as contributions to traditional group health plans would have been, and the estimates assume that tax-preferred salary reductions for individual health insurance coverage are the same as salary reductions for traditional group health plan coverage. Thus, by modeling construction there is no change in income or payroll tax revenues for this group of firms and employees (other than the changes in the PTC discussed later in this preamble). The Departments solicited comments on these assumptions, and comments received are summarized further below.

While the tax preference is assumed to be unchanged for this group, after-tax out-of-pocket costs could increase for some employees (whose premiums or cost sharing are higher in the individual market than in a traditional group health plan) and decrease for others.

A small number of employees who are currently offered a traditional group health plan nonetheless obtain individual health insurance coverage and the PTC, because the traditional group health plan is unaffordable to them or does not provide MV. Some of these employees would no longer be eligible for the PTC for their Exchange coverage when the employer switches from a traditional group health plan to an individual coverage HRA because the HRA is determined to be affordable under the final PTC rules.<sup>302</sup> In addition, some employees who are offered individual coverage HRAs would not accept them, and would be newly able to obtain the PTC because the offer of the HRA would be considered to be unaffordable under the final PTC rules, even though the traditional group health plan they were previously offered is affordable under current rules.<sup>303</sup>

<sup>302</sup> As noted later in this section of the preamble, however, the Departments' estimates assume that individuals with incomes below 200 percent of the federal poverty level are not newly ineligible for the PTC by individual coverage HRA offers.

<sup>303</sup> The number of persons newly eligible for the PTC is expected to be very small. Under the

*Transitions from no employer-sponsored health benefit to individual coverage HRAs.* The Departments expect some employees to be offered individual coverage HRAs when they previously received no offer of an employer-sponsored health plan. As a result, taxable wages will fall and non-taxable wages will rise, reducing income tax and payroll tax revenues. Under this circumstance, some Exchange enrollees who previously claimed the PTC will be precluded from claiming the PTC as a result of the offer or acceptance of the HRA, reducing PTC transfers. As explained further below, the Departments assume that PTC spending is reduced only among Exchange enrollees with incomes greater than 200 percent of the federal poverty level.

*Transitions from traditional group health plans to individual coverage HRAs integrated with Medicare.*

Currently, there are about 2.5 million people for whom employer coverage is the primary payer and Medicare is secondary. Earlier in this preamble, the Departments clarify that plan sponsors may allow amounts made available under an individual coverage HRA to be used to pay for Medicare and Medigap premiums, as well as other medical care expenses.<sup>304</sup> Once premiums (and deductibles for medical care expenses) are paid by the individual coverage HRA, there would be few funds available to pay for medical care expenses. Hence, Medicare would effectively become the primary payer in the vast majority of cases.

The total costs to the Medicare Part A program will increase because Medicare Part A will effectively become the primary payer. Because enrollment in Medicare Part A and B or Part C<sup>305</sup> is a requirement to be covered by an individual coverage HRA that is integrated with Medicare and because employees offered an individual coverage HRA will not have access to a traditional group health plan through their employer, the vast majority of employees are expected to enroll in Medicare Part B (and many in Part D).

assumption that employers contribute the same amount towards an individual coverage HRA as they would for traditional group health plan coverage, employees would become newly eligible for the PTC (if otherwise eligible) only if the lowest cost silver plan premium for self-only individual health insurance coverage is greater than the total cost of the lowest cost MV plan offered by the employer (including the employee and employer share of premiums).

<sup>304</sup> Note, however, that an individual coverage HRA may not, under its terms, limit reimbursement only to expenses not covered by Medicare.

<sup>305</sup> Currently, very few working aged Medicare enrollees have enrolled in Medicare Part C and these estimates are based on the assumption that this is not likely to change.

Per enrollee premiums for Medicare Part B and D will be slightly lower due to the improved health of the Medicare risk pool; however, net costs to the Medicare program will increase due to increased enrollment and because premiums for Medicare Part B will not fully offset the costs of the program.<sup>306</sup>

*Summary of estimated transfers and coverage changes.* The Departments estimate that once employers fully adjust to the final rules, roughly 800,000 firms will offer individual coverage HRAs. The Departments further estimate that it will take employers and employees about five years to fully adjust to the final rules, with about 10 percent of take-up occurring in 2020 and the full effect realized in 2024 and beyond.

This would result in an estimated 1.1 million individuals receiving an individual coverage HRA in 2020, growing to 11.4 million in 2029. Conversely, the number of individuals in traditional group health plan coverage will fall by an estimated 0.6 million (0.4 percent) in 2020 and 6.9 million (4.5 percent) in 2029. Similarly, the number of individuals in individual health insurance coverage without an individual coverage HRA will fall by an estimated 0.4 million (2.4 percent) in 2020 and 3.8 million (24.8 percent) in

2029. The number of uninsured persons will fall by an estimated 0.1 million (0.1 percent) in 2020 and 0.8 million (1.4 percent) in 2029.<sup>307</sup> See Table 2 for details.

The modeling suggests that employees in firms that would switch from offering traditional group health plan coverage to offering an individual coverage HRA would have, on average, slightly higher expected healthcare expenses than employees in other firms and current individual market enrollees. As a result, premiums in the individual market would be expected to increase by about 1 percent as a result of the final rules, throughout the 2020–2029 period examined. The Treasury Department model is nationally representative and does not necessarily reflect the expected experience for every market. The premium increase could be larger in some markets if some adverse selection results, and premiums could fall in other markets. Furthermore, some employers might take longer to adopt the individual coverage HRA, preferring to wait to see how premiums change; and, this delay in adoption might be more likely in markets that are currently in worse condition. Such differing behavior adds uncertainty to the estimates.

Income and payroll tax revenue is expected to fall by about \$500 million in fiscal year 2020 and \$15.5 billion in 2029, as firms newly offer tax-preferred health benefits in the form of individual coverage HRAs. At the same time, total PTC (including the refundable and non-refundable portion of the credit) is expected to fall by about \$300 million in 2020 and by about \$6.2 billion in 2029. In total, the final rules are estimated to reduce tax revenue by about \$200 million in fiscal year 2020, \$9.3 billion in fiscal year 2029, and \$51.2 billion over the 10-year period through fiscal year 2029.<sup>308</sup>

The Departments assume that about 1 percent of the 2.5 million individuals for whom employer coverage is the primary payer and Medicare is the secondary payer will enroll in an individual coverage HRA integrated with Medicare by the end of the projection period. As a result, the final integration rules are estimated to increase costs to the Medicare trust funds by less than \$50 million in 2020, \$0.3 billion in 2029, and \$1.9 billion over the ten-year period through fiscal year 2029. The impacts for Medicare Part B and D reflect the net impact to the federal government after the payment of premiums.

TABLE 2—ESTIMATED EFFECTS OF INDIVIDUAL COVERAGE HRAS ON INSURANCE COVERAGE AND TAX REVENUES, 2020–2029

Calendar year	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
<b>Change in Coverage [Millions]:<sup>a</sup></b>										
Individual health insurance coverage with HRA .....	1.1	2.7	5.3	8.1	10.9	11.0	11.2	11.4	11.4	11.4
Traditional group health plan .....	-0.6	-1.7	-3.3	-5.0	-6.7	-6.8	-6.8	-6.8	-6.9	-6.9
Individual health insurance coverage without HRA .....	-0.4	-0.9	-1.8	-2.7	-3.6	-3.6	-3.7	-3.8	-3.8	-3.8
Uninsured .....	-0.1	-0.2	-0.3	-0.5	-0.6	-0.7	-0.7	-0.7	-0.7	-0.8
Fiscal year	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
<b>Change in Revenue [Billions]:</b>										
Premium Tax Credit Reduction .....	0.3	0.8	1.8	3.0	4.4	4.7	5.4	5.7	6.0	6.2
Other Income and Payroll Tax Reduction .....	0.5	1.7	3.8	6.4	9.4	10.9	12.6	13.9	14.7	15.5
Net Revenue Reduction .....	0.2	1.0	1.9	3.4	5.0	6.2	7.2	8.3	8.8	9.3
Medicare Part A <sup>b</sup> .....	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Medicare Part B .....	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Medicare Part D .....	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1
Total Medicare Outlay Cost <sup>c</sup> .....	0.0	0.0	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.3
Total Cost <sup>d</sup> .....	0.2	1.0	2.0	3.6	5.2	6.4	7.5	8.5	9.1	9.6

**Notes:**

a. Millions of covered lives, annualized.

b. 0 = less than \$50 million.

c. Note that the sum of estimated impacts for Medicare Part A, B and D may not equal net Medicare Outlay Cost due to rounding.

d. May not add to sum, due to rounding.

<sup>306</sup> Employees who are entitled to Medicare on the basis of age generally tend to have lower healthcare costs than the average Medicare beneficiary, improving the overall health of the Medicare risk pool.

<sup>307</sup> These estimates are annualized counts (e.g., two persons with six months of coverage each count

as one covered person), and reflect only coverage for persons under age 65. For more information about the Treasury Department's baseline estimates, see "Treasury's Baseline Estimates of Health Coverage, Fiscal Year 2019 Budget Exercise" June 2018, available at <https://www.treasury.gov/resource-center/tax-policy/tax-analysis/Documents/>

*Treasury%27s-Baseline-Estimates-of-Health-Coverage-FY-2019.pdf.*

<sup>308</sup> These revenue estimates do not account for the possibility that the final rules could lead to increased taxable wages.

At least one commenter stated that the negative effects of the proposed rules, particularly the increase in the individual market premiums and the attendant fiscal costs, are likely to outweigh the benefits to employers and their employees. As noted earlier in the preamble, the increase in individual market premiums is a modest 1 percent. While the net fiscal cost in 2025 is \$6.2 billion, this includes the cost of new coverage for 0.7 million individuals. In addition, as discussed earlier, the integrated coverage HRA provides employers and employees with an additional option for providing health benefits, a benefit that the Departments have not quantified. Therefore, the Departments have concluded that the benefits of allowing integration of individual coverage with HRAs substantially outweigh the costs.

The Departments acknowledge that the extent to which firms will offer individual coverage HRAs and the results on individual market risk pools and premiums, federal tax revenues, and private costs and benefits are highly uncertain. The Departments invited comments on the modeling assumptions and proposed estimates of the proposed rules and assumptions.

Several commenters stated that the Departments' analysis failed to take account of variation in individual market risk across geographic areas. The Departments' acknowledge that the quantitative estimates are derived from a nationally representative model, largely because the MEPS-HC is a nationally representative survey. The Departments do not know of any readily available data on the distribution of health claims at the firm level for specific rating areas or states. If the health risk in the individual market relative to that of employer risk pools varies across geographic areas, a nationally based model will understate the extent to which employees might transition to individual markets with healthier risk pools and overstate movement into less healthy individual markets. This would understate potential premium increases in some markets and overstate them or understate premium decreases in others. To examine this possibility, the Departments estimated the correlation between individual market premiums and traditional group coverage premiums in all rating areas across the country.<sup>309</sup> The Departments found that

premiums in the two markets are positively correlated, and that the correlation is statistically significant. In other words, where premiums for individual health insurance coverage are higher, premiums in the traditional employer market also tend to be higher. The Departments also do not find any evidence that, to date, employers have substantially dropped coverage or disproportionately dropped coverage and sent less healthy employees to individual markets with healthier risk pools. Even if the difference between individual market health risk and group market health risk currently varies across location, there is no clear reason why that variation would not persist when the individual coverage HRA is available. As a result of these observations, the Departments conclude that there is little indication that the individual coverage HRA will be disproportionately used in areas with healthier individual market risk pools. Moreover, it is not evident that adverse selection into the individual market would be much more likely in these lower cost areas, or that those risk pools would not be able to absorb additional enrollees from the group market.

One commenter suggested that the Treasury Department model does not adequately account for variation in expected claims risk across employers, because it does not explicitly account for the tendency of sicker workers to work alongside otherwise sicker workers, and for healthy workers to work alongside other healthy workers. The Treasury Department model imputes the expected health care expenses of families from MEPS-HC data, controlling for type of coverage, age, gender, family size and type, employment status, education, race, health status, geographic characteristics and other characteristics. The Treasury

Department constructed firms using Form W-2 and other tax data. The Treasury Department then matched the MEPS-HC health expenses of families to families in the tax data (and thereby to employees within firms), by income, family size and type, age, gender and other variables common to the MEPS-HC and tax data sets. The model should reflect the clustering of sicker or healthier workers within firms if such clustering is correlated with the characteristics used in the health expense imputation and matching of MEPS-HC and tax data. In addition to conducting a survey of households' health expenditures (the MEPS-HC), the U.S. Census Bureau conducts a survey of employers regarding their health insurance costs (the Medical Expenditure Panel Survey—Insurance Component, or MEPS-IC.) To evaluate whether the distribution of imputed healthcare costs within and across firms in the Treasury Department model is in fact reasonable, the Departments obtained MEPS-IC premiums for single and family plans at each percentile of the premium distribution, and compared these to premiums in the Treasury Department model. The Departments found that the distributions looked very similar. That is, the imputed premiums appear similar to those reported in the MEPS-IC, for both lower and higher cost firms. Therefore, the Departments conclude that there is no evidence to suggest that the Treasury Department model does not reflect clustering by health status or any other important determinants of health risk and premiums.

As explained earlier in this section of the preamble, the Departments explicitly assume that persons with incomes below 200 percent of the federal poverty level who are enrolled in subsidized individual health insurance coverage in the baseline do not move to an individual coverage HRA or to uninsured status as a result of the final rules. The Departments also assume that employees with incomes above 400 percent of the federal poverty level who are currently enrolled in a traditional group health plan do not become uninsured as a result of his or her employer switching to an individual coverage HRA, even if individual health insurance coverage premiums are substantially higher than the cost of their traditional group health plan coverage. These assumptions are consistent with allowing the individual coverage HRA offer to vary across employees in certain cases, and are intended to provide estimates that reasonably reflect expected employer

*Treasury%27s-Baseline-Estimates-of-Health-Coverage-FY-2019.pdf* for a description of this estimation process. The Departments then compared this to SLCSP premiums. The Departments specifically compared single plan premiums for firms including any 30-year old covered employee to SLCSP premiums for a 30 year old, and did the same for firms including any 50-year old covered employee and SLCSP premiums for a 50 year old in the same rating area. In both cases the Departments estimated that traditional group coverage premiums increase by about 20 cents for every dollar increase in individual market premiums (p<01). The commenter provided some evidence of geographic variation in health claims in the individual market relative to claims in the small group insured market. This analysis is of limited use, because most employees who are expected to be offered an individual coverage HRA are in the large group market. The Treasury Department data for this sensitivity analysis includes premiums in firms of all sizes, but is heavily weighted to firms filing more than 250 Forms W-2, as these employers are required to report premium information.

<sup>309</sup> Specifically, the Departments extracted premiums reported on the population of Forms W-2, and estimated per person annual premiums from this information using coverage data from Forms 1095-B and C. See <https://www.treasury.gov/resource-center/tax-policy/tax-analysis/Documents/>

and employee behavior. The Departments acknowledge that imposition of these assumptions reduces both the amount of estimated PTC savings and the amount of estimated individual coverage HRA revenue costs. In addition, by imposing this restriction, the analysis does not reflect the extent to which lower-income employees would face higher insurance costs if an individual coverage HRA offer renders them ineligible for the PTC.

One commenter suggested that the Departments explicitly model coverage choices for individuals with incomes below 200 percent or above 400 percent of the federal poverty level. Other commenters expressed concern that low-income workers likely would face higher coverage costs (and perhaps take-up less coverage and face worse financial or health outcomes) because they will lose eligibility for PTC. One commenter suggested that the individual coverage HRA rules could only benefit families with incomes in excess of 400 percent of the federal poverty level. However this commenter did not take into account the decline in PTC as income rises as well as the tax benefit of employer-provided individual coverage HRAs. In order to consider these concerns more fully, the Departments performed additional analysis to evaluate the potential effect of the individual coverage HRA on receipt of PTC and changes in tax liability across income classes, under the Departments' preferred assumption that persons with low incomes do not lose PTC and an alternative scenario where the Departments do not impose this assumption.

Under the Departments' preferred set of assumptions, the individual coverage HRA reduces tax revenues by a total of \$6.2 billion in calendar year 2025, consisting of \$10.9 billion in reduced income and payroll taxes partly offset by \$4.7 billion in reduced PTC (including both the refundable and non-refundable portions of the credit). In comparison, the individual coverage HRA increases tax revenues \$1.1 billion among taxpayers who are enrolled in individual health insurance coverage in the Exchange in the baseline. Over 0.9 million families with incomes between 200 and 400 percent of the federal poverty level pay \$2.1 billion more in taxes (that is, on net the loss in PTC exceeds the value of income and payroll tax exclusions received for the individual coverage HRA), or an average of nearly \$2,300. However, they are not expected to become uninsured, because while the tax preference for the HRA is less than the PTC, the after-tax cost of

coverage is less than the expected cost of healthcare. About 0.4 million families with incomes over 400 percent of the poverty level pay nearly \$1.1 billion less in taxes, with an average tax cut of nearly \$2,900. Note that these estimates include only the effects on families with individuals currently enrolled in individual health insurance coverage in the Exchange, and do not reflect the tax decreases experienced by newly insured persons, or by persons currently enrolled in individual health insurance coverage outside of the Exchange. In addition, the estimates for families with incomes below 400 percent of the federal poverty level are net changes, and include gains for families for whom the tax exclusion value of the individual coverage HRA exceeds the PTC offset by losses for families for whom the PTC exceeds the value of tax exclusion gained.

Under an alternative assumption where persons with incomes below 200 percent of the federal poverty level also lose PTC if their employer offers an affordable individual coverage HRA, about 0.9 million additional families would pay an additional \$3.5 billion in taxes (in the form of lost PTC that is not offset by the value of income and payroll taxes received for individual coverage HRA), with an average tax increase of nearly \$4,000. These families are not projected to become uninsured. The 10-year cost of the final rules would fall from an estimated \$51.2 billion to \$23.7 billion. However, as noted earlier, the Departments do not expect such large tax increases among lower-income families to occur. Rather, the Departments expect employees who currently receive substantial amounts of PTC but are in firms where employees overall are better off with an individual coverage HRA will seek out employers that do not offer an individual coverage HRA or traditional group health plan, or that employers will reduce individual coverage HRA offers or decide not to offer an individual coverage HRA, so as not to render all or certain classes of employees ineligible for the PTC. This may be particularly true for firms that do not offer a traditional group health plan in the baseline.

In addition, the Departments performed an alternative analysis of the number of persons with incomes in excess of 400 percent of the federal poverty level who are predicted to become uninsured if employers do not vary contributions to individual coverage HRAs by age and employees do not switch employers to avoid an increase in health insurance costs. (In other words, in this scenario the Departments relax their assumption that

no higher income persons become uninsured as a result of moving from traditional group health plan coverage to being offered an individual coverage HRA.) In this alternative simulation, about 1 percent of persons in families with incomes above 400 percent of the federal poverty level with traditional group health plan coverage under the baseline become uninsured (or nearly 900,000 individuals). However, as noted earlier in this section of the preamble, the Departments do not expect such transitions to occur. Under this alternative simulation, older individuals are more likely to become uninsured, in large part because the Treasury Department's model fails to account for the variation in individual coverage HRA contributions by age as permitted under the final rules. Under the final rules, we expect that employers will vary individual coverage HRA offers so as not to completely unwind the cross-subsidies of older employees by younger employees and avoid markedly increasing older employees' coverage costs. In the event that coverage costs for particular employees substantially increase, those employees are expected to seek employment at firms that continue to offer traditional group health plan coverage.

Several commenters stated that employers would likely provide the same amount of individual coverage HRA contributions to all employees in a class of employees, without age variation. As a result, older workers could face higher coverage costs and younger workers could face lower costs when they move from traditional group health plan coverage to an age-rated individual health insurance plan. However, varying HRA amounts based on age is allowed under the final rules, subject to certain limits, and other commenters suggested that employers would utilize this option, thereby maintaining existing cross-subsidies of older workers, which clearly has economic utility to firms, to some extent.

Several commenters suggested that the Departments' estimates of individual coverage HRA take-up are overstated, because the estimates do not account for increased hassle costs of enrolling in individual health insurance coverage, compared to the cost of enrolling in a traditional group health plan. The Departments acknowledge earlier in this section of the preamble that some individuals will face higher administrative costs associated with choosing individual health insurance plans and enrolling in coverage. This could result in fewer employers offering individual coverage HRAs and fewer

employees enrolling in individual health insurance coverage integrated with an HRA. However, commenters did not attempt to quantify such costs. Because the magnitude of these costs (in total and relative to the cost of enrolling in a traditional group health plan) is uncertain, the Departments are unable to quantify the likely effect on individual coverage HRA take-up.

The Departments particularly emphasize that these estimates assume that every employee in a firm would be offered either an individual coverage HRA or a traditional group health plan (but not both and not a choice between the two), or no employer health benefit. The estimates further assume that a firm offering an individual coverage HRA would offer the same benefit to each employee in the firm, and would not vary the contribution by location, age, or other permitted factors other than self-only versus non-self-only benefits.<sup>310</sup> In other words, the estimates assume that the final rules will be effective in preventing firms from dividing their employees by health status or other factors in a way that would allow firms to capture greater tax subsidies or increase individual market premiums or the PTC.

In estimating the impact of the final rules on individual coverage HRA participation and transfers, including individual market premium increases, it

<sup>310</sup> The Departments imposed two constraints on the microsimulation that could be consistent with allowing the individual coverage HRA offer to vary across classes of employees within a firm. First, the Departments assume that persons with incomes below 200 percent of the federal poverty level who are enrolled in subsidized individual health insurance coverage in the baseline do not move to an individual coverage HRA or to uninsured status as a result of the final rules. This is consistent with assuming that employers with low-wage workers currently receiving Medicaid or the PTC do not begin to offer individual coverage HRAs large enough to render such employees ineligible for the PTC or from receiving public coverage. This constraint is also consistent with the assumption that employees who would experience a substantial subsidy loss will move to other jobs that allow them to retain their current coverage. This assumption reduces the amount of PTC savings generated by the final rules, and also reduces the tax revenue cost of providing individual coverage HRAs to such employees. Second, the Departments assume that employees with incomes above 400 percent of the federal poverty level who are enrolled in a traditional group health plan do not become uninsured as a result of the final rules, even if individual health insurance plan premiums are substantially higher than the cost of their traditional group health plan coverage. This is consistent with assuming that employers will provide larger individual coverage HRAs to older employees or to employees in higher-cost markets than they will provide to other employees in their firms, in order to ensure affordable coverage. It is also consistent with assuming that employees will move to other firms, if they face large premium or cost-sharing increases when their employers switch from traditional group health plan coverage to individual coverage HRAs.

is important to take into account the relative sizes of the employer market and the individual health insurance market and the relative health risk of individuals that are likely to transition from group to individual market coverage. Because the number of individuals in traditional group health plans is large relative to the number of individuals in individual health insurance coverage, relatively small changes in employer offers of coverage can result in large changes in individual market premiums.<sup>311</sup>

The Departments invited comments on the extent to which firms with healthy or less healthy risk pools would utilize individual coverage HRAs. The Departments specifically sought comments on the extent to which employers would offer different benefits to different classes of employees, including the rating area class and combinations of the classes, and the resulting effect on individual market premiums. Many commenters responded, generally emphasizing the importance of a stable individual health insurance market and the need to maintain and, if possible, strengthen conditions to prevent adverse selection as a result of the individual coverage HRA.

Many commenters noted that, because the employer group market is very large relative to the individual market, even a relatively minor shift of higher-cost individuals from traditional group health plans to the individual market would markedly increase individual market premiums. In a similar vein, one commenter noted that the individual market in their state is too small to absorb the high health costs from the few employers who have high enough health costs to make the individual coverage HRA strategy economically attractive. Commenters also noted that healthcare costs are distributed very unevenly, and that, as a result, moving a small number of the highest-cost employees to the individual market can have a large impact on premiums. Several commenters provided their own scenarios showing that if employers are able to send a relatively small number of high-cost individuals to the individual market it could result in a very large increase in premiums in the individual market. Under one example, if 1 percent to 4 percent of the employer market with various above-average-fractions of higher-cost employees migrates to the individual market,

<sup>311</sup> The Treasury Department projects that over 150 million persons under age 65 will be enrolled in employer-sponsored group health plans in 2020, compared to about 15 million in the individual market.

premiums have the potential to increase 3 percent to 83 percent. In an example presented by another commenter, if as few as 5 percent of the persistent top spenders in the large group market move to individual market coverage, the average individual market claim would increase by 15 percent. Under a third example discussed by a third commenter, if 10 percent of employers designed individual coverage HRAs to shift the sickest individuals into the individual market, premiums would increase by 17.3 percent. If however 100 percent of employers engage in shifting their sickest employees, premiums would increase by 93.1 percent in the individual market. The Departments note that these scenarios do not take into account the conditions in the proposed or final rules intended to prevent adverse selection. As such they help to illustrate why the Departments proposed, and are finalizing, conditions designed to prevent adverse selection. These examples are not inconsistent with the illustrative scenario presented by the Departments in the preamble to the proposed rules.

Many commenters said it was important that the final rules not give employees a choice between a traditional group health plan and an individual coverage HRA in order to prevent adverse selection in the individual market, as was prohibited under the proposed rules. One commenter gave specifics noting that it is the employer that is empowered with deciding which health benefits to offer. Thus, according to the commenter, it is not likely that employers would offer both an individual coverage HRA and a traditional group health plan if the employer anticipated that such a choice would increase claims cost in its traditional group health plan. The commenter noted that without the condition in the proposed and final rules prohibiting plan sponsors from offering employees a choice between a traditional group health plan and an individual coverage HRA, there would be market segmentation caused by incenting high-cost individuals to enroll in individual market coverage as well as potential adverse selection based on difference in benefits, cost-sharing levels, and networks.

Many commenters said that it is important that the final rules retain the condition that individuals be required to obtain individual health insurance coverage in order to be covered by an individual coverage HRA. One commenter suggested that, otherwise, healthy individuals might opt out of the individual market (comprehensive coverage) and use the individual

coverage HRA to cover out-of-pocket spending or for noncompliant coverage, potentially increasing adverse selection in the individual market. Relatedly, many commenters supported the prohibition on integration of an HRA with STLDI. If enrollees were given a choice of individual health insurance coverage or STLDI, in conjunction with an individual coverage HRA, commenters explained that healthy employees would be more likely to purchase the less expensive STLDI plans, creating adverse selection for the individual market.

Commenters generally supported the condition that individual coverage HRAs be offered on the same terms to an entire class of employees and that the classes to which a plan sponsor may offer HRAs on different terms be limited to the classes enumerated in the proposed rules and any combinations of those classes. One commenter noted that the same terms requirement and the enumerated classes reduce the ability of employers to target high-cost workers by targeting particular worker classes. The commenter explained that allowing employers to define classes more narrowly would increase the opportunity for employers to target high-cost workers, thereby increasing the adverse selection risk in the individual market. Some commenters recommended that the number of permitted classes not be expanded in general to avoid increasing the risk of adverse selection in the individual market.

One commenter noted that the proposed permitted classes of employees could be combined to offer employers opportunities to segment highly specific subsets of employees, including the more costly populations, resulting in higher premiums in the individual market. Several other commenters expressed concerns that the proposed integration conditions would not be adequate to protect against additional risk segmentation. Another commenter suggested that premiums in the individual market could rise because the proposed rules create uncertainty, causing insurers to include an additional risk factor when setting premiums. Further, the commenter urged that the proposed rules be withdrawn as they would be detrimental to consumers and health insurance markets in that particular state. One state with an approved PPACA section 1332 state innovation waiver authorizing a re-insurance program asserted that the proposed rules could dismantle the market stability that has been achieved through state based mechanisms and that states

with re-insurance programs will unintentionally subsidize employer health plans due to the influx of people with high claims.

After consideration of these comments and related economic literature,<sup>312</sup> the Departments concluded that the conditions contained in the proposed rules intended to mitigate the risk of adverse selection (including the prohibition on offering an employee a choice between an individual coverage HRA or a traditional plan, the same terms requirement, the requirement that individuals with individual coverage HRAs be enrolled in individual health insurance coverage, and the prohibition on integration with STLDI) are necessary and, as retained in the final rules, support the Departments' finding that the effect of the rule on individual market premiums will be modest.

Several commenters suggested that additional rules should be adopted to prevent adverse selection. For example, one commenter stated that employers should be forbidden from using health status of any individual or class of employees as a factor when differentiating between classes of employees. Another encouraged strong federal oversight to ensure employer compliance with the conditions. Yet another commenter recommended the Departments use a facts and circumstances test to determine whether individual coverage HRAs are targeted to high cost employees, in addition to requiring compliance with the conditions in the final rules.

The Departments decline to add a facts and circumstances test to the final rules. DOL has enforcement jurisdiction

<sup>312</sup> Although adverse selection has been observed in many instances, relatively recent empirical research suggests that any harm from adverse selection could, in some circumstances, be modest. Most of the literature is related to choices between plans within a firm or other contexts that are not directly analogous to an employer's choice between offering a traditional group plan or an individual coverage HRA, and as a result the applicability of the research is somewhat unclear. Therefore the Departments are including in the final rule provisions specifically intended to mitigate against adverse selection while at the same time giving employers an important new way to provide health benefits. See e.g., Einav, Liran, Amy Finkelstein, and Jonathan Levin, "Beyond Testing: Empirical Models of Insurance Markets," *Annual Review of Economics*, 2010, 2: 311–326; Einav, Liran, Amy Finkelstein, and Mark Cullen, "Estimating Welfare in Insurance Markets Using Variation in Prices," *Quarterly Journal of Economics*, 2010, 125 (3): 877–921; Bundorf, M. Kate, Jonathan Levin, and Neale Mahoney, "Pricing and Welfare in Health Plan Choice," *American Economic Review*, 2012, 102 (7): 3214–3248; and Cardon, James H. and Igal Hendel, "Asymmetric Information in Health Insurance: Evidence from the National Medical Expenditure Survey," *RAND Journal of Economics*, 2001, 32 (3): 408–427.

over private sector employer-sponsored group health plans, and HHS has enforcement jurisdiction over public sector group health plans, such as those sponsored by state and local governments. Individual coverage HRAs are group health plans, and DOL and HHS will monitor individual coverage HRAs' compliance with applicable requirements, consistent with the general approach to enforcement with respect to other group health plans. The Departments are of the view that it is unnecessary to include specific enforcement guidance for individual coverage HRAs in the final rules. However the Departments may provide additional guidance if the Departments become aware of arrangements that are inconsistent with the conditions of the final rules.

One commenter noted that the lack of a limit on the maximum individual coverage HRA amount could result in more employers with older or sicker employee populations providing very large individual coverage HRAs and sending those high-cost individuals to the individual market. This commenter suggested limiting individual coverage HRA contributions to a maximum amount. Another commenter pointed out that an employer could provide an individual coverage HRA that covered both the premiums and cost-sharing expenses up to the maximum out-of-pocket limit (\$7,900 in 2019) for an expensive employee and still reduce health costs. This commenter supported the same terms requirement and other rules preventing benign discrimination to shield against market segmentation. In previous guidance on HRAs, including on integration of HRAs with other coverage, the Departments provided no minimum or maximum contribution amount. Similarly, the Departments decline to impose a minimum or maximum contribution amount on individual coverage HRAs under the final rules, in order to provide employers with flexibility and because the Departments have imposed other conditions to address the potential for adverse selection.

Commenters also recommended that the conditions to prevent adverse selection in the proposed rules be strengthened by applying the integration conditions to the aggregated controlled group of employers rather than to the common-law employer. The Departments have concluded that applying the classes of employees at the common law employer level will avoid complexity for employers and that applying a minimum class size requirement in certain circumstances, at the common law employer level, is a

more straightforward way of addressing the adverse selection concerns raised by some commenters. Therefore, the Departments are not adopting the suggestion.

One commenter suggested the final rules should not allow using rating area as a separate class of employees because it presents risk for health factor discrimination, allowing employers to isolate an employee or a few employees with costly medical expenses who happen to work at the same primary site. While the Departments appreciate and considered the concern raised by commenters, the Departments have determined, based on information regarding the significant differences in individual market premiums between rating areas within some states and significant differences in the number of individual health insurance plans available between rating areas within some states, that it would be an unreasonable limitation on employer flexibility, and, thus, employee welfare, to prohibit employers from offering different benefits based on different work site rating areas.

One commenter argued that the allowable variation in individual coverage HRA contributions by employee age and number of dependents would need to be parallel to the variation in premiums by age and family size in the individual market to avoid the risk that employers target large contributions to high-cost employees. Another commenter pointed out that employers' ability to vary individual coverage HRA amounts by age should not be limitless, but should be subject to sound actuarial guardrails, such as the 3 to 1 PPACA age band between the youngest and oldest employees. The Departments agree. In the final rules, employers are permitted to vary contributions based on the age of the participant as long as the contribution for the oldest participant is within a 3 to 1 ratio of the contribution for the youngest participant. Further, the same maximum dollar amount attributable to the increase in age must be made available to all participants of the same age in the same class of employees.

Some commenters recommended removing as a permitted class of employees the class based on employees who have not yet attained 25 years of age because this would enable employers to offer individual coverage HRAs to older employees while keeping young, generally healthier employees in a traditional group health plan, increasing adverse selection risk for the individual market. In addition, commenters noted that there is no clear

need for this class of employees as employers do not typically vary current coverage offering for employees over and under age 25. After consideration of these comments, the Departments are omitting this class in the final rules.

Several commenters suggested a minimum class size requirement so that employers cannot combine classes in a way that less healthy employees can be isolated into separate classes from healthy employees. According to these commenters, each classification should be required to include a certain minimum number and/or percentage of employees. The Departments agree and sought to develop a rule that is narrowly tailored to mitigate the risk of adverse selection, especially when combining classes, and to avoid overly burdening employers or unnecessarily hampering the increased use and flexibility of individual coverage HRAs. In order to balance these considerations, the final rules include a minimum class size requirement that varies based on employer size and that applies only to certain classes of employees in certain circumstances in which the potential for health factor discrimination is greatest. In general, the minimum is equal to 10 employees for an employer with fewer than 100 employees; equal to 10 percent of the total number of employees (rounded down to a whole number), for an employer with 100 to 200 employees; and equal to 20 employees for an employer that has more than 200 employees. See earlier in this preamble and the final rules for more detail.

Multiple commenters noted that large employers and self-insured employers with a greater share of less-healthy employees could be more likely to offer individual coverage HRAs than employers with healthier employees. The resulting adverse selection could worsen the individual market risk pool and increase premiums. The Departments acknowledge that the integration conditions generally do not address this potential problem. This effect has been included in the modeling and hence is reflected in the overall results. As discussed earlier in this preamble, this effect along with other effects of the final rules result in a premium increase of only about 1 percent, indicating a very small effect on the individual market risk pool.

Other commenters thought individual coverage HRAs could reduce adverse selection in the individual market. Some commenters noted that the proposed rules would result in many employees moving to the individual market, thereby expanding the market and stabilizing premiums. One commenter argued that although some

employers may have a higher-risk group of employees, in general, working employees are lower-risk than individuals in the individual market. Other commenters stated that employers may not necessarily be incentivized to segment their risk, that is, they may be interested in offering individual coverage HRAs for reasons unrelated to risk. Another commenter argued that commonly purchased stop-loss coverage mitigates the incentive to move individuals to the individual market; that HIPAA generally prohibits group health plans and health insurance issuers in the group market from discriminating against individuals based on health factors; that the requirement that to provide MV employer plans provide "substantial coverage" of inpatient hospital services and physician services makes it hard for employers to incentivize high cost individuals to move to the individual market by providing limited benefits; and that the proposed rules' same terms requirement and the restriction on integration of individual coverage HRAs with STLDI all work together to eliminate the opportunities for employers to encourage higher-risk employees to obtain coverage in the individual market. One commenter noted that the Departments struck an important balance between providing additional alternatives for employers while curtailing the opportunity for some employers to selectively segment risk and shift their highest-cost employees to the already fragile individual market. The Departments agree that the final rules, with the integration conditions, strike the right balance and have the potential to strengthen the individual market.

Several commenters further recommended that the Departments add as a permitted class to the final rules, salaried and hourly employees, so that employers may be permitted to make different offers of coverage, to salaried and non-salaried workers. Commenters in support of allowing salaried and hourly workers as permitted classes of employees explained that this would provide additional flexibility for employers without increasing the risk of adverse selection. Reasons for this conclusion included: The classification is used for a variety of purposes and reclassifying employees may violate the FLSA, ERISA and other laws that prohibit employers from reclassifying workers solely for the purposes of interfering with health benefits. One commenter stated that under such a rule employers would have more potential for risk selection than in the permitted

classes under the proposed rules. After consideration of these comments, the Departments are allowing employees who are paid on a salaried basis and non-salaried employees (such as hourly employees) as permitted classes of employees in the final rule, subject to the minimum class size requirement.

The Departments also recognized that transition from coverage under a traditional group health plan to coverage under an individual coverage HRA could represent a substantial change from an employee perspective, and as a result employers may find it difficult to transition to individual coverage HRAs. Because new hires are unlikely to increase adverse selection in the individual market and, if added to the individual market, would likely lower average risk, the Departments have added flexibility for employers by allowing employers to continue to offer traditional group health plans to current employees while offering individual coverage HRAs to newly hired employees. Recognizing that the new hire subclass will start small as employees are hired after the employer-specified hiring date for a class of individuals, the new hire subclass is not subject to the minimum class size requirement. However, if an employer later chooses to further subdivide a new hire subclass, each subdivision would be subject to any minimum class size requirements that otherwise would apply.

Several commenters suggested that the Departments delay implementation of the final rules until further analysis, particularly regarding risk segmentation, could be conducted. However, commenters offered few concrete suggestions to inform additional analysis. While the Departments acknowledge that the exact effects of the final rules are subject to uncertainty, the Departments conclude that the benefits of the rules will outweigh any costs, and that the benefits of promulgating the rules without further delay will outweigh the benefits of additional analysis. As recommended by a number of comments, the Departments will continue to closely monitor premiums and the stability of the individual market.

The Departments also emphasize that these estimates assume that employers would contribute the same amount to individual coverage HRAs as they would to traditional group health plans and that employees would elect the same amount of salary reduction to pay for individual health plans and cost sharing as they would if they were enrolled in a traditional group health plan. But, as noted above, some

employees who would be offered individual coverage HRAs under the proposed rules would choose plans with lower premiums and higher deductibles and copayments and narrower provider networks than they would choose if offered a traditional group health plan. However, some workers would probably choose more expansive coverage than what they were offered in a traditional group health plan, and a key benefit of this rule is that it expands workers' ability to choose coverage that best suits their preferences. Those workers who choose plans with higher cost sharing and narrower provider networks and become more cost-conscious consumers of healthcare will likely reduce healthcare costs and insurance premiums, eventually reducing average HRA amounts and salary reductions. The Departments requested comments on the assumption that employer and employee tax-preferred spending on healthcare would be the same for individual coverage HRAs as for traditional group health plans.

One commenter questioned the Departments' basis for this assumption. Based on conversations with employers of all sizes and industries, the commenter concluded that it appears likely that a good portion of employers would contribute substantially less to individual coverage HRAs than what they are currently contributing to traditional group health plans. The commenter suggested that this would be particularly true for certain classes of employees, and that this may result in some employees and dependents becoming uninsured. Several commenters expressed concern that employers would contribute less to individual coverage HRAs than they currently contribute to their traditional group health plans, with the result that coverage would be less affordable for employees. One commenter suggested that employers offering an individual coverage HRA be required to provide a minimum amount to ensure that the HRAs are adequate for the purchase of individual health insurance coverage. As discussed above, the Departments decline to adopt this suggestion. In general, workers bear the cost of employer contributions to health benefits in the form of reductions in wages and non-health benefits. The current tax system subsidizes health benefits, and it is not clear that minimum employer contributions would improve employee welfare. Other commenters suggested that employers should be required to vary the amount of the individual coverage HRA by age, geographic region, and/or family size, as

these factors result in variations in premiums for individual health insurance coverage. The Departments are not adopting this suggestion. The Departments recognize that the cost of individual health insurance coverage will vary across employees, and because the intent of the rule is to expand rather than restrict employer choices regarding how to provide coverage, the final rules allow (but do not require) employers to take these factors into account in certain circumstances and subject to certain conditions. After consideration of these comments, the Departments acknowledge that introduction of the individual coverage HRA could lead employers to provide lower health benefits and higher taxable wages than they would if they provided a traditional group plan. However, because the extent to which employers will do so is uncertain, this effect is not accounted for in the Departments' quantitative estimates of transfers (that is, the fiscal cost) arising from the rules. Moreover, the Departments are of the view that employers will design employee compensation packages to the benefit of employees since employers aim to attract and maintain talent.

In addition, the estimates assume that the entire individual coverage HRA balance is spent on healthcare premiums and cost sharing each year. However, the Departments are of the view that many employers would allow employees to carry unspent individual coverage HRA balances over from year to year, and that some employers would allow employees to continue to spend accumulated individual coverage HRA funds even after separating from their employer. Moreover, individual coverage HRA benefits are generally subject to COBRA protections, such that, for example, some employees could elect to use accumulated funds for up to 18 months after separation from service. The ability to carry over benefits from year to year could further encourage employees to curtail healthcare spending, particularly less efficient spending. This effect could be modest for several reasons. First, unlike HSA balances, which can be withdrawn for non-health purposes subject to tax but without penalty after age 65 and with a 20 percent penalty before age 65, individual coverage HRAs may only be used to reimburse expenses for medical care. In addition, unlike HSAs, individual coverage HRAs are not the property of the employee and employers may limit the amount that can be carried over from year-to-year or accessed by the employee after separation, subject to applicable COBRA

or other continuation of coverage requirements.

These estimates further assume that all individual health insurance coverage integrated with an HRA would be treated as subject to and compliant with PHS Act sections 2711 and 2713. The proposed rules prohibit an individual coverage HRA from being integrated with STLDI and excepted benefits, which are not subject to or generally compliant with PHS Act sections 2711 and 2713. Grandfathered coverage in the individual market is not subject to the annual dollar prohibition in PHS Act section 2711 or to the preventive services requirements in PHS Act section 2713. However, the proposed rules provided that employees nor employers were required to confirm that individual health insurance coverage integrated with an HRA is not grandfathered coverage, as requiring such confirmation would be administratively burdensome and the Departments expected that the number of employees who might use an individual coverage HRA to buy such coverage would be extremely small, because individuals can only renew and cannot newly enroll in grandfathered individual health insurance coverage.

Commenters generally agreed that the vast majority of individual health insurance coverage is compliant with PHS Act sections 2711 and 2713. As noted earlier in the preamble, many commenters emphasized the importance of requiring individual coverage HRAs to be integrated with individual health insurance coverage, and not with STLDI, in order to ensure the health and stability of the individual market risk pool. The Departments considered these comments and are finalizing the requirement that individuals covered by an individual coverage HRA must be enrolled in individual health insurance coverage, as proposed. Further, under the final rules, an individual coverage HRA may not be integrated with STLDI.

In summary, the Departments recognize that allowing HRAs to be integrated with individual health insurance coverage creates the potential for some adverse selection and increased premiums in the individual health insurance market. To prevent that occurrence, the Departments are retaining in the final rules the key conditions intended to prevent adverse selection and health factor discrimination. In addition, the Departments are strengthening the conditions intended to prevent of adverse selection, including by adding a minimum class size requirement that applies to certain classes of employees in certain circumstances and removing

as a permitted class of employees the class of employees under age 25, which had the potential to increase adverse selection. The addition of the special rule for new hires could also improve the health of the overall individual market risk pool. While the Departments have also made changes in the final rules in order to provide employers with additional flexibility, such as adding as new permitted classes of employees non-salaried and salaried employees as well as staffing firm temporary employees (as well as adopting the special rule for new hires), the Departments have done so in a way that is narrowly tailored to avoid creating the risk of adverse selection. Therefore, after consideration of these changes and public comments, the Departments are finalizing the economic modeling of the individual coverage HRA without changing the key assumptions.

In light of the Departments' quantitative estimates and qualitative analysis, the Departments conclude that the benefits of the individual coverage HRA outweigh the costs. In particular, the Departments estimate that the final rules will increase the number of individuals with health insurance and have only a small effect on individual market premiums. The final rules will significantly increase flexibility and choices of health coverage for employers and employees. As a result, employers will benefit from having another choice of a tax-preferred health benefit to offer their employees, potentially enabling them to attract and retain workers. In addition, the increased use of HRAs could potentially reduce healthcare spending and ultimately result in increased taxable wages.

### 3. Impact of Excepted Benefit HRA

The final rules also provide for recognition of a new limited excepted benefit HRA under which amounts newly made available for each plan year are limited to \$1,800 (indexed for inflation for plan years beginning after December 31, 2020). Among other conditions, to offer the excepted benefit HRA, the employer must offer the employee a group health plan that is not limited to excepted benefits and that is not an HRA or other account-based group health plan, but the employee would not need to enroll in this group health plan. The benefit would be funded by the employer, and in the Treasury Department's modeling, this means that it would be paid for by all employees in the firm through an overall reduction in wages. The benefit could be used to pay for any medical expense, other than premiums for individual health insurance coverage,

group health plan coverage (other than COBRA or other continuation coverage), or Medicare Part B or D. The excepted benefit HRA could be used to pay premiums for coverage that consists solely of excepted benefits and for other premiums, such as premiums for STLDI (subject to the exception described later in this section of the preamble).

Due to the availability of other tax preferences for health benefits, including the tax exclusion for employer-sponsored benefits, salary reductions for group and off-Exchange individual health insurance coverage premiums when integrated with an individual coverage HRA, health FSAs, and non-excepted benefit HRAs, the Departments are of the view that this new excepted benefit would be adopted by a small number of firms. However, it could provide flexibility for firms that want to provide a tax preference to employees that choose STLDI instead of the employer's traditional group health plan.

Several commenters noted that the excepted benefit HRA could adversely impact the small employer group market as employers in the small group market would be more likely to offer an excepted benefit HRA that reimburses STLDI premiums (because these employers are less likely to be directly affected by the risk shifting due to the fact that the small group market is community rated) and healthier employees would be more likely to opt out of the traditional small employer group plan and use the excepted benefit to pay for health coverage out of pocket or purchase STLDI. Several commenters also expressed concern about the negative impact on the individual market, as the excepted benefit HRA could draw some enrollees away to STLDI plans. One commenter expressed concern that sicker employees within a firm, who could not obtain STLDI, would bear greater costs. As explained earlier in this preamble, the Departments do not believe that allowing the excepted benefit HRA to be used to purchase STLDI creates a significant risk pooling concern. However, to mitigate potential adverse selection affecting the small group market, the final rules provide that the Departments may restrict excepted benefit HRAs from being able to reimburse STLDI premiums for certain employers in a state, if certain criteria are satisfied.

Several commenters opposed the new excepted benefit HRA because it would allow employers to provide a smaller health benefit. One commenter expressed particular concern that low-wage employers would be particularly

attracted to this option, to the detriment of employees. The Departments conclude that this is not an important risk or concern. First, employees must have the option to receive a traditional group health plan instead of the excepted benefit HRA, and ERISA-covered employers must provide a notice of the dollar limits and other limitations of the excepted benefit HRA. In addition, the costs of coverage are borne all or in part by employees, in the form of reduced wages, and any reduction in costly health benefits is expected to be offset by increased wages. Third, employees who decline an employer's offer of a traditional group health plan may obtain coverage through a spouse or the individual market, and this coverage may also be subsidized through a tax exclusion or PTC. Therefore, the availability of this new tax-preferred benefit is expected to benefit employees, not harm them.

Several commenters expressed concern that adding another type of excepted benefit and another type of HRA would create confusion among employers and employees, potentially resulting in costly mistakes. Some commenters expressed concern that the excepted benefit HRA would increase uninsurance among employees who forego coverage or use the benefit to purchase STLDI (which need not provide comprehensive benefits), thus putting employees at risk or poor financial or health outcomes.

Other commenters supported the provision of the excepted benefit HRA as proposed, including one who expressed support for providing employers with the greatest possible flexibility to provide health benefits on a tax preferred basis. The Departments agree that the excepted benefit HRA will provide additional flexibility for employers, and for employees who want to pay for their health care costs in ways other than enrolling in their employer-offered traditional group health plan. The Departments continue to expect that due to the availability of other tax preferences for health benefits, including larger tax preferences for employer-provided benefits and the PTC for individual health insurance coverage, that adoption of the excepted benefit HRA is likely to be modest, such that the risk of introducing adverse selection into other markets is low. The Departments conclude that the benefits of this additional choice and flexibility provided by this new tax preferred excepted benefit outweigh the likely costs.

### C. Regulatory Alternatives

In developing the final rules, the Departments considered various alternative approaches.

*Retaining prohibition on integration of HRAs with individual health insurance coverage.* The Departments considered retaining the existing prohibition on integration of HRAs with individual health insurance coverage, in particular in light of commenters who raised concerns that allowing HRAs to be integrated with individual health insurance coverage could lead to adverse selection and health factor discrimination in the individual market. However, the Departments determined that the adverse selection concerns that gave rise to the prohibition, and which some commenters raised, can be adequately addressed by including appropriate mitigating conditions in the final rules. Moreover, the alternative approach of continuing to prohibit the integration of HRAs with individual health insurance coverage would foreclose the benefits that the Departments expect to result from allowing individual coverage HRAs, including increased flexibility and choices of health coverage options for employers and employees; possibly reduced healthcare spending and increased taxable wages for workers currently in firms that offer traditional group health plans; and increased numbers of low- and moderate-wage workers (and their family members) with health insurance coverage.

*Integration conditions to prevent against adverse selection.* The proposed rules contained a number of conditions intended to mitigate the risk of adverse selection, including that an employer may not offer any employee a choice between a traditional group health plan and an individual coverage HRA and that, if an employer offers an individual coverage HRA, it must do so on the same terms and conditions for all the employees in the class of employees subject to certain exceptions. The Departments considered a number of alternatives related to these conditions in developing the final rules. As to the prohibition on choice between an individual coverage HRA and a traditional group health plan, the Departments considered the alternative of allowing all employers, or, employers that would qualify to participate in the small group market, to offer employees a choice between an individual coverage HRA and a traditional group health plan. However, the Departments determined that retaining this condition as proposed is important to prevent against adverse selection and

commenters generally agreed. The Departments did consider that the incentives for employers in the small group market to segment risk are lower than for other employers offering experience-rated coverage or self-insured plans. However, the Departments would not expect many small employers to offer this choice because the coverage in the small group market and individual market is quite similar and because small employers that purchase health insurance would not have an incentive to segment their risk pool. Although allowing small employers to offer a choice would not provide small employers much benefit, it would increase the complexity of the final rules for entities involved in implementation, such as the Exchanges, and could cause uncertainty for issuers. Accordingly, the Departments decline to provide an exception for small employers to the condition that a plan sponsor may not offer an employee a choice between a traditional group health plan and an individual coverage HRA. However, the Departments are generally supportive of maximizing employee choice and employer flexibility and so may revisit this issue in future rulemaking once the Departments have had the opportunity to gauge the results of the initial implementation of individual coverage HRAs.

With respect to the proposed condition that an employer must offer an individual coverage HRA on the same terms to all employees within a class of employees, the Departments considered whether to allow individual coverage HRAs to increase amounts based on age, without any related parameters, as proposed, or, as an alternative, whether to place an outer limit on the ability to age vary, as some commenters suggested the Departments should do to protect against adverse selection. Upon consideration of these comments, the Departments determined that imposing a limit on the ability to increase HRA amounts based on age is justified in order to protect against adverse selection. In designing that limitation on age variation, the Departments considered a number of alternatives, including incorporating the federal and state age curves and tying the variation to a specific premium for a specific policy that a participant in the class of employees could purchase. However, the Departments determined that these options would be unduly complex and that imposing the 3 to 1 limit on the variation of HRA amounts within a class based on age, which is generally based on the degree of age

variation allowed in individual market premiums under PHS Act section 2701, sufficiently limits the potential for abuse.

The proposed rules provided that plan sponsors may apply the integration conditions on a class-by-class basis such that an employer may offer an individual coverage HRA to a class of employees while offering a traditional group health plan to another class of employees or may offer different individual coverage HRAs, with different terms, to different classes of employees. The Departments considered whether to retain the ability of employers to offer or vary individual coverage HRAs for different classes of employees or whether employers should be required to offer all employees an individual coverage HRA if any employee is offered an individual coverage HRA. Although some commenters raised concerns that the classes of employees could be manipulated leading to health factor discrimination and adverse selection, the Departments decided to finalize the ability to offer and vary individual coverage HRAs on a class-by-class basis because this aspect of the rule provides employers with the flexibility needed to achieve increased HRA usability and to maximize employee welfare, which is a sentiment expressed by a number of commenters. However, the Departments acknowledge the concern regarding the potential for adverse selection and health factor discrimination and, therefore, have concluded that additional safeguards are needed in certain circumstances, as described later in this section of the preamble.

Under the proposed rules, the Departments enumerated eight permitted classes of employees and also allowed employers to combine the classes of employees. In the process of finalizing the rules, the Departments considered, as an alternative, whether to provide classes of employees based on a more general standard (like the one that applies under the HIPAA nondiscrimination rules, with a broader employment-based classification standard) or whether to finalize generally as proposed, such that the final rules would list the specific permitted classes. The Departments determined that a broad and open-ended standard would not be sufficient to mitigate the risk of adverse selection and therefore under the final rules, the Departments enumerate the permitted classes.

The Departments considered a number of alternatives with regard to which classes of employees should be permitted under the final rules. The

proposed rules contained, as a permitted class of employees, employees who had not attained age 25. The Departments considered whether to retain this class in the final rules or whether to remove this from the list of permitted classes, in response to commenters who asserted that this class could lead to adverse selection and does not reflect the categories employers typically use to offer benefits. In response to these comments, the Departments determined that the final rules should not include the under-age-25 class of employees in the list of permitted classes.

Further, under the proposed rules, the Departments did not include salaried employees and hourly employees as permitted classes of employees. In finalizing the rules, the Departments considered whether to add hourly and salaried employees as permitted classes or whether to finalize the rule as proposed. In proposing the rules, the Departments had noted that they did not include these classes in the list of permitted classes due to a concern that employers might easily be able to change an employee's status from salaried to hourly (and in certain circumstances, from hourly to salaried), which could lead to adverse selection. Commenters asserted that contrary to the Departments' concerns these classes are not easy to manipulate and that hourly and salaried employees should be added as permitted classes, in order to increase the use of individual coverage HRAs. The Departments have concluded that the benefits of employer flexibility, increased utilization of individual coverage HRAs, and maximizing employee welfare outweigh the potential risk of adverse selection and health factor discrimination, due to a reconsideration of the extent to which these categories could be manipulated and because of the application of a minimum class size requirement, discussed later in this section of the preamble. Therefore, the Departments add employees paid on a salary basis and non-salaried employees (such as hourly employees) to the list of permitted classes in the final rules.

The Departments also considered, in response to comments, whether to add as a class of employees temporary workers employed by staffing firms. The Departments determined that adding this class could increase the usability of HRAs for staffing firms and benefit their employees. The Departments also determined that this class would be difficult to manipulate, and that, therefore, this class does not raise a substantial risk of adverse selection or health factor discrimination.

Accordingly, the Departments add temporary workers employed by staffing firms to the classes of employees permitted under the final rules.

The Departments also considered whether or not to add other classes to the list of permitted classes, as suggested by commenters, including classes based on status as a field worker (such as craft workers and laborers), role or job title, employee tenure, being subject to the Davis Bacon Act and Related Acts or the Service Contract Act, exempt or non-exempt status under the Fair Labor Standards Act, and religion or status as a minister. The Departments considered each of these suggestions and determined that these suggested classes of employees should not be permitted as they raise various issues, including ease of manipulation and potential for adverse selection and health factor discrimination, industry-specificity, and administrability and definitional challenges.

*Additional integration safeguards.* The Departments considered a number of alternative regulatory approaches to address the concern, acknowledged by the Departments and expressed by a number of commenters, that there is a potential for certain of the permitted classes of employees to be manipulated in way that could lead to adverse selection and health factor discrimination. The Departments considered not adopting additional safeguards, in order to minimize burden and complexity and based on the possibility that other economic incentives related to attracting and retaining talented workers would discourage employers from using the classes to segment risk. However, the Departments have concluded that it is appropriate to apply a minimum class size requirement under the final rules in certain circumstances. The Departments sought to develop a rule that is narrowly tailored both to mitigate the risk of adverse selection and health factor discrimination while also avoiding overly burdening employers or unnecessarily hampering the use and flexibility of HRAs to maximize employee welfare.

The Departments considered a number of alternatives in designing the minimum class size requirement. The Departments considered whether to apply the minimum class size requirement to all permitted classes of employees or only to the classes of employees that raise more significant concerns about manipulation. The Departments determined that the minimum class size requirement should apply to only certain of the classes, referred to as the applicable classes (that

is, full-time employees, part-time employees, salaried employees, non-salaried employees, and, in general, employees whose primary site of employment is in a rating area). The Departments also determined that the minimum class size requirement should apply if any of these applicable classes are combined with any other class, except if the combined class is the result of one of the applicable classes and the class of employees in a waiting period, because the Departments determined that that combined class is not easily manipulable. Similarly, although a class of employees based on worksites in a rating area is an applicable class for purposes of the minimum class size requirement, a class of employees based on an entire state or a combination of two or more entire states is not subject to the minimum class size requirement, because in that case, weighing concerns about manipulability against the intent to provide employers with flexibility and choice, the Departments determined the application of the minimum class size requirement was not warranted.

If a class of employees is subject to the minimum class size requirement, the class must include a minimum number of employees for the individual coverage HRA to be offered to that class. As to the number of employees a class must contain to satisfy the minimum class size requirement, the Departments considered a number of alternatives including whether to provide one number for all employers or base the threshold on employer size. The Departments also considered providing a set number or a number calculated as a percentage of the employer's employees. The Departments determined that this safeguard should be narrowly tailored, so as to prevent against adverse selection without unduly restricting employer flexibility. Therefore, under the final rules, the applicable minimum class size varies based on the size of the employer for smaller employers (that is, those with under 200 employees) and for employers with 200 or more employees, the applicable class size minimum is set at 20.

In response to comments, the Departments also considered whether, in addition to, or instead of, a minimum class size requirement, the final rules should contain an anti-abuse rule that would give the Departments the discretion to determine whether an individual coverage HRA is offered in a manner that is intended to segment sicker workers based on all the facts and circumstances. Therefore, even if an employer followed the other rules set forth in the final rules, this additional

rule would nevertheless permit the Departments to address instances of discrimination based on a health factor. The Departments decline to add a facts and circumstances test to the final rules, because the Departments have concluded that the minimum class size requirement adequately balances the need to prevent health factor discrimination with the need to provide employers with certainty in order to encourage expansion and use of individual coverage HRAs. Moreover, other applicable nondiscrimination laws continue to apply. A new facts and circumstances test would add significant uncertainty for employers while adding little additional protection mitigating adverse selection and health factor discrimination.

*Additional flexibility for the transition to individual coverage HRAs from traditional group health plans.* The Departments also considered regulatory alternatives that would allow employers to phase in offering individual coverage HRAs, in response to comments noting that the transition from traditional group health plans to individual coverage HRAs could be a substantial change from an employee perspective. The Departments considered whether additional flexibility was needed, in particular because the permitted classes of employees that apply under the final rules provide employers some flexibility to manage the transition to individual coverage HRAs. However, the Departments also considered that certain additional flexibility could benefit employers and employees, without adding significant complexity or increasing the risk of adverse selection. Accordingly, the final rules provide that, notwithstanding the general rule that a plan sponsor may only offer either a traditional group health plan or an individual coverage HRA to a class of employees, a plan sponsor that offers a traditional group health plan to a class of employees may prospectively offer employees in that class hired on or after a certain date in the future an individual coverage HRA, while continuing to offer employees in the class hired before the new hire date a traditional group health plan.

*Alternatives considered regarding excepted benefit HRAs.* As proposed, the excepted benefit HRA would allow for the reimbursement of premiums for STLDI. In response to commenters requesting that the excepted benefit HRA not be permitted to reimburse STLDI premiums due to adverse selection concerns and concerns about the comprehensiveness of STLDI, the Departments considered whether to finalize as proposed or whether to

prohibit the reimbursement of STLDI premiums under all excepted benefit HRAs. The Departments also considered whether to prohibit the reimbursement of STLDI premiums for only certain excepted benefit HRAs, more specifically, those sponsored by employers that offer traditional group health plans in the small group market, where commenters asserted this aspect of the rule would have particularly damaging effects because employers would not have a direct negative financial consequence from offering the excepted benefit for STLDI in addition to a traditional small group market plan in which case lower-risk employees would likely choose the STLDI and higher-risk employees would choose the traditional small group market health plan. The Departments determined that excepted benefit HRAs generally should be allowed to reimburse premiums for STLDI because it can be a viable health insurance option for many people in many circumstances, no individual is required to enroll in STLDI, and STLDI disclosure requirements are sufficient to apprise consumers of its limits. As explained earlier in this preamble, the Departments do not expect that allowing the excepted benefit HRA to reimburse STLDI premiums will produce adverse selection in the small group market. In particular, the Departments note that individuals who choose to use the excepted benefit HRA to purchase STLDI are likely to be uninsured otherwise, including lower-wage workers who are increasingly declining employer offers of traditional group coverage.<sup>313</sup> The purchase of STLDI coverage by these individuals will have no effect on the small group or individual market.

However, in response to concerns raised by commenters, the final rules also contain a special rule to address commenters' concerns about the potential for adverse selection in the small group markets. Under the special rule, the Departments may restrict excepted benefit HRAs from being able to reimburse STLDI premiums, for employers offering fully-insured or partially-insured traditional group health plans in the small group market in a state, if certain criteria are satisfied, including that HHS makes a finding, in consultation with DOL and the Treasury

<sup>313</sup>In 1999, 17 percent of workers eligible for employer coverage at small firms (those with 3 to 199 workers) turned down the offer of employer coverage. By 2011, this share had climbed to 22 percent, and in 2018 it was 27 percent. See Kaiser Family Foundation, "Employer Health Benefits 2018 Survey," Figure 3.1, available at <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018>.

Department, that the reimbursement of premiums for STLDI by excepted benefit HRAs has caused significant harm to the small group market in the state that is the principal place of business of the small employer and this finding must be made after submission of a written recommendation by the applicable state regulatory authority of such state.

The proposed excepted benefit HRA rules did not contain a specific notice requirement. However, several commenters suggested that the final rules impose certain notice requirements for excepted benefit HRAs, including to inform participants and beneficiaries of the annual dollar limit for benefits under the excepted benefit HRA, other terms and conditions of the excepted benefit HRA, and participants' and beneficiaries' rights under the excepted benefit HRA. In response, the Departments considered whether to impose a notice requirement, whether to finalize as proposed with no notice requirement, or whether to explain the disclosure requirements otherwise applicable to excepted benefit HRAs. In the final rules, the Departments do not impose a notice requirement on private-sector, employment-based plans covered by ERISA but, instead, explain that excepted benefit HRAs that are subject to ERISA are already subject to a number of disclosure provisions, under which excepted benefit HRAs should generally provide information on eligibility to receive benefits, annual or lifetime caps or other limits on benefits under the plan, and a description or summary of the benefits. However, for non-federal governmental plans, which are not subject to ERISA, the final rules announce HHS' intent to propose a notice requirement, similar to the disclosures required under ERISA.

Under the proposed excepted benefit HRA rules, the Departments proposed that annual amounts newly made available under the HRA would be limited to \$1,800, indexed for inflation. Many commenters supported the proposed dollar limit as a reasonable mid-point of the different limits that would result in applying various methodologies, however some requested that the limit be increased, including to allow for the additional purchase of excepted benefit policies or for more expensive STLDI policies and others requested it not be subject to any dollar limit. Some of these commenters favored a higher limit for excepted benefit HRAs based on age and number of dependents to reflect that participants who are older or have dependents are likely to have higher healthcare costs. The Departments considered as regulatory alternatives the various limits

suggested by commenters, including the annual salary reduction contribution limit for health FSAs or 15 percent of the cost of coverage under the employer's primary plan. The final rules do not remove or increase the dollar limit for the excepted benefit HRA. The Departments agree that increasing the dollar limit would encourage certain participants to rely solely on benefits reimbursed through the excepted benefit HRA and could lead to adverse selection. Also, in order to constitute a limited excepted benefit, as explained earlier in this preamble, because the benefit is not otherwise limited in scope, the HRA must have a strict dollar limit.

In determining the appropriate dollar limit for excepted benefit HRAs, the Departments considered other, similar limited excepted benefits. The Departments agree with commenters' assertions that the proposed limit was reasonable and rational, especially considering the relatively low cost of excepted benefits coverage, such as dental or vision coverage. Additionally, although the Departments recognize that healthcare expenses may be higher for participants who are older or have dependents, adopting a higher limit to account for a combination of factors like age and family size could allow an excepted benefit HRA to be too large and to resemble major medical coverage and would add significant complexity to the rule.

*Applicability date.* The proposed rules were generally proposed to be applicable for plan years beginning on or after January 1, 2020. In response to comments expressing concern that issuers, state insurance regulators, the Exchanges, and employers would not be prepared for implementation of the final rules by 2020, the Departments considered whether to finalize the applicability date as proposed or whether to delay the applicability date until 2021. The Departments have determined that, in consideration that Executive Order 13813, issued in October 2017, set forth HRA expansion as an Administration priority "in the near term," and in order to provide Americans with more options for financing their healthcare, the regulations should be applicable, as proposed, for 2020. However, the Departments acknowledge and also considered the crucial role that the Exchanges have in implementation and operationalization of the final rules, and the Departments will work closely with the Exchanges on implementation. The Departments considered the comments and the concerns raised by various State Exchanges, issuers, employers and other

stakeholders related to the ability of the Exchanges to fully implement changes related to the final rules in time for open enrollment for the 2020 plan year. The Departments recognize that Exchanges may be unable to fully implement changes related to the final rules in time for open enrollment for the 2020 plan year. However, prior to full implementation, the Departments will work with the Exchanges on their strategies to provide information to consumers about affordability of individual coverage HRAs and eligibility for APTC, including how employees can access individual health insurance coverage through the Exchanges and determine whether they should use APTC. In fact, multiple conversations have already occurred between program and operational experts at HHS and officials from State Exchanges regarding implementation in the event the rule was finalized as proposed (including with an applicability date as proposed). Ongoing technical assistance will be provided related to the development of tools and functionality by Exchanges to support employers and employees with understanding HRA affordability determinations and their impact on APTC eligibility, as well as the SEP for those with an offer of an individual coverage HRA. Specific assistance could include sharing technical and educational documentation from FFE implementation that can be leveraged to support State Exchange efforts. In addition, the Departments will provide assistance to Exchanges in developing information and tools that could be provided to employers and employees to help ensure smooth implementation before the full system changes are complete. This could include State Exchanges providing employees with information on how they can calculate HRA affordability and determine the impact on APTC in the absence of system changes that can make those calculations for the employee.

The Departments also considered that many individuals covered by an individual coverage HRA will prefer to select off-Exchange individual health insurance plans because salary reductions through a cafeteria plan may be used to pay premiums for off-Exchange coverage, if the employer so allows, and may not be used to pay premiums for Exchange coverage. To the extent a significant proportion of employees with individual coverage HRAs purchase individual health insurance coverage off the Exchange, concerns about burden on the Exchanges, and concerns regarding the

effects of timely operationalization of the PTC rules, are mitigated.

Further, the Departments have worked to release the final rules as early in 2019 as possible, in recognition of the implementation timing issues raised and the Departments note, and considered, that plan sponsors may choose if and when to offer an individual coverage HRA (or an excepted benefit HRA) and may do so any time on or after the applicability date. The Departments intend to provide the guidance necessary for plan sponsors to offer individual coverage HRAs and excepted benefit HRAs for the 2020 plan year, but the Departments also expect that plan sponsors will take the time they need to evaluate the final rules and to take advantage of these new coverage options if and when it is best for their workforce.

*D. Paperwork Reduction Act—  
Department of Health and Human  
Services*

Under the Paperwork Reduction Act of 1995 (PRA), HHS is required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to OMB for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that HHS solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of HHS’ estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

1. Wage Estimates

To derive wage estimates, the Departments generally used data from the Bureau of Labor Statistics to derive average labor costs (including a 100 percent increase for fringe benefits and overhead) for estimating the burden associated with the information collection requirements (ICRs).<sup>314</sup> Table 3 below presents the mean hourly wage, the cost of fringe benefits and overhead, and the adjusted hourly wage.

As indicated, employee hourly wage estimates have been adjusted by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly across employers, and because methods of estimating these costs vary widely across studies. Nonetheless, there is no practical alternative, and the Departments are of the view that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

TABLE 3—ADJUSTED HOURLY WAGES USED IN BURDEN ESTIMATES

Occupation title	Occupational code	Mean hourly wage (\$/hour)	Fringe benefits and overhead (\$/hour)	Adjusted hourly wage (\$/hour)
Compensation and Benefits Manager .....	11–3111	\$62.50	\$62.50	\$125.00
Lawyer .....	23–1011	68.22	68.22	136.44
All Occupations .....	00–0000	24.34	24.34	48.68

2. ICRs Regarding Substantiation of Individual Health Insurance Coverage (45 CFR 146.123(c)(5))

Under the final rules, an HRA must implement reasonable procedures to annually verify that participants or dependents, whose medical care expenses are reimbursable by the HRA are, or will be, enrolled in individual health insurance coverage or Medicare for the entire plan year on or before the first day of the plan year, or, for an individual who is not eligible to participate in the individual coverage HRA on the first day of the plan year, by the date HRA coverage begins (annual coverage substantiation requirement).

In addition to the annual substantiation of coverage, with each new request for reimbursement of an incurred medical care expense for the same plan year, the final rules provide that the HRA may not reimburse a participant for any medical care expenses unless, prior to each reimbursement, the participant provides

substantiation that the individual on whose behalf reimbursement of medical care expenses are requested to be reimbursed were enrolled in individual health insurance coverage or Medicare for the month during which the medical care expenses were incurred. The attestation may be part of the form used for requesting reimbursement.

To satisfy these substantiation requirements, the HRA may require that the participant submit a document provided by a third party (for example, an explanation of benefits or insurance card) showing that the participant and any dependent(s) covered by the individual coverage HRA are, or will be, enrolled in individual health insurance coverage or Medicare during the plan year or an attestation by the participant stating that the participant and any dependent(s) are, or will be, enrolled in individual health insurance coverage or Medicare, the date coverage began or will begin, and the name of the provider of the coverage. Additionally, nothing in the final rules would prohibit an individual coverage HRA from

establishing procedures to comply with the substantiation requirements through electronic means, so long as the procedures are reasonable to verify enrollment. The ongoing substantiation may be in the form of a written attestation by the participant, which may be part of the form used for requesting reimbursement and which will minimize the burden on plan sponsors and participants. The ongoing substantiation requirement may also be satisfied by a document from a third party. The associated cost of substantiation will be minimal and is, therefore, not estimated.

The Departments are releasing guidance providing model attestation language, separate from the final rules. However, the Departments note that individual coverage HRAs will not be required to use the model attestation. For those HRAs that elect to use the model attestation language provided by the Departments, it will further reduce burden for HRAs and participants.

The burden related to these ICRs will be reviewed under emergency review

<sup>314</sup> See May 2017 Bureau of Labor Statistics, Occupational Employment Statistics, National

Occupational Employment and Wage Estimates,

available at [https://www.bls.gov/oes/current/oes\\_nat.htm](https://www.bls.gov/oes/current/oes_nat.htm).

and approval. They have been submitted to OMB in conjunction with this final rule and are pending approval.

### 3. ICRs Regarding Notice Requirement for Individual Coverage HRA (45 CFR 146.123(c)(6))

These final rules include a requirement that an HRA provide written notice to eligible participants. In general, the HRA will be required to provide a written notice to each participant at least 90 days before the beginning of each plan year. For participants who are not yet eligible to participate at the beginning of the plan year (or who are not eligible when the notice is provided at least 90 days prior to the beginning of the plan year), the HRA must provide the notice no later than the date on which the HRA may first take effect for the participant.

However, the Departments encourage the HRA to provide the notice as soon as practicable prior to the date the HRA may first take effect. The final rules provide that if the HRA is sponsored by an employer that is established less than 120 days prior to the beginning of the first plan year of the HRA, the notice may be provided no later than the date on which the HRA may first take effect for the participant.

The written notice will be required to include certain relevant information, including a description of the terms of the HRA, including the maximum dollar amount made available that is used in the affordability determination under the Code section 36B rules including information on when the amounts will be made available (for example, monthly or annually at the beginning of the plan year); a statement of the right of the participant to opt-out of and waive future reimbursement under the HRA; a description of the potential availability of the PTC for a participant who opts out of and waives an HRA if the HRA is not affordable under the PTC rules; a description of the PTC eligibility consequences for a participant who accepts the HRA; a statement on how the participant may find assistance for determining their individual coverage HRA affordability; a statement that the participant must inform any Exchange to which they apply for advance payments of the PTC of certain relevant information; contact information (including at least a phone number) of

an individual or a group of individuals who participants may contact with questions regarding the individual coverage HRA; a statement that the participant should retain the written notice because it may be needed to determine whether the participant is allowed the PTC; a statement that the HRA may not reimburse any medical care expense unless the substantiation requirements are satisfied; a statement of availability of an SEP for employees and dependents who newly gain access to the HRA; the date as of which coverage under the HRA may first become effective and the date on which the HRA plan year ends; and a statement to clarify further that there are multiple types of HRAs and the type the participant is being offered is an individual coverage HRA.

The written notice may include other information, as long as the additional content does not conflict with the required information. The written notice will not need to include information specific to a participant.

The Departments are providing model language contemporaneously on certain aspects of the notice that are not employer-specific, including model language describing the PTC consequences of being offered and accepting an individual coverage HRA, how the participant may find information to determine whether the individual coverage HRA offered is affordable, and language to meet the requirement to include a statement regarding the availability of an SEP in the individual market for individuals for whom an individual coverage HRA is newly made available. While the Departments hope it will be useful to employers, plan sponsors will not be required to use the model language and the final rules do not prohibit an employer from providing more individualized notices, such as different notices for different classes of employees, if the employer so chooses.

The Departments estimate that for each HRA plan sponsor, a compensation and benefits manager will need 2 hours (at \$125 per hour) and a lawyer will need 1 hour (at \$136.44 per hour) to prepare the notices. The total burden for an HRA plan sponsor will be 3 hours with an equivalent cost of approximately \$386. This burden will be incurred the first time the plan

sponsor provides an individual coverage HRA. In subsequent years, the burden to update the notice is expected to be minimal and therefore is not estimated. If the HRA plan sponsor elects to use the model notice, the burden may be reduced.

HHS estimates that in 2020, an estimated 1,203 state and local government entities will offer individual coverage HRAs.<sup>315</sup> The total burden to prepare notices will be approximately 3,610 hours with an equivalent cost of approximately \$464,984. In 2021 approximately 1,805 additional state and local government entities will offer individual coverage HRAs for the first time and will incur a burden of approximately 5,415 hours with an equivalent cost of approximately \$697,476. In 2022, approximately 3,008 additional state and local government entities will offer individual coverage HRAs for the first time and will incur a burden of approximately 9,024 hours with an equivalent cost of approximately \$1.16 million.

HRA plan sponsors will provide the notice to eligible participants every year. HHS estimates that HRA plan sponsors will provide printed notices to approximately 99,178 eligible participants<sup>316</sup> in 2020, 243,438 eligible participants in 2021 and 477,859 eligible participants in 2022. The Departments anticipate that the notices will be approximately 6 pages long and the cost of materials and printing will be \$0.05 per page, with a total cost of \$0.30 per notice. It is assumed that these notices will be provided along with other benefits information with no additional mailing cost. The Departments assume that approximately 54 percent of notices will be provided electronically and approximately 46 percent will be provided in print along with other benefits information. Therefore, in 2020, state and local government entities providing individual coverage HRAs will print approximately 45,622 notices at a cost of approximately \$13,687. In 2021, approximately 111,981 notices will be printed at a cost of approximately \$33,594 and in 2022, approximately 219,815 notices will be printed at a cost of approximately \$65,945.

<sup>315</sup> U.S. Department of the Treasury, Office of Tax Analysis simulation model suggests that in 2020, approximately 80,000 employers will offer individual coverage HRAs, with 1.1 million individuals receiving an offer of an individual coverage HRA. These numbers will increase to 200,000 employers and 2.7 million individuals in 2021 and to 400,000 employers and 5.3 million

individuals in 2022. The Departments estimate that there is, on average, 1 dependent for every policyholder. The Departments also estimate that approximately 2 percent of employers are state and local government entities, accounting for approximately 14 percent of participants.

<sup>316</sup> U.S. Department of the Treasury, Office of Tax Analysis simulation model provides estimates of

the number of participants and dependents offered an individual coverage HRA. Number of eligible participants is estimated based on the assumption that 75 percent of eligible participants will enroll in their employers' plan. See Kaiser Family Foundation, "2017 Employer Health Benefits Survey", Section 3, <https://www.kff.org/health-costs/report/2017-employer-health-benefits-survey/>.

TABLE 4—ANNUAL BURDEN AND COSTS

Year	Estimated number of employers newly offering HRAs	Estimated number of notices to all eligible participants	Total annual burden (hours)	Total estimated labor cost	Total estimated printing and materials cost
2020 .....	1,203	99,178	3,610	\$464,984	\$13,687
2021 .....	1,805	243,438	5,415	697,476	33,594
2022 .....	3,008	477,859	9,024	1,162,461	65,945
3 year average .....	2,005	273,492	6,016	774,974	37,742

The burden related to these ICRs will be reviewed under emergency review and approval. They have been submitted to OMB in conjunction with this final rule and are pending approval.

#### 4. ICRs Regarding Notice Requirement for Excepted Benefit HRAs

In response to commenters' concerns, the final rules announce HHS' intent to propose a notice requirement with respect to excepted benefit HRAs sponsored by nonfederal governmental plan sponsors in future notice and comment rulemaking. It is anticipated that the proposed excepted benefit HRA notice would describe conditions pertaining to eligibility to receive benefits, annual or lifetime caps or other limits on benefits under the plan, and a description or summary of the benefits consistent with the requirements of 29 CFR 2520.102-3(j)(2), (3). At that time, HHS will estimate the burden associated with this requirement, solicit public comment, and request OMB approval in accordance with the PRA, as may be necessary.

#### 5. ICRs Regarding Notification of Termination of Coverage (45 CFR 146.123(c)(1)(iii))

Under the final rules, if an individual's health insurance coverage is cancelled or terminated, including retroactively, for failure to pay premiums or any other reason (for example, a rescission), the individual coverage HRA must require that the individual notify the HRA that coverage has been cancelled or terminated and the date on which the cancellation or termination is effective. The associated cost of this notification will be minimal and is, therefore, not estimated.

The burden related to these ICRs will be reviewed under emergency review and approval. They have been submitted to OMB in conjunction with this final rule and are pending approval.

#### 6. ICRs Regarding Special Rule for Excepted Benefit HRAs (45 CFR 146.145(b)(3)(viii)(F))

Under the final rules, an excepted benefit HRA offered by certain small employers must not reimburse premiums for STLDI in a state, if the Secretary of HHS makes a finding (in consultation with the Secretaries of Labor and the Treasury) that the reimbursement of premiums for STLDI by excepted benefit HRAs has caused significant harm to the small group market in the state that is the principal place of business of the small employer. The finding by the Secretary of HHS may be made only after submission of a written recommendation by the applicable state authority of such state, in a form and manner as specified in guidance published by HHS. The written recommendation must include evidence that the reimbursement of premiums for STLDI by excepted benefit HRAs established by fully-insured or partially-insured small employers in the state has caused significant harm to the state's small group market, including with respect to premiums. HHS anticipates fewer than 10 states will submit recommendations annually.

Under 5 CFR 1320.3(c)(4), this ICR will not be subject to the PRA as we anticipate it will affect fewer than 10 entities in a 12-month period.

#### 7. ICRs Regarding SEPs (45 CFR 155.420(d)(14))

The final SEP rules include a new SEP at 45 CFR 155.420(d)(14), to allow individuals who newly gain access to an individual coverage HRA or are newly provided a QSEHRA to enroll in or change their individual health insurance coverage. As stated earlier in the preamble, the FFEs will require individuals to submit documentation to confirm their SEP eligibility prior to effectuating their enrollment, and encourages State Exchanges to do so, as

well. Consistent with other SEPs subject to pre-enrollment verification, individuals will be required to provide supporting documentation, such as the HRA notice required under the final rules, within 30 days of plan selection.

HHS estimates that an additional 330,000 consumers will submit documents in 2020 to verify their eligibility to enroll through the SEP in the Exchanges, and that a consumer will, on average, spend approximately 1 hour gathering and submitting required documentation. Using the average hourly wage for all occupations (at an hourly rate of \$48.68), the opportunity cost to a consumer completing this task is estimated to be approximately \$48.68. The total annual burden on those consumers submitting documentation will be approximately 330,000 hours with an equivalent cost of approximately \$16,064,400. As new individual coverage HRA enrollments increase, these costs also increase in subsequent years. In 2021, an additional 480,000 consumers will submit documents and incur burden of 480,000 hours with an equivalent cost of approximately \$23,366,400 and in 2022 an additional 780,000 consumers will submit documents and incur burden of 780,000 hours with an equivalent cost of approximately \$37,970,400. The three-year average is 530,000 additional consumers submitting documents, with a total burden of 530,000 hours and an equivalent cost of \$25,800,400 per year.

HHS will amend the information collection currently approved under OMB control number 0938-1207 (Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment (CMS-10468)) to account for this additional burden.

TABLE 5—ANNUAL RECORDKEEPING AND REPORTING REQUIREMENTS

Regulation section	OMB control No.	Respondents	Responses	Burden per response (hours)	Total annual burden (hours)	Hourly labor cost of reporting	Total labor cost of reporting	Printing and materials cost	Total cost
§ 146.123(c)(6) (Notice for Individual Coverage HRAs).	0938—NEW .....	2,005	273,492	3	6,016	\$128.81	\$774,974	\$37,742	\$812,716
45 CFR 155.420(d)(14) (SEP) .....	0938—1207 .....	530,000	530,000	1	530,000	48.68	25,800,400	0	25,800,400
Total .....	.....	532,005	803,492	.....	536,016	.....	26,575,374	37,742	26,613,116

8. Submission of PRA-Related Comments

HHS has submitted a copy of the final rules to OMB for its review of the rule’s information collection and recordkeeping requirements. The requirements are not effective until they have been approved by OMB.

To obtain copies of the supporting statement and any related forms for the collections discussed in this rule, please visit CMS’ website at [www.cms.hhs.gov/PaperworkReductionActof1995](http://www.cms.hhs.gov/PaperworkReductionActof1995), or call the Reports Clearance Office at 410–786–1326. HHS invites public comments on these information collection requirements. If you wish to comment, please identify the rule (CMS–9918–F), the ICR’s CFR citation, CMS ID number, and OMB control number. Comments and recommendations must be received by the OMB desk officer via one of the following transmissions:

OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax: (202) 395–5806 OR, Email: [OIRA\\_submission@omb.eop.gov](mailto:OIRA_submission@omb.eop.gov).

To obtain copies of a supporting statement and any related forms for the collection(s) summarized in this rule, you may make your request using one of following:

1. Access CMS’ website address at <https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html>.
2. Email your request, including your address, phone number, OMB number, and CMS document identifier, to [Paperwork@cms.hhs.gov](mailto:Paperwork@cms.hhs.gov).
3. Call the Reports Clearance Office at (410) 786–1326.

ICR-related comments are due July 22, 2019.

*E. Paperwork Reduction Act—Department of Labor and Department of the Treasury*

As part of the continuing effort to reduce paperwork and respondent burden, the Departments conduct a preclearance consultation program to provide the general public and federal agencies with an opportunity to comment on proposed and continuing collections of information in accordance

with the PRA. This helps to ensure that the public understands the Departments’ collection instructions, respondents can provide the requested data in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the Departments can properly assess the impact of collection requirements on respondents.

Under the PRA, an agency may not conduct or sponsor, and an individual is not required to respond to, a collection of information unless it displays a valid OMB control number. In accordance with the requirements of the PRA, DOL published notice on October 29, 2018 (83 FR 54420, 54454) requesting an OMB control number for three new information collections (ICs) contained in the proposed rules. Two ICs are sponsored jointly by DOL and the Treasury Department: (1) Verification of Enrollment in Individual Health Insurance Coverage (26 CFR 54.9802–4(c)(5), 29 CFR 2590.702–2(c)(5) and 45 CFR 146.123(c)(5)); and (2) HRA Notice to Participants (26 CFR 54.9802–4(c)(6), 29 CFR 2590.702–2(c)(6) and 45 CFR 146.123(c)(6)). A third IC is sponsored solely by DOL (29 CFR 2510.3–1): (3) Notice to Participants that Individual Health Insurance Coverage Policy is Not Subject to Title I of ERISA. In response to comments received on the proposal, the Departments have added two additional information collections entitled *Participant Notify Individual Coverage HRA of Cancelled or Terminated Coverage* (26 CFR 54.9802–4(c)(1)(iii), 29 CFR 2590.702–2(c)(1)(iii) and 45 CFR 146.123(c)(1)(iii)) and *Notice for Excepted Benefit HRAs* (26 CFR 54.9831–1(c)(3)(viii)(E), 29 CFR 2590.732(c)(3)(viii)(E) and 45 CFR 146.145(c)(3)(viii)(E)).

With regard to the Treasury Department, the collection of information contained in these regulations is submitted to OMB for review in accordance with the PRA as follows. The collection of information in these regulations is in 26 CFR 54.9815–2711(d)(4) and 26 CFR 54.9802–4(c)(1)(iii), (c)(5) and (c)(6). The burden for the collection of information

contained in these regulations is reflected in the burden for OMB Control Number 1545–0123 for the U. S. Business Income Tax Return, 1545–0074 for U.S. Individual Income Tax Return, and 1545–0047 Return of Organizations Exempt From Income Tax. The estimated annual burden per respondent, estimated annual burden per recordkeeper, or estimated number of respondents is updated annually.

The Departments submitted an information collection request (ICR) to OMB in accordance with 44 U.S.C. 3507(d) contemporaneously with the publication of the proposed rules for OMB’s review. A copy of the ICR may be obtained by contacting the PRA addressee identified or at <http://www.RegInfo.gov>. PRA Addressee: G. Christopher Cosby, Office of Policy and Research, U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue NW, Room N– 5718, Washington, DC 20210. Telephone (202) 693–8410; Fax: (202) 219–5333. These are not toll-free numbers. ICRs submitted to OMB also are available at <http://www.RegInfo.gov>.

In connection with the final rules, the Departments are submitting an ICR to OMB requesting approval of a new collection of information under OMB Control Number 1210–0160. Below is a description of the information collections contained in the final rules and their burden.

1. Verification of Enrollment in Individual Health Insurance Coverage

In order for an HRA to be integrated with individual health insurance coverage (or Medicare, if applicable), among other requirements, in general, the HRA must implement, and comply with, reasonable procedures to substantiate that participants and dependents covered by the HRA are, or will be, enrolled in individual health insurance coverage (or Medicare, if applicable) for the plan year (or for the portion of the plan year the individual is covered by the HRA, if applicable). This requirement may be satisfied by providing a document from a third party, like an issuer, verifying coverage. As an alternative procedure, this requirement may also be satisfied if the

HRA requires participants to provide an attestation of coverage, including the date coverage begins and the provider of the coverage.

In addition, following the initial substantiation of coverage, with each new request for reimbursement of an incurred medical care expense for the same plan year, the HRA may not reimburse participants for any medical care expenses unless, prior to each reimbursement, the participant provides substantiation that the individual whose medical care expenses are requested to be reimbursed continues to be enrolled in individual health insurance coverage (or Medicare, if applicable) for the month during which the medical care expenses were incurred. The HRA must implement, and comply with, reasonable procedures to satisfy this requirement. This substantiation may be in the form of a written attestation by the participant, which may be part of the form used for requesting reimbursement, or a document from a third party (for example, a health insurance issuer).

Documentation, including proof that expenditure of funds is for a medical care expense, is currently universal when seeking reimbursement from an HRA. For the new requirements contained in the final rules regarding verification of enrollment in individual health insurance coverage (or Medicare, if applicable), the HRA can require proof of coverage or attestations of coverage as part of the processes that already exist for when participants seek reimbursement from HRAs for premiums or other medical care expenses. The additional burden is de minimis, because the attestation can be a part of the information already required when seeking reimbursement. To the extent an HRA develops additional processes for the requirement that individuals verify enrollment in individual health insurance coverage (or Medicare) for the plan year, the additional burden is also expected to be de minimis because it involves either attestation or providing documents that already exist.

The Departments are providing model attestation language, separate from the final rules. However, the Departments

note that individual coverage HRAs will not be required to use the model attestation. For those HRAs that elect to use the model attestation language provided by the Departments, it will further reduce burden for the HRAs and participants.

Section II.A.8 of this preamble discusses comments received on the requirement to verify enrollment including II.A.8.a In General, II.A.8.b Methods of Substantiation, and II.A.8.c Reliance on Documentation or Attestation.

## 2. HRA Notice to Participants

The final rules (29 CFR 2590.702–2(c)(6)(ii)) require an HRA to provide written notice to eligible participants including, among other things, the following information: (1) A description of the terms of the HRA, including the amounts newly made available as used in the affordability determination under the Code section 36B final rules; (2) a statement of the right of the participant to opt-out of and waive future reimbursement under the HRA; (3) a description of the potential availability of the PTC for a participant who opts out of and waives an HRA if the HRA is not affordable under the final PTC rules; and (4) a description of the PTC eligibility consequences for a participant who accepts the HRA. The written notice may include other information, as long as the additional information does not conflict with the required information. The written notice does not need to include information specific to a participant. In response to public comments, the Departments are separately publishing a model notice that can be used to satisfy these requirements, although the HRA will be required to add certain information specific to the particular HRA. The Departments note that individual coverage HRAs will not be required to use the model notice. For those HRAs that elect to use the model notice language provided by the Departments, it will further reduce burden for the HRAs.

In general, the HRA must provide the written notice to each participant at least 90 days before the beginning of each plan year. For participants who are

not yet eligible to participate at the beginning of the plan year (or who are not eligible when the notice is provided at least 90 days prior to the beginning of the plan year), the HRA must provide the notice no later than the date on which the HRA may first take effect for the participant. Also, for any participant who is employed by an employer that is first established less than 120 days before the beginning of the first plan year of the HRA, the notice must be provided no later than the date on which the HRA may first take effect for the participant.

Section II.A.9 of the preamble discusses comments received on the notice, the Departments' responses and changes made to the notice requirement including II.A.9.a Notice Content, II.A.9.b Notice Individualization, II.A.9.c Model Notice, II.A.9.d Notice Timing and Delivery.

The Departments estimate that a compensation and benefits manager would require two hours (at \$125 per hour) and a lawyer would require one hour (at \$136.44 per hour) to prepare the notice for each HRA. Thus, the total hour burden for each HRA would be 3 hours with an equivalent cost of approximately \$386. The Departments estimate that each notice would be six pages, with total materials and printing cost of \$0.30 per notice (\$0.05 per page). The Departments estimate that 78,797 private employers would<sup>317</sup> newly offer individual coverage HRAs in 2020<sup>318</sup> as a result of the final rules in the first year. Therefore, the Departments estimate the total hour burden for these HRAs to prepare the notices would be 236,390 hours with an equivalent cost of \$30,450,216.

All individual coverage HRAs are required to annually send the notice to all eligible participants (those eligible to enroll). The Departments estimate that there would be 634,155 eligible participants at private employers in 2020 that would need to receive the notice.<sup>319</sup> The Departments assume that approximately 54 percent of notices would be provided electronically and approximately 46 percent would be provided in print along with other benefits information. Therefore, a total of 291,711 notices will be printed at a

<sup>317</sup> U.S. Department of the Treasury, Office of Tax Analysis used a simulation model to obtain these estimates. For 2020, the model estimated that 80,000 employers will offer individual coverage HRAs and 1.1 million individuals will be offered those HRAs. Based on DOL estimates about 98 percent of these will be in the private market, and the rest will be through public employers like state and local governments. There are on average one dependent for every policy holder. "Health Insurance Coverage Bulletin", Abstract of the Auxiliary Data for the March 2016 Annual Social

and Economic Supplement of the Current Population Survey, July 25, 2017. <https://www.dol.gov/sites/default/files/ebsa/researchers/data/health-and-welfare/health-insurance-coverage-bulletin-2016.pdf>.

<sup>318</sup> Comparable numbers for 2021 are 118,195 private employers will newly offer individual coverage HRAs and 1,556,562 eligible participants in all individual coverage HRAs will receive notices, and for 2022 196,992 private employers will newly offer individual coverage HRAs and

3,055,474 eligible participants in all individual coverage HRAs will receive notices.

<sup>319</sup> Number of eligible participants is estimated based on Treasury estimates of the number of individuals enrolled in individual coverage HRAs, the assumption that there are two enrollees per employee participant, and the assumption that 75 percent of eligible participants would enroll in their employers' plans. See Kaiser Family Foundation, "2017 Employer Health Benefits Survey", Section 3, <https://www.kff.org/health-costs/report/2017-employer-health-benefits-survey/>.

cost of \$87,513. Tables 6 and 7 provide estimates for years 2020, 2021 and 2022.

TABLE 6—BURDEN TO PREPARE HRA NOTICE FOR THE FIRST TIME-PRIVATE SECTOR EMPLOYERS

Year (a)	Number of employers newly offering HRAs (b)	Legal cost per hour (c)	Number of hours for legal (d) = 1 * (b)	Benefit manager cost per hour (e)	Number of hours for benefit manager (f) = 2 * (b)	Total hour burden (g) = (d) + (f)	Total equivalent cost (c) * (d) + (e) * (f)
2020 .....	78,797	\$136.44	78,797	\$125.00	157,593	236,390	\$30,450,216
2021 .....	118,195	136.44	118,195	125.00	236,390	354,585	45,675,324
2022 .....	196,992	136.44	196,992	125.00	393,984	590,976	76,125,539

TABLE 7—BURDEN TO PROVIDE NOTICE TO ALL ELIGIBLE PRIVATE SECTOR PARTICIPANTS

Year (a)	Total number of notices (b)	Number of notices sent by mail (c)	Cost per notice (d)	Total cost burden (e) = (c) * (d)
2020 .....	634,155	291,711	\$0.30	\$87,513
2021 .....	1,556,562	716,019	0.30	214,806
2022 .....	3,055,474	1,405,518	0.30	421,655

3. Notice to Participants That Individual Health Insurance Coverage Policy Is Not Subject to Title I of ERISA

In the final rules, DOL clarifies that individual health insurance coverage, the premiums of which are reimbursed by an HRA, QSEHRA, or supplemental salary reduction arrangement is not considered an “employee welfare benefit plan” with the consumer protections provided under ERISA, if certain safe harbor conditions are satisfied. HRA plan sponsors are required to notify participants of this fact (29 CFR 2510.3–1(l)(5)). For an HRA, this notice requirement is satisfied if annually the notice requirement in 26 CFR 54.9802–4(c)(6) and 29 CFR 2590.702–2(c)(6) is satisfied, which is part of the HRA Notice to Participants discussed earlier in this preamble. Therefore, this notice requirement imposes no additional burden. For QSEHRAs and for HRAs not subject to 26 CFR 54.9802–4(c)(6) and 29 CFR 2590.702–2(c)(6), but that reimburse premiums for individual health insurance coverage, the plan sponsor may use the following language to satisfy this condition: “The individual health insurance coverage that is paid for by this plan, if any, is not subject to the rules and consumer protections of the Employee Retirement Income Security Act. You should contact your state insurance department for more information regarding your rights and responsibilities if you purchase individual health insurance coverage.” The Departments estimate that this burden will be de minimis, because the

required text is provided in the rule and can be included with other notices.

Section II.A.9 of the preamble discusses comments received on the notice required to be provided to participants eligible for an individual coverage HRA.

4. Participant Notifies Individual Coverage HRA of Cancelled or Terminated Coverage

The final rules require that if a covered individual fails to pay the applicable premium(s) by the end of a grace period and the coverage is cancelled or terminated, including retroactively, or if individual health insurance coverage is cancelled or terminated retroactively for some other reason (for example, a rescission), the individual coverage HRA must require that the individual notify the HRA that coverage has been cancelled or terminated and the date on which the coverage cancellation or termination is effective (26 CFR 54.9802–4(c)(1)(iii), 29 CFR 2590.702–254.9801–4(c)(1)(iii) and 45 CFR 146.123(c)(1)(iii)). The Departments have concluded that the burden associated with this notification requirement is de minimis for participants that cancel coverage, because they can satisfy the requirement by making a phone call or sending an email.

Other related comments are discussed in section II.A.2.d of this preamble.

5. Notice for Excepted Benefit HRAs

In response to commenters’ concerns, the final rules announce HHS’ intent to propose a notice requirement with

respect to excepted benefit HRAs sponsored by non-federal governmental plan sponsors in future notice and comment rulemaking. It is anticipated that the proposed excepted benefit HRA notice would be required to state conditions pertaining to eligibility to receive benefits, annual or lifetime caps or other limits on benefits under the excepted benefit HRA, and a description of or summary of the benefits consistent with the content and timing of DOL’s SPD requirements.

For private-sector, employment-based plans, other notice requirements under Part 1 of ERISA already apply. For example, excepted benefit HRAs that are ERISA-covered plans must provide a SPD, SMM, and summaries of material reductions in covered services or benefits.<sup>320</sup> The excepted benefit HRA’s SPD must include, for example, the conditions pertaining to eligibility to receive benefits; a description or summary of the benefits; the circumstances that may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (for example, by exercise of subrogation or reimbursement rights) of any benefits; and the procedures governing claims for benefits under the excepted benefit HRA. Accordingly, for excepted benefit HRAs that are subject to ERISA, the burden for providing information regarding excepted benefit HRAs is captured under DOL’s SPD information collection (OMB Control Number 1210–

<sup>320</sup> See 29 CFR 2520.104b–2, 2520.104b–3(a), and (d)(3).

0039), which includes a growth factor for new SPDs and SMMs provided to participants to notify them regarding coverage under new plans and plan amendments.

Additional comments are discussed in section II.B.7 of this preamble.

The information collections are summarized as follows:

*Type of Review:* New Collection.

*Agency:* DOL—EBSA, Treasury—IRS.

*Title:* Notice for Health

Reimbursement Arrangements

integrated with Individual Health

Insurance Coverage.

*OMB Numbers:* 1210–0160 (DOL), 1545–0123, 1545–0074, and 1545–0047 (Treasury).

*Affected Public:* Private Sector.

*Total Respondents:* 1,442,876 three-year average.

*Total Responses:* 18,798,855 three-year average.

*Frequency of Response:* Annually.

*Estimated Total Annual Burden*

*Hours:* 196,992 for each agency (combined total is 393,984 hours). Three year average.

*Estimated Total Annual Burden Cost:* \$120,662 for each agency (combined total is \$241,325). Three year average.

#### F. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) and which are likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a final rule is not likely to have a significant economic impact on a substantial number of small entities, section 604 of the RFA requires that the agency prepare a final regulatory flexibility analysis describing the impact of the rule on small entities. Small entities include small businesses, organizations, and governmental jurisdictions.

The RFA generally defines a “small entity” as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA) (13 CFR 121.201), (2) a nonprofit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. (States and individuals are not included in the definition of “small entity.”) The Departments use as their measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 to 5 percent.

The Departments do not expect the final rules to produce costs or benefits

in excess of 3 to 5 percent of revenues for small entities. Entities that choose to offer an individual coverage HRA instead of a traditional group health plan are likely to experience a modest increase or decrease in administrative burden associated with health benefits. Entities that newly offer health benefits in the form of an individual coverage HRA would bear modest administrative costs. However, offering an individual coverage HRA is entirely voluntary on the part of employers, and no employer that would experience substantial costs would be expected to offer an individual coverage HRA. In addition, the final rules would provide large and small employers with an additional choice of a tax-preferred health benefit to offer their employees, potentially enabling them to attract and retain workers and maintain a healthier workforce.

In addition, section 1102(b) of the Social Security Act requires agencies to prepare a regulatory impact analysis if a rule may have a significant economic impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. The final rules will not have a direct effect on small rural hospitals though there may be an indirect effect. By reducing the number of uninsured persons, the final rules could reduce administrative costs, such as billing costs and the costs of helping patients obtain public health benefits. The final rules could also reduce the cost of uncompensated care borne by small rural hospitals and other healthcare providers (and shift such costs to insured persons). However, the Departments have determined that the final rules will not have a significant impact on the operations of a substantial number of small rural hospitals.

#### G. Impact of Regulations on Small Business—Department of the Treasury

Pursuant to section 7805(f) of the Code, the proposed rule that preceded this final rule was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business, and no comments were received.

#### H. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a final rule that includes any Federal mandate that may result in expenditures in any 1 year by state, local, or Tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars, updated

annually for inflation. In 2019, that threshold is approximately \$154 million. These final rules do not include any Federal mandate that may result in expenditures by state, local, or tribal governments, or by the private sector in excess of that threshold.

#### I. Federalism

Executive Order 13132 outlines fundamental principles of federalism. It requires adherence to specific criteria by Federal agencies in formulating and implementing policies that have “substantial direct effects” on the states, the relationship between the national government and states, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have these federalism implications must consult with state and local officials, and describe the extent of their consultation and the nature of the concerns of state and local officials in the preamble to the final rules. Federal officials have discussed the issues related to implementation of the policies in the proposed rules with state regulatory officials. Over multiple individual and group conversations, federal and state officials shared information about how and when Exchange systems and processes could be updated to support implementation of individual coverage HRAs while minimizing burden and confusion for both employers and consumers. State Exchanges expressed interest in how the FFEs would update information and systems to support employers and employees with HRA affordability determinations and the impact on APTC eligibility. The FFEs explained possible ways in which the federal platform would approach these issues and operations if the rules were finalized as proposed and agreed to share related documentation once implementation begins, to support state efforts. Some State Exchanges expressed concerns in these conversations that fully implementing these changes would take several months and likely would not be finished before individual coverage HRAs become available starting on January 1, 2020. The FFEs offered suggestions for information that could be provided to employers and consumers to address these concerns and ensure smooth implementation before system changes are complete.

#### J. Congressional Review Act

This final rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5

U.S.C. 801 *et seq.*) and will be transmitted to the Congress and to the Comptroller General for review in accordance with such provisions.

*K. Reducing Regulation and Controlling Regulatory Cost*

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017 and requires that the costs associated with significant new regulations “shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations.” This final rule is an Executive Order 13771 deregulatory action.

**Statutory Authority**

The Department of the Treasury regulations are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor regulations are adopted pursuant to the authority contained in 29 U.S.C. 1002, 1135, 1182, 1185d, 1191a, 1191b, and 1191c; Secretary of Labor’s Order 1–2011, 77 FR 1088 (Jan. 9, 2012).

The Department of Health and Human Services regulations are adopted pursuant to the authority contained in sections 2701 through 2763, 2791, 2792, and 2794 of the PHS Act (42 U.S.C. 300gg–300gg–63, 300gg–91, 300gg–92 and 300gg–94), as amended; sections 1311 and 1321 of PPACA (42 U.S.C. 13031 and 18041).

**List of Subjects**

*26 CFR Part 1*

Income taxes, Reporting and recordkeeping requirements.

*26 CFR Part 54*

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

*29 CFR Part 2510*

Employee benefit plans, Pensions.

*29 CFR Part 2590*

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

*45 CFR Parts 144 and 146*

Health care, Health insurance, Reporting and recordkeeping requirements.

*45 CFR Part 147*

Health care, Health insurance, Reporting and recordkeeping

requirements, and State regulation of health insurance.

*45 CFR Part 155*

Exchange establishment standards and other related standards under the Affordable Care Act.

**Kirsten Wielobob,**

*Deputy Commissioner for Services and Enforcement, Internal Revenue Service.*

Approved: June 6, 2019.

**David J. Kautter,**

*Assistant Secretary of the Treasury (Tax Policy).*

Signed at Washington, DC, this 10th day of June, 2019.

**Preston Rutledge,**

*Assistant Secretary, Employee Benefits Security Administration, Department of Labor.*

Dated: June 7, 2019.

**Seema Verma,**

*Administrator, Centers for Medicare & Medicaid Services.*

Dated: June 7, 2019.

**Alex M. Azar II,**

*Secretary, Department of Health and Human Services.*

**DEPARTMENT OF THE TREASURY**

**Internal Revenue Service**

**Amendments to the Regulations**

Accordingly, 26 CFR parts 1 and 54 are amended as follows:

**PART 1—INCOME TAXES**

■ **Paragraph 1.** The authority citation for part 1 continues to read in part as follows:

**Authority:** 26 U.S.C. 7805.

\* \* \* \* \*

■ **Par 2.** Section 1.36B–0 is amended by—

■ a. Adding entries for §§ 1.36B–2(c)(3)(i)(A) and (B).

■ b. Revising the entry for § 1.36B–2(c)(5).

■ c. Adding entries for §§ 1.36B–2(c)(5)(i) and (ii), 1.36B–2(c)(5)(iii), 1.36B–2(c)(5)(iii)(A) and (B), and 1.36B–2(c)(5)(iv) through (ix).

The additions and revision read as follows:

**§ 1.36B–0 Table of contents.**

\* \* \* \* \*

**§ 1.36B–2 Eligibility for premium tax credit.**

\* \* \* \* \*

(c) \* \* \*

(3) \* \* \*

(i) In general.

(A) Plans other than health reimbursement arrangements (HRAs) or other account-based group health plans

described in paragraph (c)(3)(i)(B) of this section.

(B) HRAs and other account-based group health plans integrated with individual health insurance coverage.

\* \* \* \* \*

(5) Affordable HRA or other account-based group health plan.

(i) In general.

(ii) Required HRA contribution.

(iii) Monthly amounts.

(A) Monthly lowest cost silver plan premium.

(B) Monthly HRA amount.

(iv) Employee safe harbor.

(v) Amounts used for affordability determination.

(vi) Affordability for part-year period.

(vii) Related individual not allowed as a personal exemption deduction.

(viii) Post-employment coverage.

(ix) Examples.

\* \* \* \* \*

■ **Par. 3.** Section 1.36B–2 is amended by:

■ a. Redesignating the text of paragraph (c)(3)(i) as paragraph (c)(3)(i)(A).

■ b. Revising the subject heading to newly designated paragraph (c)(3)(i)(A).

■ c. Adding paragraph (c)(3)(i)(B).

■ d. Adding a sentence at the end of paragraphs (c)(3)(ii) and (c)(3)(v)(A)(1) and (2).

■ e. Revising paragraphs (c)(3)(v)(A)(3) and (5).

■ f. Adding a sentence at the end of paragraph (c)(3)(vi).

■ g. Adding paragraph (c)(5).

■ h. Revising paragraph (e)(1).

■ i. Adding paragraph (e)(3).

The revisions and additions read as follows:

**§ 1.36B–2 Eligibility for premium tax credit.**

\* \* \* \* \*

(c) \* \* \*

(3) \* \* \*

(i) \* \* \*

(A) *Plans other than health reimbursement arrangements (HRAs) or other account-based group health plans described in paragraph (c)(3)(i)(B) of this section.* \* \* \*

(B) *HRAs and other account-based group health plans integrated with individual health insurance coverage.* An employee who is offered an HRA or other account-based group health plan that would be integrated with individual health insurance coverage (or Medicare Part A and B or Medicare Part C), within the meaning of §§ 54.9802–4 and 54.9815–2711(d)(4) of this chapter, if the employee enrolls in individual health insurance coverage (or Medicare Part A and B or Medicare Part C), and an individual who is offered the HRA or

other account-based group health plan because of a relationship to the employee (a related HRA individual), are eligible for minimum essential coverage under an eligible employer-sponsored plan for any month for which the HRA or other account-based group health plan is offered if the HRA or other account-based group health plan is affordable for the month under paragraph (c)(5) of this section or if the employee does not opt out of and waive future reimbursements from the HRA or other account-based group health plan. An HRA or other account-based group health plan described in this paragraph (c)(3)(i)(B) that is affordable for a month under paragraph (c)(5) of this section is treated as providing minimum value for the month. For purposes of paragraphs (c)(3) and (5) of this section, the definitions under § 54.9815-2711(d)(6) of this chapter apply.

(ii) \* \* \* The plan year for an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is the plan's 12-month coverage period (or the remainder of the 12-month coverage period for a newly eligible individual or an individual who enrolls during a special enrollment period).

\* \* \* \* \*

(v) \* \* \*

(A) \* \* \*

(1) \* \* \* See paragraph (c)(5) of this section for rules for when an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is affordable for an employee for a month.

(2) \* \* \* See paragraph (c)(5) of this section for rules for when an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is affordable for a related HRA individual for a month.

(3) *Employee safe harbor.* An eligible employer-sponsored plan is not affordable for an employee or a related individual for a plan year if, when the employee or a related individual enrolls in a qualified health plan for a period coinciding with the plan year (in whole or in part), an Exchange determines that the eligible employer-sponsored plan is not affordable for that plan year. This paragraph (c)(3)(v)(A)(3) does not apply to a determination made as part of the redetermination process described in 45 CFR 155.335 unless the individual receiving an Exchange redetermination notification affirmatively responds and provides current information about affordability. This paragraph (c)(3)(v)(A)(3) does not apply for an individual who, with intentional or reckless disregard for the facts, provides

incorrect information to an Exchange concerning the portion of the annual premium for coverage for the employee or related individual under the plan. A reckless disregard of the facts occurs if the taxpayer makes little or no effort to determine whether the information provided to the Exchange is accurate under circumstances that demonstrate a substantial deviation from the standard of conduct a reasonable person would observe. A disregard of the facts is intentional if the taxpayer knows that the information provided to the Exchange is inaccurate. See paragraph (c)(5) of this section for an employee safe harbor that applies when an Exchange determines that an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is not affordable for an employee or a related HRA individual for the period of enrollment in a qualified health plan.

\* \* \* \* \*

(5) *Employer contributions to HRAs integrated with eligible employer-sponsored plans.* Amounts newly made available for the current plan year under an HRA that an employee may use to pay premiums, or may use to pay cost-sharing or benefits not covered by the primary plan in addition to premiums, reduce the employee's required contribution if the HRA would be integrated, within the meaning of § 54.9815-2711(d)(2) of this chapter, with an eligible employer-sponsored plan for an employee enrolled in the plan. The eligible employer-sponsored plan and the HRA must be offered by the same employer. Employer contributions to an HRA described in this paragraph (c)(3)(v)(A)(5) reduce an employee's required contribution only to the extent the amount of the annual contribution is required under the terms of the plan or otherwise determinable within a reasonable time before the employee must decide whether to enroll in the eligible employer-sponsored plan.

\* \* \* \* \*

(vi) \* \* \* An HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section that is affordable for a month under paragraph (c)(5) of this section is treated as providing minimum value for the month.

\* \* \* \* \*

(5) *Affordable HRA or other account-based group health plan—(i) In general.* Except as otherwise provided in this paragraph (c)(5), an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is affordable for a month if the employee's required HRA

contribution (as defined in paragraph (c)(5)(ii) of this section) for the month does not exceed 1/12 of the product of the employee's household income for the taxable year and the required contribution percentage (as defined in paragraph (c)(3)(v)(C) of this section).

(ii) *Required HRA contribution.* An employee's required HRA contribution is the excess of—

(A) The monthly premium for the lowest cost silver plan for self-only coverage of the employee offered in the Exchange for the rating area in which the employee resides, over

(B) The monthly self-only HRA or other account-based group health plan amount (or the monthly maximum amount available to the employee under the HRA or other account-based group health plan if the HRA or other account-based group health plan provides for reimbursements up to a single dollar amount regardless of whether an employee has self-only or other-than-self-only coverage).

(iii) *Monthly amounts—(A) Monthly lowest cost silver plan premium.* For purposes of paragraph (c)(5)(ii)(A) of this section, the premium for the lowest cost silver plan is determined without regard to any wellness program incentive that affects premiums unless the wellness program incentive relates exclusively to tobacco use, in which case the incentive is treated as earned. If the premium differs for tobacco users and non-tobacco users, the premium for the lowest cost silver plan is the premium that applies to non-tobacco users. For the purpose of this paragraph (c)(5)(iii)(A), the term wellness program incentive has the same meaning as the term reward in 26 CFR 54.9802-1(f)(1)(i). A silver-level qualified health plan that is used for purposes of determining a taxpayer's lowest cost silver plan for self-only coverage under paragraph (c)(5)(ii)(A) of this section does not cease to be the taxpayer's lowest cost silver plan for self-only coverage solely because the plan terminates or closes to enrollment during the taxable year.

(B) *Monthly HRA amount.* For purposes of paragraph (c)(5)(ii)(B) of this section, the monthly self-only HRA or other account-based group health plan amount is the self-only HRA or other account-based group health plan amount newly made available under the HRA for the plan year, divided by the number of months in the plan year the HRA or other account-based group health plan is available to the employee. The monthly maximum amount available to the employee under the HRA or other account-based group health plan is the maximum amount

newly made available for the plan year to the employee under the plan, divided by the number of months in the plan year the HRA or other account-based group health plan is available to the employee.

(iv) *Employee safe harbor.* An HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is not affordable for a month for an employee or a related HRA individual if, when the employee or related HRA individual enrolls in a qualified health plan for a period coinciding with the period the HRA or other account-based group health plan is available to the employee or related HRA individual (in whole or in part), an Exchange determines that the HRA or other account-based group health plan is not affordable for the period of enrollment in the qualified health plan. This paragraph (c)(5)(iv) does not apply to a determination made as part of the redetermination process described in 45 CFR 155.335 unless the individual receiving an Exchange redetermination notification affirmatively responds and provides current information about affordability. This paragraph (c)(5)(iv) does not apply for an individual who, with intentional or reckless disregard for the facts, provides incorrect information to an Exchange concerning the relevant HRA or other account-based group health plan amount offered by the employee's employer. A reckless disregard of the facts occurs if the taxpayer makes little or no effort to determine whether the information provided to the Exchange is accurate under circumstances that demonstrate a substantial deviation from the standard of conduct a reasonable person would observe. A disregard of the facts is intentional if the taxpayer knows that the information provided to the Exchange is inaccurate.

(v) *Amounts used for affordability determination.* Only amounts that are newly made available for the plan year of the HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section and determinable within a reasonable time before the beginning of the plan year of the HRA or other account-based health plan are considered in determining whether an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is affordable. Amounts made available for a prior plan year that carry over to the current plan year are not taken into account for purposes of this paragraph (c)(5). Similarly, amounts made available to account for amounts remaining in a different HRA or other account-based group health plan the

employer previously provided to the employee and under which the employee is no longer covered are not taken into account for purposes of this paragraph (c)(5).

(vi) *Affordability for part-year period.* Affordability under this paragraph (c)(5) is determined separately for each employment period that is less than a full calendar year or for the portions of the plan year of an employer's HRA or other account-based group health plan that fall in different taxable years of an applicable taxpayer. An HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is affordable for a part-year period if the employee's annualized required HRA contribution for the part-year period does not exceed the required contribution percentage of the applicable taxpayer's household income for the taxable year. The employee's annualized required HRA contribution is the employee's required HRA contribution for the part-year period times a fraction, the numerator of which is 12 and the denominator of which is the number of months in the part-year period during the applicable taxpayer's taxable year. Only full calendar months are included in the computation under this paragraph (c)(5)(vi).

(vii) *Related individual not allowed as a personal exemption deduction.* A related HRA individual is treated as ineligible for minimum essential coverage under an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section for months that the employee opted out of and waived future reimbursements from the HRA or other account-based group health plan and the employee is not allowed a personal exemption deduction under section 151 for the related HRA individual.

(viii) *Post-employment coverage.* An individual who is offered an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section, for months after an employee terminates employment with the employer offering the HRA or other account-based group health plan, is eligible for minimum essential coverage under the HRA or other account-based group health plan for months after termination of employment only if the employee does not forfeit or opt out of and waive future reimbursements from the HRA or other account-based group health plan for months after termination of employment.

(ix) *Examples.* The following examples illustrate the provisions of this paragraph (c)(5). The required contribution percentage is defined in

paragraph (c)(3)(v)(C) of this section and is updated annually. Because the required contribution percentage for 2020 has not yet been determined, the examples assume a required contribution percentage for 2020 of 9.78 percent.

(A) *Example 1: Determination of affordability—(1) Facts.* In 2020 Taxpayer A is single, has no dependents, and has household income of \$28,000. A is an employee of Employer X for all of 2020. X offers its employees an HRA described in paragraph (c)(3)(i)(B) of this section that reimburses \$2,400 of medical care expenses for single employees with no children (the self-only HRA amount) and \$4,000 for employees with a spouse or children for the medical expenses of the employees and their family members. A enrolls in a qualified health plan through the Exchange in the rating area in which A resides and remains enrolled for all of 2020. The monthly premium for the lowest cost silver plan for self-only coverage of A that is offered in the Exchange for the rating area in which A resides is \$500.

(2) *Conclusion.* A's required HRA contribution, as defined in paragraph (c)(5)(ii) of this section, is \$300, the excess of \$500 (the monthly premium for the lowest cost silver plan for self-only coverage of A) over \$200 (1/12 of the self-only HRA amount provided by Employer X to its employees). In addition, 1/12 of the product of 9.78 percent and A's household income is \$228 ( $\$28,000 \times .0978 = \$2,738$ ;  $\$2,738/12 = \$228$ ). Because A's required HRA contribution of \$300 exceeds \$228 (1/12 of the product of 9.78 percent and A's household income), the HRA is unaffordable for A for each month of 2020 under paragraph (c)(5) of this section. If A opts out of and waives future reimbursements from the HRA, A is not eligible for minimum essential coverage under the HRA for each month of 2020 under paragraph (c)(3)(i)(B) of this section.

(B) *Example 2: Determination of affordability for a related HRA individual—(1) Facts.* In 2020 Taxpayer B is married and has one child who is a dependent of B for 2020. B has household income of \$28,000. B is an employee of Employer X for all of 2020. X offers its employees an HRA described in paragraph (c)(3)(i)(B) of this section that reimburses \$3,600 of medical care expenses for single employees with no children (the self-only HRA amount) and \$5,000 for employees with a spouse or children for the medical expenses of the employees and their family members. B, B's spouse, and B's child enroll in a qualified health plan through the Exchange in the rating area in which B resides and they remain enrolled for all of 2020. No advance credit payments are made for their coverage. The monthly premium for the lowest cost silver plan for self-only coverage of B that is offered in the Exchange for the rating area in which B resides is \$500.

(2) *Conclusion.* B's required HRA contribution, as defined in paragraph (c)(5)(ii) of this section, is \$200, the excess of \$500 (the monthly premium for the lowest cost silver plan for self-only coverage for B) over \$300 (1/12 of the self-only HRA amount

provided by Employer X to its employees). In addition, 1/12 of the product of 9.78 percent and B's household income for 2020 is \$228 (\$28,000 × .0978 = \$2,738; \$2,738/12 = \$228). Because B's required HRA contribution of \$200 does not exceed \$228 (1/12 of the product of 9.78 percent and B's household income for 2020), the HRA is affordable for B under paragraph (c)(5) of this section, and B is eligible for minimum essential coverage under an eligible employer-sponsored plan for each month of 2020 under paragraph (c)(3)(i)(B) of this section. In addition, B's spouse and child are also eligible for minimum essential coverage under an eligible employer-sponsored plan for each month of 2020 under paragraph (c)(3)(i)(B) of this section.

(C) *Example 3: Exchange determines that HRA is unaffordable—(1) Facts.* The facts are the same as in paragraph (c)(5)(ix)(B) of this section (Example 2), except that B, when enrolling in Exchange coverage for B's family, received a determination by the Exchange that the HRA was unaffordable, because B believed B's household income would be lower than it turned out to be. Consequently, advance credit payments were made for their 2020 coverage.

(2) *Conclusion.* Under paragraph (c)(5)(iv) of this section, the HRA is considered unaffordable for B, B's spouse, and B's child for each month of 2020 provided that B did not, with intentional or reckless disregard for the facts, provide incorrect information to the Exchange concerning the HRA.

(D) *Example 4: Affordability determined for part of a taxable year (part-year period)—(1) Facts.* Taxpayer C is an employee of Employer X. C's household income for 2020 is \$28,000. X offers its employees an HRA described in paragraph (c)(3)(i)(B) of this section that reimburses medical care expenses of \$3,600 for single employees without children (the self-only HRA amount) and \$5,000 to employees with a spouse or children for the medical expenses of the employees and their family members. X's HRA plan year is September 1 to August 31 and C is first eligible to participate in the HRA for the period beginning September 1, 2020. C enrolls in a qualified health plan through the Exchange in the rating area in which C resides for all of 2020. The monthly premium for the lowest cost silver plan for self-only coverage of C that is offered in the Exchange for the rating area in which C resides for 2020 is \$500.

(2) *Conclusion.* Under paragraph (c)(3)(vi) of this section, the affordability of the HRA is determined separately for the period September 1 through December 31, 2020, and for the period January 1 through August 31, 2021. C's required HRA contribution, as defined in paragraph (c)(5)(ii) of this section, for the period September 1 through December 31, 2020, is \$200, the excess of \$500 (the monthly premium for the lowest cost silver plan for self-only coverage for C) over \$300 (1/12 of the self-only HRA amount provided by X to its employees). In addition, 1/12 of the product of 9.78 percent and C's household income is \$228 (\$28,000 × .0978 = \$2,738; \$2,738/12 = \$228). Because C's required HRA contribution of \$200 does not exceed \$228, the HRA is affordable for C for

each month in the period September 1 through December 31, 2020, under paragraph (c)(5) of this section. Affordability for the period January 1 through August 31, 2021, is determined using C's 2021 household income and required HRA contribution.

(E) *Example 5: Carryover amounts ignored in determining affordability—(1) Facts.* Taxpayer D is an employee of Employer X for all of 2020 and 2021. D is single. For each of 2020 and 2021, X offers its employees an HRA described in paragraph (c)(3)(i)(B) of this section that provides reimbursement for medical care expenses of \$2,400 to single employees with no children (the self-only HRA amount) and \$4,000 to employees with a spouse or children for the medical expenses of the employees and their family members. Under the terms of the HRA, amounts that an employee does not use in a calendar year may be carried over and used in the next calendar year. In 2020, D used only \$1,500 of her \$2,400 maximum reimbursement and the unused \$900 is carried over and may be used by D in 2021.

(2) *Conclusion.* Under paragraph (c)(5)(v) of this section, only the \$2,400 self-only HRA amount offered to D for 2021 is considered in determining whether D's HRA is affordable for D. The \$900 carryover amount is not considered in determining the affordability of the HRA.

\* \* \* \* \*

(e) \* \* \*  
(1) Except as provided in paragraphs (e)(2) and (3) of this section, this section applies to taxable years ending after December 31, 2013.

\* \* \* \* \*

(3) Paragraphs (c)(3)(i)(B) and (c)(5) of this section, and the last sentences of paragraphs (c)(3)(ii), (c)(3)(v)(A)(1) through (3), and (c)(3)(vi) of this section apply to taxable years beginning on or after January 1, 2020.

**PART 54—PENSION EXCISE TAXES**

**Par. 4.** The authority citation for part 54 is amended by adding an entry for § 54.9802–4 in numerical order to read in part as follows:

**Authority:** 26 U.S.C. 7805.

\* \* \* \* \*

Section 54.9802–4 is also issued under 26 U.S.C. 9833.

\* \* \* \* \*

**■ Par. 5.** Section 54.9801–2 is amended by revising the definition of “Group health insurance coverage” to read as follows:

**§ 54.9801–2 Definitions.**

\* \* \* \* \*

*Group health insurance coverage* means health insurance coverage offered in connection with a group health plan. Individual health insurance coverage reimbursed by the arrangements described in 29 CFR 2510.3–1(l) is not offered in connection with a group

health plan, and is not group health insurance coverage, provided all the conditions in 29 CFR 2510.3–1(l) are satisfied.

\* \* \* \* \*

**■ Par. 6.** Section 54.9802–4 is added to read as follows:

**§ 54.9802–4 Special Rule Allowing Integration of Health Reimbursement Arrangements (HRAs) and Other Account-Based Group Health Plans with Individual Health Insurance Coverage and Medicare and Prohibiting Discrimination In HRAs and Other Account-Based Group Health Plans.**

(a) *Scope.* This section applies to health reimbursement arrangements (HRAs) and other account-based group health plans, as defined in § 54.9815–2711(d)(6)(i) of this chapter. For ease of reference, the term “HRA” is used in this section to include other account-based group health plans. For related regulations, see 26 CFR 1.36B–2(c)(3)(i) and (c)(5), 29 CFR 2510.3–1(l), and 45 CFR 155.420.

(b) *Purpose.* This section provides the conditions that an HRA must satisfy in order to be integrated with individual health insurance coverage for purposes of Public Health Service Act (PHS Act) sections 2711 and 2713 and § 54.9815–2711(d)(4) of this chapter (referred to as an individual coverage HRA). This section also allows an individual coverage HRA to be integrated with Medicare for purposes of PHS Act sections 2711 and 2713 and § 54.9815–2711(d)(4), subject to the conditions provided in this section (see paragraph (e) of this section). Some of the conditions set forth in this section specifically relate to compliance with PHS Act sections 2711 and 2713 and some relate to the effect of having or being offered an individual coverage HRA on eligibility for the premium tax credit under section 36B. In addition, this section provides conditions that an individual coverage HRA must satisfy in order to comply with the nondiscrimination provisions in section 9802 and PHS Act section 2705 (which is incorporated in section 9815) and that are consistent with the provisions of the Patient Protection and Affordable Care Act, Public Law 111–148 (124 Stat. 119 (2010)), and the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (124 Stat. 1029 (2010)), each as amended, that are designed to create a competitive individual market. These conditions are intended to prevent an HRA plan sponsor from intentionally or unintentionally, directly or indirectly, steering any participants or dependents with adverse health factors away from its traditional group health plan, if any,

and toward individual health insurance coverage.

(c) *General rule.* An HRA will be considered to be integrated with individual health insurance coverage for purposes of PHS Act sections 2711 and 2713 and § 54.9815–2711(d)(4) of this chapter and will not be considered to discriminate in violation of section 9802 and PHS Act section 2705 solely because it is integrated with individual health insurance coverage, provided that the conditions of this paragraph (c) are satisfied. See paragraph (e) of this section for how these conditions apply to an individual coverage HRA integrated with Medicare. For purposes of this section, medical care expenses means medical care expenses as defined in § 54.9815–2711(d)(6)(ii) of this chapter and Exchange means Exchange as defined in 45 CFR 155.20.

(1) *Enrollment in individual health insurance coverage—(i) In general.* The HRA must require that the participant and any dependent(s) are enrolled in individual health insurance coverage that is subject to and complies with the requirements in PHS Act section 2711 (and § 54.9815–2711(a)(2) of this chapter) and PHS Act section 2713 (and § 54.9815–2713(a)(1) of this chapter), for each month that the individual(s) are covered by the HRA. For purposes of this paragraph (c), all individual health insurance coverage, except for individual health insurance coverage that consists solely of excepted benefits, is treated as being subject to and complying with PHS Act sections 2711 and 2713. References to individual health insurance coverage in this paragraph (c) do not include individual health insurance coverage that consists solely of excepted benefits.

(ii) *Forfeiture.* The HRA must provide that if any individual covered by the HRA ceases to be covered by individual health insurance coverage, the HRA will not reimburse medical care expenses that are incurred by that individual after the individual health insurance coverage ceases. In addition, if the participant and all dependents covered by the participant's HRA cease to be covered by individual health insurance coverage, the participant must forfeit the HRA. In either case, the HRA must reimburse medical care expenses incurred by the individual prior to the cessation of individual health insurance coverage to the extent the medical care expenses are otherwise covered by the HRA, but the HRA may limit the period to submit medical care expenses for reimbursement to a reasonable specified time period. If a participant or dependent loses coverage under the HRA for a reason other than cessation of

individual health insurance coverage, COBRA and other continuation coverage requirements may apply.

(iii) *Grace periods and retroactive termination of individual health insurance coverage.* In the event an individual is initially enrolled in individual health insurance coverage and subsequently timely fails to pay premiums for the coverage, with the result that the individual is in a grace period, the individual is considered to be enrolled in individual health insurance coverage for purposes of this paragraph (c)(1) and the individual coverage HRA must reimburse medical care expenses incurred by the individual during that time period to the extent the medical care expenses are otherwise covered by the HRA. If the individual fails to pay the applicable premium(s) by the end of the grace period and the coverage is cancelled or terminated, including retroactively, or if the individual health insurance coverage is cancelled or terminated retroactively for some other reason (for example, a rescission), an individual coverage HRA must require that a participant notify the HRA that coverage has been cancelled or terminated and the date on which the cancellation or termination is effective. After the individual coverage HRA has received the notice of cancellation or termination, the HRA may not reimburse medical care expenses incurred on and after the date the individual health insurance coverage was cancelled or terminated, which is considered to be the date of termination of coverage under the HRA.

(2) *No traditional group health plan may be offered to same participants.* To the extent a plan sponsor offers any class of employees (as defined in paragraph (d) of this section) an individual coverage HRA, the plan sponsor may not also offer a traditional group health plan to the same class of employees, except as provided in paragraph (d)(5) of this section. For purposes of this section, a traditional group health plan is any group health plan other than either an account-based group health plan or a group health plan that consists solely of excepted benefits. Therefore, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any participant or dependent.

(3) *Same terms requirement—(i) In general.* If a plan sponsor offers an individual coverage HRA to a class of employees described in paragraph (d) of this section, the HRA must be offered on the same terms to all participants within the class, except as provided in

paragraphs (c)(3)(ii) through (vi) and (d)(5) of this section.

(ii) *Carryover amounts, salary reduction arrangements, and transfer amounts.* Amounts that are not used to reimburse medical care expenses for any plan year that are made available to participants in later plan years are disregarded for purposes of determining whether an HRA is offered on the same terms, provided that the method for determining whether participants have access to unused amounts in future years, and the methodology and formula for determining the amounts of unused funds which they may access in future years, is the same for all participants in a class of employees. In addition, the ability to pay the portion of the premium for individual health insurance coverage that is not covered by the HRA, if any, by using a salary reduction arrangement under section 125 is considered to be a term of the HRA for purposes of this paragraph (c)(3). Therefore, an HRA is not provided on the same terms unless the salary reduction arrangement, if made available to any participant in a class of employees, is made available on the same terms to all participants (other than former employees, as defined in paragraph (c)(3)(iv) of this section) in the class of employees. Further, to the extent that a participant in an individual coverage HRA was previously covered by another HRA and the current individual coverage HRA makes available amounts that were not used to reimburse medical care expenses under the prior HRA (transferred amounts), the transferred amounts are disregarded for purposes of determining whether the HRA is offered on the same terms, provided that if the HRA makes available transferred amounts, it does so on the same terms for all participants in the class of employees.

(iii) *Permitted variation.* An HRA does not fail to be provided on the same terms solely because the maximum dollar amount made available to participants in a class of employees to reimburse medical care expenses for any plan year increases in accordance with paragraph (c)(3)(iii)(A) or (B) of this section.

(A) *Variation due to number of dependents.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available to those participants to reimburse medical care expenses for any plan year increases as the number of the participant's dependents who are covered under the HRA increases, so long as the same

maximum dollar amount attributable to the increase in family size is made available to all participants in that class of employees with the same number of dependents covered by the HRA.

(B) *Variation due to age.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available under the terms of the HRA to those participants to reimburse medical care expenses for any plan year increases as the age of the participant increases, so long as the requirements in paragraphs (c)(3)(iii)(B)(1) and (2) of this section are satisfied. For the purpose of this paragraph (c)(3)(iii)(B), the plan sponsor may determine the age of the participant using any reasonable method for a plan year, so long as the plan sponsor determines each participant's age for the purpose of this paragraph (c)(3)(iii)(B) using the same method for all participants in the class of employees for the plan year and the method is determined prior to the plan year.

(1) The same maximum dollar amount attributable to the increase in age is made available to all participants who are the same age.

(2) The maximum dollar amount made available to the oldest participant(s) is not more than three times the maximum dollar amount made available to the youngest participant(s).

(iv) *Former employees.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers the HRA to some, but not all, former employees within a class of employees. However, if a plan sponsor offers the HRA to one or more former employees within a class of employees, the HRA must be offered to the former employee(s) on the same terms as to all other employees within the class, except as provided in paragraph (c)(3)(ii) of this section. For purposes of this section, a former employee is an employee who is no longer performing services for the employer.

(v) *New employees or new dependents.* For a participant whose coverage under the HRA becomes effective later than the first day of the plan year, the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees whose coverage became effective as of the first day of the plan year, or is pro-rated consistent with the portion of the plan year in which the participant is covered by the HRA.

Similarly, if the HRA provides for variation in the maximum amount made available to participants in a class of employees based on the number of a participant's dependents covered by the HRA, and the number of a participant's dependents covered by the HRA changes during a plan year (either increasing or decreasing), the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees who had the same number of dependents covered by the HRA on the first day of the plan year or is pro-rated for the remainder of the plan year after the change in the number of the participant's dependents covered by the HRA consistent with the portion of the plan year in which that number of dependents are covered by the HRA. The method the HRA uses to determine amounts made available for participants whose coverage under the HRA is effective later than the first day of the plan year or who have changes in the number of dependents covered by the HRA during a plan year must be the same for all participants in the class of employees and the method must be determined prior to the beginning of the plan year.

(vi) *HSA-compatible HRAs.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers participants in a class of employees a choice between an HSA-compatible individual coverage HRA and an individual coverage HRA that is not HSA compatible, provided both types of HRAs are offered to all participants in the class of employees on the same terms. For the purpose of this paragraph (c)(3)(vi), an HSA-compatible individual coverage HRA is an individual coverage HRA that is limited in accordance with applicable guidance under section 223 such that an individual covered by such an HRA is not disqualified from being an eligible individual under section 223.

(vii) *Examples.* The following examples illustrate the provisions of this paragraph (c)(3), without taking into account the provisions of paragraph (d) of this section. In each example, the HRA is an individual coverage HRA that has a calendar year plan year and may reimburse any medical care expenses, including premiums for individual health insurance coverage (except as provided in paragraph (c)(3)(vii)(E) of this section (*Example 5*)). Further, in each example, assume the HRA is offered on the same terms, except as

otherwise specified in the example and that no participants or dependents are Medicare beneficiaries.

(A) *Example 1: Carryover amounts permitted—(1) Facts.* For 2020 and again for 2021, Plan Sponsor A offers all employees \$7,000 each in an HRA, and the HRA provides that amounts that are unused at the end of a plan year may be carried over to the next plan year, with no restrictions on the use of the carryover amounts compared to the use of newly available amounts. At the end of 2020, some employees have used all of the funds in their HRAs, while other employees have balances remaining that range from \$500 to \$1,750 that are carried over to 2021 for those employees.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(A) (*Example 1*) for 2020 because Plan Sponsor A offers all employees the same amount, \$7,000, in an HRA for that year. The same terms requirement is also satisfied for 2021 because Plan Sponsor A again offers all employees the same amount for that year, and the carryover amounts that some employees have are disregarded in applying the same terms requirement because the amount of the carryover for each employee (that employee's balance) and each employee's access to the carryover amounts is based on the same terms.

(B) *Example 2: Employees hired after the first day of the plan year—(1) Facts.* For 2020, Plan Sponsor B offers all employees employed on January 1, 2020, \$7,000 each in an HRA for the plan year. Employees hired after January 1, 2020, are eligible to enroll in the HRA with an effective date of the first day of the month following their date of hire, as long as they have enrolled in individual health insurance coverage effective on or before that date, and the amount offered to these employees is pro-rated based on the number of months remaining in the plan year, including the month which includes their coverage effective date.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(B) (*Example 2*) for 2020 because Plan Sponsor B offers all employees employed on the first day of the plan year the same amount, \$7,000, in an HRA for that plan year and all employees hired after January 1, 2020, a pro-rata amount based on the portion of the plan year during which they are enrolled in the HRA.

(C) *Example 3: HRA amounts offered vary based on number of dependents—(1) Facts.* For 2020, Plan Sponsor C offers its employees the following amounts in an HRA: \$1,500, if the employee is the only individual covered by the HRA; \$3,500, if the employee and one dependent are covered by the HRA; and \$5,000, if the employee and more than one dependent are covered by the HRA.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(C) (*Example 3*) because paragraph (c)(3)(iii)(A) of this section allows the maximum dollar amount made available in an HRA to increase as the number of the participant's

dependents covered by the HRA increases and Plan Sponsor C makes the same amount available to each employee with the same number of dependents covered by the HRA.

(D) *Example 4: HRA amounts offered vary based on increases in employees' ages—(1) Facts.* For 2020, Plan Sponsor D offers its employees the following amounts in an HRA: \$1,000 each for employees age 25 to 35; \$2,000 each for employees age 36 to 45; \$2,500 each for employees age 46 to 55; and \$4,000 each for employees over age 55.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is not satisfied in this paragraph (c)(3)(vii)(D) (*Example 4*) because the terms of the HRA provide the oldest participants (those over age 55) with more than three times the amount made available to the youngest participants (those ages 25 to 35), in violation of paragraph (c)(3)(iii)(B)(2) of this section.

(E) *Example 5: Application of same terms requirement to premium only HRA—(1) Facts.* For 2020, Plan Sponsor E offers its employees an HRA that reimburses only premiums for individual health insurance coverage, up to \$10,000 for the year. Employee A enrolls in individual health insurance coverage with a \$5,000 premium for the year and is reimbursed \$5,000 from the HRA. Employee B enrolls in individual health insurance coverage with an \$8,000 premium for the year and is reimbursed \$8,000 from the HRA.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(E) (*Example 5*) because Plan Sponsor E offers the HRA on the same terms to all employees, notwithstanding that some employees receive a greater amount of reimbursement than others based on the cost of the individual health insurance coverage selected by the employee.

(4) *Opt out.* Under the terms of the HRA, a participant who is otherwise eligible for coverage must be permitted to opt out of and waive future reimbursements on behalf of the participant and all dependents eligible for the HRA from the HRA once, and only once, with respect to each plan year. The HRA may establish timeframes for enrollment in (and opting out of) the HRA but, in general, the opportunity to opt out must be provided in advance of the first day of the plan year. For participants who become eligible to participate in the HRA on a date other than the first day of the plan year (or who become eligible fewer than 90 days prior to the plan year or for whom the notice under paragraph (c)(6) of this section is required to be provided as set forth in paragraph (c)(6)(i)(C) of this section), or for a dependent who newly becomes eligible during the plan year, this opportunity must be provided during the applicable HRA enrollment period(s) established by the HRA for these individuals. Further, under the terms of the HRA, upon termination of employment, for a

participant who is covered by the HRA, either the remaining amounts in the HRA must be forfeited or the participant must be permitted to permanently opt out of and waive future reimbursements from the HRA on behalf of the participant and all dependents covered by the HRA.

(5) *Reasonable procedures for coverage substantiation—(i) Substantiation of individual health insurance coverage for the plan year.* The HRA must implement, and comply with, reasonable procedures to substantiate that participants and each dependent covered by the HRA are, or will be, enrolled in individual health insurance coverage for the plan year (or for the portion of the plan year the individual is covered by the HRA, if applicable). The HRA may establish the date by which this substantiation must be provided, but, in general, the date may be no later than the first day of the plan year. However, for a participant who is not eligible to participate in the HRA on the first day of the plan year (or who becomes eligible fewer than 90 days prior to the plan year or for whom the notice under paragraph (c)(6) of this section is required to be provided as set forth in paragraph (c)(6)(i)(C) of this section), the HRA may establish the date by which this substantiation must be provided, but that date may be no later than the date the HRA coverage begins. Similarly, for a participant who adds a new dependent during the plan year, the HRA may establish the date by which this substantiation must be provided, but the date may be no later than the date the HRA coverage for the new dependent begins; however, to the extent the dependent's coverage under the HRA is effective retroactively, the HRA may establish a reasonable time by which this substantiation is required, but must require it be provided before the HRA will reimburse any medical care expense for the newly added dependent. The reasonable procedures an HRA may use to implement the substantiation requirement set forth in this paragraph (c)(5)(i) may include a requirement that a participant substantiate enrollment by providing either:

(A) A document from a third party (for example, the issuer or an Exchange) showing that the participant and any dependents covered by the HRA are, or will be, enrolled in individual health insurance coverage (for example, an insurance card or an explanation of benefits document pertaining to the relevant time period or documentation from the Exchange showing that the individual has completed the application and plan selection); or

(B) An attestation by the participant stating that the participant and dependent(s) covered by the HRA are, or will be, enrolled in individual health insurance coverage, the date coverage began or will begin, and the name of the provider of the coverage.

(ii) *Coverage substantiation with each request for reimbursement of medical care expenses.* Following the initial substantiation of coverage, with each new request for reimbursement of an incurred medical care expense for the same plan year, the HRA may not reimburse a participant for any medical care expenses unless, prior to each reimbursement, the participant substantiates that the individual on whose behalf medical care expenses are requested to be reimbursed continues to be enrolled in individual health insurance coverage for the month during which the medical care expenses were incurred. The HRA must implement, and comply with, reasonable procedures to satisfy this requirement. This substantiation may be in the form of a written attestation by the participant, which may be part of the form used to request reimbursement, or a document from a third party (for example, a health insurance issuer) showing that the participant or the dependent, if applicable, are or were enrolled in individual health insurance coverage for the applicable month.

(iii) *Reliance on substantiation.* For purposes of this paragraph (c)(5), an HRA may rely on the participant's documentation or attestation unless the HRA, its plan sponsor, or any other entity acting in an official capacity on behalf of the HRA has actual knowledge that any individual covered by the HRA is not, or will not be, enrolled in individual health insurance coverage for the plan year (or applicable portion of the plan year) or the month, as applicable.

(6) *Notice requirement—(i) Timing.* The HRA must provide a written notice to each participant:

(A) At least 90 calendar days before the beginning of each plan year for any participant who is not described in either paragraph (c)(6)(i)(B) or (C) of this section;

(B) No later than the date on which the HRA may first take effect for the participant, for any participant who is not eligible to participate at the beginning of the plan year (or is not eligible to participate at the time the notice is provided at least 90 calendar days before the beginning of the plan year pursuant to paragraph (c)(6)(i)(A) of this section); or

(C) No later than the date on which the HRA may first take effect for the

participant, for any participant who is employed by an employer that is first established less than 120 days before the beginning of the first plan year of the HRA; this paragraph (c)(6)(i)(C) applies only with respect to the first plan year of the HRA.

(ii) *Content.* The notice must include all the information described in this paragraph (c)(6)(ii) (and may include any additional information that does not conflict with that information). To the extent that the Departments of the Treasury, Labor and Health and Human Services provide model notice language for certain elements of this required notice, HRAs are permitted, but not required, to use the model language.

(A) A description of the terms of the HRA, including the maximum dollar amount available for each participant (including the self-only HRA amount available for the plan year (or the maximum dollar amount available for the plan year if the HRA provides for reimbursements up to a single dollar amount regardless of whether a participant has self-only or other than self-only coverage)), any rules regarding the proration of the maximum dollar amount applicable to any participant (or dependent, if applicable) who is not eligible to participate in the HRA for the entire plan year, whether (and which of) the participant's dependents are eligible for the HRA, a statement that there are different kinds of HRAs (including a qualified small employer health reimbursement arrangement) and the HRA being offered is an individual coverage HRA, a statement that the HRA requires the participant and any covered dependents to be enrolled in individual health insurance coverage (or Medicare Part A and B or Medicare Part C, if applicable), a statement that the coverage in which the participant and any covered dependents must be enrolled cannot be short-term, limited-duration insurance or consist solely of excepted benefits, if the HRA is subject to the Employee Retirement Income Security Act (ERISA), a statement that individual health insurance coverage in which the participant and any covered dependents are enrolled is not subject to ERISA, if the conditions under 29 CFR 2510.3-1(l) are satisfied, the date as of which coverage under the HRA may first become effective (both for participants whose coverage will become effective on the first day of the plan year and for participants whose HRA coverage may become effective at a later date), the dates on which the HRA plan year begins and ends, and the dates on which the amounts newly made available under the HRA will be made available.

(B) A statement of the right of the participant to opt out of and waive future reimbursements from the HRA, as set forth under paragraph (c)(4) of this section.

(C) A description of the potential availability of the premium tax credit if the participant opts out of and waives future reimbursements from the HRA and the HRA is not affordable for one or more months under § 1.36B-2(c)(5) of this chapter, a statement that even if the participant opts out of and waives future reimbursements from an HRA, the offer will prohibit the participant (and, potentially, the participant's dependents) from receiving a premium tax credit for the participant's coverage (or the dependent's coverage, if applicable) on an Exchange for any month that the HRA is affordable under § 1.36B-2(c)(5) of this chapter, a statement describing how the participant may find assistance with determining affordability, a statement that, if the participant is a former employee, the offer of the HRA does not render the participant (or the participant's dependents, if applicable) ineligible for the premium tax credit regardless of whether it is affordable under § 1.36B-2(c)(5) of this chapter, and a statement that if the participant or dependent is enrolled in Medicare, he or she is ineligible for the premium tax credit without regard to the offer or acceptance of the HRA;

(D) A statement that if the participant accepts the HRA, the participant may not claim a premium tax credit for the participant's Exchange coverage for any month the HRA may be used to reimburse medical care expenses of the participant, and a premium tax credit may not be claimed for the Exchange coverage of the participant's dependents for any month the HRA may be used to reimburse medical care expenses of the dependents.

(E) A statement that the participant must inform any Exchange to which the participant applies for advance payments of the premium tax credit of the availability of the HRA; the self-only HRA amount available for the HRA plan year (or the maximum dollar amount available for the plan year if the HRA provides for reimbursements up to a single dollar amount regardless of whether a participant has self-only or other than self-only coverage) as set forth in the written notice in accordance with paragraph (c)(6)(ii)(A) of this section; whether the HRA is also available to the participant's dependents and if so, which ones; the date as of which coverage under the HRA may first become effective; the date on which the plan year begins and the date on

which it ends; and whether the participant is a current employee or former employee.

(F) A statement that the participant should retain the written notice because it may be needed to determine whether the participant is allowed a premium tax credit on the participant's individual income tax return.

(G) A statement that the HRA may not reimburse any medical care expense unless the substantiation requirement set forth in paragraph (c)(5)(ii) of this section is satisfied and a statement that the participant must also provide the substantiation required by paragraph (c)(5)(i) of this section.

(H) A statement that if the individual health insurance coverage (or coverage under Medicare Part A and B or Medicare Part C) of a participant or dependent ceases, the HRA will not reimburse any medical care expenses that are incurred by the participant or dependent, as applicable, after the coverage ceases, and a statement that the participant must inform the HRA if the participant's or dependent's individual health insurance coverage (or coverage under Medicare Part A and B or Medicare Part C) is cancelled or terminated retroactively and the date on which the cancellation or termination is effective.

(I) The contact information (including a phone number) for an individual or a group of individuals who participants may contact in order to receive additional information regarding the HRA. The plan sponsor may determine which individual or group of individuals is best suited to be the specified contact.

(J) A statement of availability of a special enrollment period to enroll in or change individual health insurance coverage, through or outside of an Exchange, for the participant and any dependents who newly gain access to the HRA and are not already covered by the HRA.

(d) *Classes of employees*—(1) *In general.* This paragraph (d) sets forth the rules for determining classes of employees. Paragraph (d)(2) of this section sets forth the specific classes of employees; paragraph (d)(3) of this section sets forth a minimum class size requirement that applies in certain circumstances; paragraph (d)(4) of this section sets forth rules regarding the definition of “full-time employees,” “part-time employees,” and “seasonal employees”; paragraph (d)(5) of this section sets forth a special rule for new hires; and paragraph (d)(6) of this section addresses student premium reduction arrangements. For purposes of this section, including determining

classes under this paragraph (d), the employer is the common law employer and is determined without regard to the rules under sections 414(b), (c), (m), and (o) that would treat the common law employer as a single employer with certain other entities.

(2) *List of classes.* Participants may be treated as belonging to a class of employees based on whether they are, or are not, included in the classes described in this paragraph (d)(2). If the individual coverage HRA is offered to former employees, former employees are considered to be in the same class in which they were included immediately before separation from service. Before each plan year, a plan sponsor must determine for the plan year which classes of employees it intends to treat separately and the definition of the relevant class(es) it will apply, to the extent these regulations permit a choice. After the classes and the definitions of the classes are established for a plan year, a plan sponsor may not make changes to the classes of employees or the definitions of those relevant classes with respect to that plan year.

(i) Full-time employees, defined at the election of the plan sponsor to mean either full-time employees under section 4980H (and § 54.4980H-1(a)(21) of this chapter) or employees who are not part-time employees (as described in § 1.105-11(c)(2)(iii)(C) of this chapter);

(ii) Part-time employees, defined at the election of the plan sponsor to mean either employees who are not full-time employees under section 4980H (and under § 54.4980H-1(a)(21) of this chapter (which defines full-time employee)) or employees who are part-time employees as described in § 1.105-11(c)(2)(iii)(C) of this chapter;

(iii) Employees who are paid on a salary basis;

(iv) Non-salaried employees (such as, for example, hourly employees);

(v) Employees whose primary site of employment is in the same rating area as defined in 45 CFR 147.102(b);

(vi) Seasonal employees, defined at the election of the plan sponsor to mean seasonal employees as described in either § 54.4980H-1(a)(38) or § 1.105-11(c)(2)(iii)(C) of this chapter;

(vii) Employees included in a unit of employees covered by a particular collective bargaining agreement (or an appropriate related participation agreement) in which the plan sponsor participates (as described in § 1.105-11(c)(2)(iii)(D) of this chapter);

(viii) Employees who have not satisfied a waiting period for coverage (if the waiting period complies with § 54.9815-2708 of this chapter);

(ix) Non-resident aliens with no U.S.-based income (as described in § 1.105-11(c)(2)(iii)(E) of this chapter);

(x) Employees who, under all the facts and circumstances, are employees of an entity that hired the employees for temporary placement at an entity that is not the common law employer of the employees and that is not treated as a single employer with the entity that hired the employees for temporary placement under section 414(b), (c), (m), or (o); or

(xi) A group of participants described as a combination of two or more of the classes of employees set forth in paragraphs (d)(2)(i) through (x) of this section.

(3) *Minimum class size requirement—*  
(i) *In general.* If a class of employees is subject to the minimum class size requirement as set forth in this paragraph (d)(3), the class must consist of at least a minimum number of employees (as described in paragraphs (d)(3)(iii) and (iv) of this section), otherwise, the plan sponsor may not treat that class as a separate class of employees. Paragraph (d)(3)(ii) of this section sets forth the circumstances in which the minimum class size requirement applies to a class of employees, paragraph (d)(3)(iii) of this section sets forth the rules for determining the applicable class size minimum, and paragraph (d)(3)(iv) of this section sets forth the rules for a plan sponsor to determine if it satisfies the minimum class size requirement with respect to a class of employees.

(ii) *Circumstances in which minimum class size requirement applies—*(A) The minimum class size requirement applies only if a plan sponsor offers a traditional group health plan to one or more classes of employees and offers an individual coverage HRA to one or more other classes of employees.

(B) The minimum class size requirement does not apply to a class of employees offered a traditional group health plan or a class of employees offered no coverage.

(C) The minimum class size requirement applies to a class of employees offered an individual coverage HRA if the class is full-time employees, part-time employees, salaried employees, non-salaried employees, or employees whose primary site of employment is in the same rating area (described in paragraph (d)(2)(i), (ii), (iii), (iv), or (v) of this section, respectively, and referred to collectively as the applicable classes or individually as an applicable class), except that:

(1) In the case of the class of employees whose primary site of

employment is in the same rating area (as described in paragraph (d)(2)(v) of this section), the minimum class size requirement does not apply if the geographic area defining the class is a State or a combination of two or more entire States; and

(2) In the case of the classes of employees that are full-time employees and part-time employees (as described in paragraphs (d)(2)(i) and (ii) of this section, respectively), the minimum class size requirement applies only to those classes (and the classes are only applicable classes) if the employees in one such class are offered a traditional group health plan while the employees in the other such class are offered an individual coverage HRA. In such a case, the minimum class size requirement applies only to the class offered an individual coverage HRA.

(D) A class of employees offered an individual coverage HRA is also subject to the minimum class size requirement if the class is a class of employees created by combining at least one of the applicable classes (as defined in paragraph (d)(3)(ii)(C) of this section) with any other class, except that the minimum class size requirement shall not apply to a class that is the result of a combination of one of the applicable classes and a class of employees who have not satisfied a waiting period (as described in paragraph (d)(2)(viii) of this section).

(iii) *Determination of the applicable class size minimum—*(A) *In general.* The minimum number of employees that must be in a class of employees that is subject to the minimum class size requirement (the applicable class size minimum) is determined prior to the beginning of the plan year for each plan year of the individual coverage HRA and is:

(1) 10, for an employer with fewer than 100 employees;

(2) A number, rounded down to a whole number, equal to 10 percent of the total number of employees, for an employer with 100 to 200 employees; and

(3) 20, for an employer with more than 200 employees.

(B) *Determining employer size.* For purposes of this paragraph (d)(3), the number of employees of an employer is determined in advance of the plan year of the HRA based on the number of employees that the employer reasonably expects to employ on the first day of the plan year.

(iv) *Determining if a class satisfies the applicable class size minimum.* For purposes of this paragraph (d)(3), whether a class of employees satisfies the applicable class size minimum for a

plan year of the individual coverage HRA is based on the number of employees in the class offered the individual coverage HRA as of the first day of the plan year. Therefore, this determination is not based on the number of employees that actually enroll in the individual coverage HRA, and this determination is not affected by changes in the number of employees in the class during the plan year.

(4) *Consistency requirement.* For any plan year, a plan sponsor may define “full-time employee,” “part-time employee,” and “seasonal employee” in accordance with the relevant provisions of sections 105(h) or 4980H, as set forth in paragraphs (d)(2)(i), (ii), and (vi) of this section, if:

(i) To the extent applicable under the HRA for the plan year, each of the three classes of employees are defined in accordance with section 105(h) or each of the three classes of employees are defined in accordance with section 4980H for the plan year; and

(ii) The HRA plan document sets forth the applicable definitions prior to the beginning of the plan year to which the definitions will apply.

(5) *Special rule for new hires—(i) In general.* Notwithstanding paragraphs (c)(2) and (3) of this section, a plan sponsor that offers a traditional group health plan to a class of employees may prospectively offer the employees in that class of employees who are hired on or after a certain future date (the new hire date) an individual coverage HRA (with this group of employees referred to as the new hire subclass), while continuing to offer employees in that class of employees who are hired before the new hire date a traditional group health plan (with the rule set forth in this sentence referred to as the special rule for new hires). For the new hire subclass, the individual coverage HRA must be offered on the same terms to all participants within the subclass, in accordance with paragraph (c)(3) of this section. In accordance with paragraph (c)(2) of this section, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any employee in the new hire subclass or to any employee in the class who is not a member of the new hire subclass.

(ii) *New hire date.* A plan sponsor may set the new hire date for a class of employees prospectively as any date on or after January 1, 2020. A plan sponsor may set different new hire dates prospectively for separate classes of employees.

(iii) *Discontinuation of use of special rule for new hires and multiple applications of the special rule for new*

*hires.* A plan sponsor may discontinue use of the special rule for new hires at any time for any class of employees. In that case, the new hire subclass is no longer treated as a separate subclass of employees. In the event a plan sponsor applies the special rule for new hires to a class of employees and later discontinues use of the rule to the class of employees, the plan sponsor may later apply the rule if the application of the rule would be permitted under the rules for initial application of the special rule for new hires. If a plan sponsor, in accordance with the requirements for the special rule for new hires, applies the rule to a class of employees subsequent to any prior application and discontinuance of the rule to that class, the new hire date must be prospective.

(iv) *Application of the minimum class size requirement under the special rule for new hires.* The minimum class size requirement set forth in paragraph (d)(3) of this section does not apply to the new hire subclass. However, if a plan sponsor subdivides the new hire subclass subsequent to creating the new hire subclass, the minimum class size requirement set forth in paragraph (d)(3) of this section applies to any class of employees created by subdividing the new hire subclass, if the minimum class size requirement otherwise applies.

(6) *Student employees offered student premium reduction arrangements.* For purposes of this section, if an institution of higher education (as defined in the Higher Education Act of 1965) offers a student employee a student premium reduction arrangement, the employee is not considered to be part of the class of employees to which the employee would otherwise belong. For the purpose of this paragraph (d)(6) and paragraph (f)(1) of this section, a student premium reduction arrangement is defined as any program offered by an institution of higher education under which the cost of insured or self-insured student health coverage is reduced for certain students through a credit, offset, reimbursement, stipend or similar arrangement. A student employee offered a student premium reduction arrangement is also not counted for purposes of determining the applicable class size minimum under paragraph (d)(3)(iii) of this section. If a student employee is not offered a student premium reduction arrangement (including if the student employee is offered an individual coverage HRA instead), the student employee is considered to be part of the class of employees to which the employee otherwise belongs and is counted for purposes of determining the applicable

class size minimum under paragraph (d)(3)(iii) of this section.

(e) *Integration of Individual Coverage HRAs with Medicare—(1) General rule.* An individual coverage HRA will be considered to be integrated with Medicare (and deemed to comply with PHS Act sections 2711 and 2713 and § 54.9815–2711(d)(4) of this chapter), provided that the conditions of paragraph (c) of this section are satisfied, subject to paragraph (e)(2) of this section. Nothing in this section requires that a participant and his or her dependents all have the same type of coverage; therefore, an individual coverage HRA may be integrated with Medicare for some individuals and with individual health insurance coverage for others, including, for example, a participant enrolled in Medicare Part A and B or Part C and his or her dependents enrolled in individual health insurance coverage.

(2) *Application of conditions in paragraph (c) of this section—(i) In general.* Except as provided in paragraph (e)(2)(ii) of this section, in applying the conditions of paragraph (c) of this section with respect to integration with Medicare, a reference to “individual health insurance coverage” is deemed to refer to coverage under Medicare Part A and B or Part C. References in this section to integration of an HRA with Medicare refer to integration of an individual coverage HRA with Medicare Part A and B or Part C.

(ii) *Exceptions.* For purposes of the statement regarding ERISA under the notice content element under paragraph (c)(6)(ii)(A) of this section and the statement regarding the availability of a special enrollment period under the notice content element under paragraph (c)(6)(ii)(J) of this section, the term individual health insurance coverage means only individual health insurance coverage and does not also mean coverage under Medicare Part A and B or Part C.

(f) *Examples—(1) Examples regarding classes and the minimum class size requirement.* The following examples illustrate the provisions of paragraph (c)(3) of this section, taking into account the provisions of paragraphs (d)(1) through (4) and (d)(6) of this section. In each example, the HRA is an individual coverage HRA that may reimburse any medical care expenses, including premiums for individual health insurance coverage and it is assumed that no participants or dependents are Medicare beneficiaries.

(i) *Example 1: Collectively bargained employees offered traditional group health*

plan; non-collectively bargained employees offered HRA—(A) *Facts*. For 2020, Plan Sponsor A offers its employees covered by a collective bargaining agreement a traditional group health plan (as required by the collective bargaining agreement) and all other employees (non-collectively bargained employees) each an HRA on the same terms.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(i) (*Example 1*) because collectively bargained and non-collectively bargained employees may be treated as different classes of employees, one of which may be offered a traditional group health plan and the other of which may be offered an individual coverage HRA, and Plan Sponsor A offers the HRA on the same terms to all participants who are non-collectively bargained employees. The minimum class size requirement does not apply to this paragraph (f)(1)(i) (*Example 1*) even though Plan Sponsor A offers one class a traditional group health plan and one class the HRA because collectively bargained and non-collectively bargained employees are not applicable classes that are subject to the minimum class size requirement.

(ii) *Example 2: Collectively bargained employees in one unit offered traditional group health plan and in another unit offered HRA—(A) Facts*. For 2020, Plan Sponsor B offers its employees covered by a collective bargaining agreement with Local 100 a traditional group health plan (as required by the collective bargaining agreement), and its employees covered by a collective bargaining agreement with Local 200 each an HRA on the same terms (as required by the collective bargaining agreement).

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(ii) (*Example 2*) because the employees covered by the collective bargaining agreements with the two separate bargaining units (Local 100 and Local 200) may be treated as two different classes of employees and Plan Sponsor B offers an HRA on the same terms to the participants covered by the agreement with Local 200. The minimum class size requirement does not apply to this paragraph (f)(1)(ii) (*Example 2*) even though Plan Sponsor B offers the Local 100 employees a traditional group health plan and the Local 200 employees an HRA because collectively bargained employees are not applicable classes that are subject to the minimum class size requirement.

(iii) *Example 3: Employees in a waiting period offered no coverage; other employees offered an HRA—(A) Facts*. For 2020, Plan Sponsor C offers its employees who have completed a waiting period that complies with the requirements for waiting periods in § 54.9815–2708 of this chapter each an HRA on the same terms and does not offer coverage to its employees who have not completed the waiting period.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(iii) (*Example 3*) because employees who have completed a waiting period and employees who have not completed a waiting period may be treated as different classes and Plan

Sponsor C offers the HRA on the same terms to all participants who have completed the waiting period. The minimum class size requirement does not apply to this paragraph (f)(1)(iii) (*Example 3*) because Plan Sponsor C does not offer at least one class of employees a traditional group health plan and because the class of employees who have not completed a waiting period and the class of employees who have completed a waiting period are not applicable classes that are subject to the minimum class size requirement.

(iv) *Example 4: Employees in a waiting period offered an HRA; other employees offered a traditional group health plan—(A) Facts*. For 2020, Plan Sponsor D offers its employees who have completed a waiting period that complies with the requirements for waiting periods in § 54.9815–2708 of this chapter a traditional group health plan and offers its employees who have not completed the waiting period each an HRA on the same terms.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(iv) (*Example 4*) because employees who have completed a waiting period and employees who have not completed a waiting period may be treated as different classes and Plan Sponsor D offers an HRA on the same terms to all participants who have not completed the waiting period. The minimum class size requirement does not apply to this paragraph (f)(1)(iv) (*Example 4*) even though Plan Sponsor D offers employees who have completed a waiting period a traditional group health plan and employees who have not completed a waiting period an HRA because the class of employees who have not completed a waiting period is not an applicable class that is subject to the minimum class size requirement (nor is the class made up of employees who have completed the waiting period).

(v) *Example 5: Staffing firm employees temporarily placed with customers offered an HRA; other employees offered a traditional group health plan—(A) Facts*. Plan Sponsor E is a staffing firm that places certain of its employees on temporary assignments with customers that are not the common law employers of Plan Sponsor E's employees or treated as a single employer with Plan Sponsor E under section 414(b), (c), (m), or (o) (unrelated entities); other employees work in Plan Sponsor E's office managing the staffing business (non-temporary employees). For 2020, Plan Sponsor E offers its employees who are on temporary assignments with customers each an HRA on the same terms. All other employees are offered a traditional group health plan.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(v) (*Example 5*) because the employees who are hired for temporary placement at an unrelated entity and non-temporary employees of Plan Sponsor E may be treated as different classes of employees and Plan Sponsor E offers an HRA on the same terms to all participants temporarily placed with customers. The minimum class size requirement does not apply to this paragraph

(f)(1)(v) (*Example 5*) even though Plan Sponsor E offers one class a traditional group health plan and one class the HRA because the class of employees hired for temporary placement is not an applicable class that is subject to the minimum class size requirement (nor is the class made up of non-temporary employees).

(vi) *Example 6: Staffing firm employees temporarily placed with customers in rating area 1 offered an HRA; other employees offered a traditional group health plan—(A) Facts*. The facts are the same as in paragraph (f)(1)(v) of this section (*Example 5*), except that Plan Sponsor E has work sites in rating area 1 and rating area 2, and it offers its 10 employees on temporary assignments with a work site in rating area 1 an HRA on the same terms. Plan Sponsor E has 200 other employees in rating areas 1 and 2, including its non-temporary employees in rating areas 1 and 2 and its employees on temporary assignments with a work site in rating area 2, all of whom are offered a traditional group health plan.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(vi) (*Example 6*) because, even though the employees who are temporarily placed with customers generally may be treated as employees of a different class, because Plan Sponsor E is also using a rating area to identify the class offered the HRA (which is an applicable class for the minimum class size requirement) and is offering one class the HRA and another class the traditional group health plan, the minimum class size requirement applies to the class offered the HRA, and the class offered the HRA fails to satisfy the minimum class size requirement. Because Plan Sponsor E employs 210 employees, the applicable class size minimum is 20, and the HRA is offered to only 10 employees.

(vii) *Example 7: Employees in State 1 offered traditional group health plan; employees in State 2 offered HRA—(A) Facts*. Plan Sponsor F employs 45 employees whose work site is in State 1 and 7 employees whose primary site of employment is in State 2. For 2020, Plan Sponsor F offers its 45 employees in State 1 a traditional group health plan, and each of its 7 employees in State 2 an HRA on the same terms.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(vii) (*Example 7*) because Plan Sponsor F offers the HRA on the same terms to all employees with a work site in State 2 and that class is a permissible class under paragraph (d) of this section. This is because employees whose work sites are in different rating areas may be considered different classes and a plan sponsor may create a class of employees by combining classes of employees, including by combining employees whose work site is in one rating area with employees whose work site is in a different rating area, or by combining all employees whose work site is in a state. The minimum class size requirement does not apply to this paragraph (f)(1)(vii) (*Example 7*) because the minimum class size requirement does not apply if the geographic area defining a class

of employees is a state or a combination of two or more entire states.

(viii) *Example 8: Full-time seasonal employees offered HRA; all other full-time employees offered traditional group health plan; part-time employees offered no coverage—(A) Facts.* Plan Sponsor G employs 6 full-time seasonal employees, 75 full-time employees who are not seasonal employees, and 5 part-time employees. For 2020, Plan Sponsor G offers each of its 6 full-time seasonal employees an HRA on the same terms, its 75 full-time employees who are not seasonal employees a traditional group health plan, and offers no coverage to its 5 part-time employees.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(viii) (*Example 8*) because full-time seasonal employees and full-time employees who are not seasonal employees may be considered different classes and Plan Sponsor G offers the HRA on the same terms to all full-time seasonal employees. The minimum class size requirement does not apply to the class offered the HRA in this paragraph (f)(1)(viii) (*Example 8*) because part-time employees are not offered coverage and full-time employees are not an applicable class subject to the minimum class size requirement if part-time employees are not offered coverage.

(ix) *Example 9: Full-time employees in rating area 1 offered traditional group health plan; full-time employees in rating area 2 offered HRA; part-time employees offered no coverage—(A) Facts.* Plan Sponsor H employs 17 full-time employees and 10 part-time employees whose work site is in rating area 1 and 552 full-time employees whose work site is in rating area 2. For 2020, Plan Sponsor H offers its 17 full-time employees in rating area 1 a traditional group health plan and each of its 552 full-time employees in rating area 2 an HRA on the same terms. Plan Sponsor H offers no coverage to its 10 part-time employees in rating area 1. Plan Sponsor H reasonably expects to employ 569 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(ix) (*Example 9*) because employees whose work sites are in different rating areas may be considered different classes and Plan Sponsor H offers the HRA on the same terms to all full-time employees in rating area 2. The minimum class size requirement applies to the class offered the HRA in this paragraph (f)(1)(ix) (*Example 9*) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. However, the minimum class size requirement applies only to the class offered the HRA, and Plan Sponsor H offers the HRA to the 552 full-time employees in rating area 2 on the first day of the plan year, satisfying the minimum class size requirement (because the applicable class size minimum for Plan Sponsor H is 20).

(x) *Example 10: Employees in rating area 1 offered HRA; employees in rating area 2*

*offered traditional group health plan—(A) Facts.* The facts are the same as in paragraph (f)(1)(ix) of this section (*Example 9*) except that Plan Sponsor H offers its 17 full-time employees in rating area 1 the HRA and offers its 552 full-time employees in rating area 2 the traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(x) (*Example 10*) because, even though employees whose work sites are in different rating areas generally may be considered different classes and Plan Sponsor H offers the HRA on the same terms to all participants in rating area 1, the HRA fails to satisfy the minimum class size requirement. Specifically, the minimum class size requirement applies to this paragraph (f)(1)(x) (*Example 10*) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. Further, the applicable class size minimum for Plan Sponsor H is 20 employees, and the HRA is only offered to the 17 full-time employees in rating area 1 on the first day of the HRA plan year.

(xi) *Example 11: Employees in State 1 and rating area 1 of State 2 offered HRA; employees in all other rating areas of State 2 offered traditional group health plan—(A) Facts.* For 2020, Plan Sponsor I offers an HRA on the same terms to a total of 200 employees it employs with work sites in State 1 and in rating area 1 of State 2. Plan Sponsor I offers a traditional group health plan to its 150 employees with work sites in other rating areas in State 2. Plan Sponsor I reasonably expects to employ 350 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xi) (*Example 11*). Plan Sponsor I may treat all of the employees with a work site in State 1 and rating area 1 of State 2 as a class of employees because employees whose work sites are in different rating areas may be considered different classes and a plan sponsor may create a class of employees by combining classes of employees, including by combining employees whose work site is in one rating area with a class of employees whose work site is in a different rating area. The minimum class size requirement applies to the class of employees offered the HRA (made up of employees in State 1 and in rating area 1 of State 2) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. In this case, the class is made up of a state plus a rating area which is not the entire state. However, this class satisfies the minimum class size requirement because the applicable class size minimum for Plan Sponsor I is 20, and Plan Sponsor I offered the HRA to 200 employees on the first day of the plan year.

(xii) *Example 12: Salaried employees offered a traditional group health plan; hourly employees offered an HRA—(A) Facts.* Plan Sponsor J has 163 salaried employees and 14 hourly employees. For 2020, Plan Sponsor J offers its 163 salaried employees a

traditional group health plan and each of its 14 hourly employees an HRA on the same terms. Plan Sponsor J reasonably expects to employ 177 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xii) (*Example 12*) because, even though salaried and hourly employees generally may be considered different classes and Plan Sponsor J offers the HRA on the same terms to all hourly employees, the HRA fails to satisfy the minimum class size requirement. Specifically, the minimum class size requirement applies in this paragraph (f)(1)(xii) (*Example 12*) because employees who are paid on a salaried basis and employees who are not paid on a salaried basis are applicable classes subject to the minimum class size requirement. Because Plan Sponsor J reasonably expects to employ between 100 and 200 employees on the first day of the plan year, the applicable class size minimum is 10 percent, rounded down to a whole number. Ten percent of 177 total employees, rounded down to a whole number is 17, and the HRA is offered to only 14 hourly employees.

(xiii) *Example 13: Part-time employees and full-time employees offered different HRAs; no traditional group health plan offered—(A) Facts.* Plan Sponsor K has 50 full-time employees and 7 part-time employees. For 2020, Plan Sponsor K offers its 50 full-time employees \$2,000 each in an HRA otherwise provided on the same terms and each of its 7 part-time employees \$500 in an HRA otherwise provided on the same terms. Plan Sponsor K reasonably expects to employ 57 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xiii) (*Example 13*) because full-time employees and part-time employees may be treated as different classes and Plan Sponsor K offers an HRA on the same terms to all the participants in each class. The minimum class size requirement does not apply to either the full-time class or the part-time class because (although in certain circumstances the minimum class size requirement applies to a class of full-time employees and a class of part-time employees) Plan Sponsor K does not offer any class of employees a traditional group health plan, and the minimum class size requirement applies only when, among other things, at least one class of employees is offered a traditional group health plan while another class is offered an HRA.

(xiv) *Example 14: No employees offered an HRA—(A) Facts.* The facts are the same facts as in paragraph (f)(1)(xiii) of this section (*Example 13*), except that Plan Sponsor K offers its full-time employees a traditional group health plan and does not offer any group health plan (either a traditional group health plan or an HRA) to its part-time employees.

(B) *Conclusion.* The regulations set forth under this section do not apply to Plan Sponsor K because Plan Sponsor K does not offer an individual coverage HRA to any employee.

(xv) *Example 15: Full-time employees offered traditional group health plan; part-time employees offered HRA—(A) Facts.* The facts are the same as in paragraph (f)(1)(xiii) of this section (*Example 13*), except that Plan Sponsor K offers its full-time employees a traditional group health plan and offers each of its part-time employees \$500 in an HRA and otherwise on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xv) (*Example 15*) because, even though the full-time employees and the part-time employees generally may be treated as different classes, in this paragraph (f)(1)(xv) (*Example 15*), the minimum class size requirement applies to the part-time employees, and it is not satisfied. Specifically, the minimum class size requirement applies to the part-time employees because that requirement applies to an applicable class offered an HRA when one class is offered a traditional group health plan while another class is offered an HRA, and to the part-time and full-time employee classes when one of those classes is offered a traditional group health plan while the other is offered an HRA. Because Plan Sponsor K reasonably expects to employ fewer than 100 employees on the first day of the HRA plan year, the applicable class size minimum for Plan Sponsor K is 10 employees, but Plan Sponsor K offered the HRA only to its 7 part-time employees.

(xvi) *Example 16: Satisfying minimum class size requirement based on employees offered HRA—(A) Facts.* Plan Sponsor L employs 78 full-time employees and 12 part-time employees. For 2020, Plan Sponsor L offers its 78 full-time employees a traditional group health plan and each of its 12 part-time employees an HRA on the same terms. Only 6 part-time employees enroll in the HRA. Plan Sponsor L reasonably expects to employ fewer than 100 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xvi) (*Example 16*) because full-time employees and part-time employees may be treated as different classes, Plan Sponsor L offers an HRA on the same terms to all the participants in the part-time class, and the minimum class size requirement is satisfied. Specifically, whether a class of employees satisfies the applicable class size minimum is determined as of the first day of the plan year based on the number of employees in a class that is offered an HRA, not on the number of employees who enroll in the HRA. The applicable class size minimum for Plan Sponsor L is 10 employees, and Plan Sponsor L offered the HRA to its 12 part-time employees.

(xvii) *Example 17: Student employees offered student premium reduction arrangements and same terms requirement—(A) Facts.* Plan Sponsor M is an institution of higher education that offers each of its part-time employees an HRA on the same terms, except that it offers its part-time employees who are student employees a student premium reduction arrangement, and the student premium reduction arrangement

provides different amounts to different part-time student employees.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xvii) (*Example 17*) because Plan Sponsor M offers the HRA on the same terms to its part-time employees who are not students and because the part-time student employees offered a student premium reduction arrangement (and their varying HRAs) are not taken into account as part-time employees for purposes of determining whether a class of employees is offered an HRA on the same terms.

(xiii) *Example 18: Student employees offered student premium reduction arrangements and minimum class size requirement—(A) Facts.* Plan Sponsor N is an institution of higher education with 25 hourly employees. Plan Sponsor N offers 15 of its hourly employees, who are student employees, a student premium reduction arrangement and it wants to offer its other 10 hourly employees an HRA for 2022. Plan Sponsor N offers its salaried employees a traditional group health plan. Plan Sponsor N reasonably expects to have 250 employees on the first day of the 2022 HRA plan year, 15 of which will have offers of student premium reduction arrangements.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xviii) (*Example 18*). The minimum class size requirement will apply to the class of hourly employees to which Plan Sponsor N wants to offer the HRA because Plan Sponsor N offers a class of employees a traditional group health plan and another class the HRA, and the minimum class size requirement generally applies to a class of hourly employees offered an HRA. Plan Sponsor N's applicable class size minimum is 20 because Plan Sponsor N reasonably expects to employ 235 employees on the first day of the plan year (250 employees minus 15 employees receiving a student premium reduction arrangement). Plan Sponsor N may not offer the HRA to its hourly employees because the 10 employees offered the HRA as of the first day of the plan year does not satisfy the applicable class size minimum.

(2) *Examples regarding special rule for new hires.* The following examples illustrate the provisions of paragraph (c)(3) of this section, taking into account the provisions of paragraph (d) of this section, in particular the special rule for new hires under paragraph (d)(5) of this section. In each example, the HRA is an individual coverage HRA that has a calendar year plan year and may reimburse any medical care expenses, including premiums for individual health insurance coverage. The examples also assume that no participants or dependents are Medicare beneficiaries.

(i) *Example 1: Application of special rule for new hires to all employees—(A) Facts.* For 2021, Plan Sponsor A offers all employees a traditional group health plan. For 2022, Plan Sponsor A offers all employees hired on or

after January 1, 2022, an HRA on the same terms and continues to offer the traditional group health plan to employees hired before that date. On the first day of the 2022 plan year, Plan Sponsor A has 2 new hires who are offered the HRA.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(i) (*Example 1*) because, under the special rule for new hires in paragraph (d)(5) of this section, the employees newly hired on and after January 1, 2022, may be treated as a new hire subclass, Plan Sponsor A offers the HRA on the same terms to all participants in the new hire subclass, and the minimum class size requirement does not apply to the new hire subclass.

(ii) *Example 2: Application of special rule for new hires to full-time employees—(A) Facts.* For 2021, Plan Sponsor B offers a traditional group health plan to its full-time employees and does not offer any coverage to its part-time employees. For 2022, Plan Sponsor B offers full-time employees hired on or after January 1, 2022, an HRA on the same terms, continues to offer its full-time employees hired before that date a traditional group health plan, and continues to offer no coverage to its part-time employees. On the first day of the 2022 plan year, Plan Sponsor B has 2 new hire, full-time employees who are offered the HRA.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(ii) (*Example 2*) because, under the special rule for new hires in paragraph (d)(5) of this section, the full-time employees newly hired on and after January 1, 2022, may be treated as a new hire subclass and Plan Sponsor B offers the HRA on the same terms to all participants in the new hire subclass. The minimum class size requirement does not apply to the new hire subclass.

(iii) *Example 3: Special rule for new hires impermissibly applied retroactively—(A) Facts.* For 2025, Plan Sponsor C offers a traditional group health plan to its full-time employees. For 2026, Plan Sponsor C wants to offer an HRA to its full-time employees hired on and after January 1, 2023, while continuing to offer a traditional group health plan to its full-time employees hired before January 1, 2023.

(B) *Conclusion.* The special rule for new hires under paragraph (d)(5) of this section does not apply in this paragraph (f)(2)(iii) (*Example 3*) because the rule must be applied prospectively. That is, Plan Sponsor C may not, in 2026, choose to apply the special rule for new hires retroactive to 2023. If Plan Sponsor C were to offer an HRA in this way, it would fail to satisfy the conditions under paragraphs (c)(2) and (3) of this section because the new hire subclass would not be treated as a subclass for purposes of applying those rules and, therefore, all full-time employees would be treated as one class to which either a traditional group health plan or an HRA could be offered, but not both.

(iv) *Example 4: Permissible second application of the special rule for new hires to the same class of employees—(A) Facts.* For 2021, Plan Sponsor D offers all of its full-time employees a traditional group health

plan. For 2022, Plan Sponsor D applies the special rule for new hires and offers an HRA on the same terms to all employees hired on and after January 1, 2022, and continues to offer a traditional group health plan to full-time employees hired before that date. For 2025, Plan Sponsor D discontinues use of the special rule for new hires, and again offers all full-time employees a traditional group health plan. In 2030, Plan Sponsor D decides to apply the special rule for new hires to the full-time employee class again, offering an HRA to all full-time employees hired on and after January 1, 2030, on the same terms, while continuing to offer employees hired before that date a traditional group health plan.

(B) *Conclusion.* Plan Sponsor D has permissibly applied the special rule for new hires and is in compliance with the requirements of paragraphs (c)(2) and (3) of this section.

(v) *Example 5: Impermissible second application of the special rule for new hires to the same class of employees—(A) Facts.* The facts are the same as in paragraph (f)(2)(iv) of this section (*Example 4*), except that for 2025, Plan Sponsor D discontinues use of the special rule for new hires by offering all full-time employees an HRA on the same terms. Further, for 2030, Plan Sponsor D wants to continue to offer an HRA on the same terms to all full-time employees hired before January 1, 2030, and to offer all full-time employees hired on or after January 1, 2030, an HRA in a different amount.

(B) *Conclusion.* Plan Sponsor D may not apply the special rule for new hires for 2030 to the class of full-time employees being offered an HRA because the special rule for new hires may only be applied to a class that is being offered a traditional group health plan.

(vi) *Example 6: New full-time employees offered different HRAs in different rating areas—(A) Facts.* Plan Sponsor E has work sites in rating area 1, rating area 2, and rating area 3. For 2021, Plan Sponsor E offers its full-time employees a traditional group health plan. For 2022, Plan Sponsor E offers its full-time employees hired on or after January 1, 2022, in rating area 1 an HRA of \$3,000, its full-time employees hired on or after January 1, 2022, in rating area 2 an HRA of \$5,000, and its full-time employees hired on or after January 1, 2022, in rating area 3 an HRA of \$7,000. Within each class offered an HRA, Plan Sponsor E offers the HRA on the same terms. Plan Sponsor E offers its full-time employees hired prior to January 1, 2022, in each of those classes a traditional group health plan. On the first day of the 2022 plan year, there is one new hire, full-time employee in rating area 1, three new hire, full-time employees in rating area 2, and 10 new hire-full-time employees in rating area 3.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(vi) (*Example 6*) because, under the special rule for new hires in paragraph (d)(5) of this section, the full-time employees in each of the three rating areas newly hired on and after January 1, 2022, may be treated as three new hire subclasses and Plan Sponsor E

offers the HRA on the same terms to all participants in the new hire subclasses. Further, the minimum class size requirement does not apply to the new hire subclasses.

(vii) *Example 7: New full-time employee class subdivided based on rating area—(A) Facts.* Plan Sponsor F offers its full-time employees hired on or after January 1, 2022, an HRA on the same terms and it continues to offer its full-time employees hired before that date a traditional group health plan. Plan Sponsor F offers no coverage to its part-time employees. For the 2025 plan year, Plan Sponsor F wants to subdivide the full-time new hire subclass so that those whose work site is in rating area 1 will be offered the traditional group health plan and those whose work site is in rating area 2 will continue to receive the HRA. Plan Sponsor F reasonably expects to employ 219 employees on January 1, 2025. As of January 1, 2025, Plan Sponsor F has 15 full-time employees whose work site is in rating area 2 and who were hired between January 1, 2022, and January 1, 2025.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(2)(vii) (*Example 7*) because the new hire subclass has been subdivided in a manner that is subject to the minimum class size requirement, and the class offered the HRA fails to satisfy the minimum class size requirement. Specifically, once the new hire subclass is subdivided the general rules for applying the minimum class size requirement apply to the employees offered the HRA in the new hire subclass. In this case, because the subdivision of the new hire full-time subclass is based on rating areas; a class based on rating areas is an applicable class subject to the minimum class size requirement; and the employees in one rating area are to be offered the HRA, while the employees in the other rating area are offered the traditional group health plan, the minimum class size requirement would apply on and after the date of the subdivision. Further, the minimum class size requirement would not be satisfied, because the applicable class size minimum for Plan Sponsor F would be 20, and only 15 employees in rating area 2 would be offered the HRA.

(viii) *Example 8: New full-time employee class subdivided based on state—(A) Facts.* The facts are the same as in paragraph (f)(2)(vii) of this section (*Example 7*), except that for the 2025 plan year, Plan Sponsor F intends to subdivide the new hire, full-time class so that those in State 1 will be offered the traditional group health plan and those in State 2 will each be offered an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(viii) (*Example 8*) because even though the new hire subclass has been subdivided, it has been subdivided in a manner that is not subject to the minimum class size requirement as the subdivision is based on the entire state.

(ix) *Example 9: New full-time employees and part-time employees offered HRA—(A) Facts.* In 2021, Plan Sponsor G offers its full-

time employees a traditional group health plan and does not offer coverage to its part-time employees. For the 2022 plan year, Plan Sponsor G offers its full-time employees hired on or after January 1, 2022, and all of its part-time employees, including those hired before January 1, 2022, and those hired on and after January 1, 2022, an HRA on the same terms, and it continues to offer its full-time employees hired before January 1, 2022, a traditional group health plan.

(B) *Conclusion.* The minimum class size requirement applies to the part-time employees offered the HRA in 2022 because the class is being offered an HRA; the special rule for new hires does not apply (because this class was not previously offered a traditional group health plan) and so it is not a new hire subclass exempt from the minimum class size requirement; another class of employees (that is, full-time hired before January 1, 2022) are being offered a traditional group health plan; and the part-time employee class is generally an applicable classes that is subject to the minimum class size requirement. However, because the full-time, new hire subclass is based on the special rule for new hires, the minimum class size requirement does not apply to full-time new hires offered an HRA in 2022.

(g) *Applicability date.* This section applies to plan years beginning on or after January 1, 2020.

■ **Par. 7.** Section 54.9815–2711 is amended by revising paragraphs (c), (d), and (e) to read as follows:

**§ 54.9815–2711 No lifetime or annual limits.**

\* \* \* \* \*

(c) *Definition of essential health benefits.* The term “essential health benefits” means essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. For the purpose of this section, a group health plan or a health insurance issuer that is not required to provide essential health benefits under section 1302(b) must define “essential health benefits” in a manner that is consistent with the following:

(1) For plan years beginning before January 1, 2020, one of the EHB-benchmark plans applicable in a State under 45 CFR 156.110, and including coverage of any additional required benefits that are considered essential health benefits consistent with 45 CFR 155.170(a)(2), or one of the three Federal Employees Health Benefits Program (FEHBP) plan options as defined by 45 CFR 156.100(a)(3), supplemented as necessary, to satisfy the standards in 45 CFR 156.110; or

(2) For plan years beginning on or after January 1, 2020, an EHB-benchmark plan selected by a State in accordance with the available options and requirements for EHB-benchmark

plan selection at 45 CFR 156.111, including an EHB-benchmark plan in a State that takes no action to change its EHB-benchmark plan and thus retains the EHB-benchmark plan applicable in that State for the prior year in accordance with 45 CFR 156.111(d)(1), and including coverage of any additional required benefits that are considered essential health benefits consistent with 45 CFR 155.170(a)(2).

(d) *Health reimbursement arrangements (HRAs) and other account-based group health plans*—(1) *In general.* If an HRA or other account-based group health plan is integrated with another group health plan or individual health insurance coverage and the other group health plan or individual health insurance coverage, as applicable, separately is subject to and satisfies the requirements in PHS Act section 2711 and paragraph (a)(2) of this section, the fact that the benefits under the HRA or other account-based group health plan are limited does not cause the HRA or other account-based group health plan to fail to satisfy the requirements of PHS Act section 2711 and paragraph (a)(2) of this section. Similarly, if an HRA or other account-based group health plan is integrated with another group health plan or individual health insurance coverage and the other group health plan or individual health insurance coverage, as applicable, separately is subject to and satisfies the requirements in PHS Act section 2713 and § 54.9815–2713(a)(1) of this chapter, the fact that the benefits under the HRA or other account-based group health plan are limited does not cause the HRA or other account-based group health plan to fail to satisfy the requirements of PHS Act section 2713 and § 54.9815–2713(a)(1) of this chapter. For the purpose of this paragraph (d), all individual health insurance coverage, except for coverage that consists solely of excepted benefits, is treated as being subject to and complying with PHS Act sections 2711 and 2713.

(2) *Requirements for an HRA or other account-based group health plan to be integrated with another group health plan.* An HRA or other account-based group health plan is integrated with another group health plan for purposes of PHS Act section 2711 and paragraph (a)(2) of this section if it satisfies the requirements under one of the integration methods set forth in paragraph (d)(2)(i) or (ii) of this section. For purposes of the integration methods under which an HRA or other account-based group health plan is integrated with another group health plan, integration does not require that the HRA or other account-based group

health plan and the other group health plan with which it is integrated share the same plan sponsor, the same plan document or governing instruments, or file a single Form 5500, if applicable. An HRA or other account-based group health plan integrated with another group health plan for purposes of PHS Act section 2711 and paragraph (a)(2) of this section may not be used to purchase individual health insurance coverage unless that coverage consists solely of excepted benefits, as defined in 45 CFR 148.220.

(i) *Method for integration with a group health plan: Minimum value not required.* An HRA or other account-based group health plan is integrated with another group health plan for purposes of this paragraph (d) if:

(A) The plan sponsor offers a group health plan (other than the HRA or other account-based group health plan) to the employee that does not consist solely of excepted benefits;

(B) The employee receiving the HRA or other account-based group health plan is actually enrolled in a group health plan (other than the HRA or other account-based group health plan) that does not consist solely of excepted benefits, regardless of whether the plan is offered by the same plan sponsor (referred to as non-HRA group coverage);

(C) The HRA or other account-based group health plan is available only to employees who are enrolled in non-HRA group coverage, regardless of whether the non-HRA group coverage is offered by the plan sponsor of the HRA or other account-based group health plan (for example, the HRA may be offered only to employees who do not enroll in an employer's group health plan but are enrolled in other non-HRA group coverage, such as a group health plan maintained by the employer of the employee's spouse);

(D) The benefits under the HRA or other account-based group health plan are limited to reimbursement of one or more of the following—co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care expenses that do not constitute essential health benefits as defined in paragraph (c) of this section; and

(E) Under the terms of the HRA or other account-based group health plan, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan at least annually and, upon termination of employment, either the remaining amounts in the HRA or other account-based group health plan are

forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan (see paragraph (d)(3) of this section for additional rules regarding forfeiture and waiver).

(ii) *Method for integration with another group health plan: Minimum value required.* An HRA or other account-based group health plan is integrated with another group health plan for purposes of this paragraph (d) if:

(A) The plan sponsor offers a group health plan (other than the HRA or other account-based group health plan) to the employee that provides minimum value pursuant to section 36B(c)(2)(C)(ii) (and its implementing regulations and applicable guidance);

(B) The employee receiving the HRA or other account-based group health plan is actually enrolled in a group health plan (other than the HRA or other account-based group health plan) that provides minimum value pursuant to section 36B(c)(2)(C)(ii) (and applicable guidance), regardless of whether the plan is offered by the plan sponsor of the HRA or other account-based group health plan (referred to as non-HRA MV group coverage);

(C) The HRA or other account-based group health plan is available only to employees who are actually enrolled in non-HRA MV group coverage, regardless of whether the non-HRA MV group coverage is offered by the plan sponsor of the HRA or other account-based group health plan (for example, the HRA may be offered only to employees who do not enroll in an employer's group health plan but are enrolled in other non-HRA MV group coverage, such as a group health plan maintained by an employer of the employee's spouse); and

(D) Under the terms of the HRA or other account-based group health plan, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan at least annually, and, upon termination of employment, either the remaining amounts in the HRA or other account-based group health plan are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan (see paragraph (d)(3) of this section for additional rules regarding forfeiture and waiver).

(3) *Forfeiture.* For purposes of integration under paragraphs (d)(2)(i)(E) and (d)(2)(ii)(D) of this section, forfeiture or waiver occurs even if the

forfeited or waived amounts may be reinstated upon a fixed date, a participant's death, or the earlier of the two events (the reinstatement event). For the purpose of this paragraph (d)(3), coverage under an HRA or other account-based group health plan is considered forfeited or waived prior to a reinstatement event only if the participant's election to forfeit or waive is irrevocable, meaning that, beginning on the effective date of the election and through the date of the reinstatement event, the participant and the participant's beneficiaries have no access to amounts credited to the HRA or other account-based group health plan. This means that upon and after reinstatement, the reinstated amounts under the HRA or other account-based group health plan may not be used to reimburse or pay medical care expenses incurred during the period after forfeiture and prior to reinstatement.

(4) *Requirements for an HRA or other account-based group health plan to be integrated with individual health insurance coverage or Medicare Part A and B or Medicare Part C.* An HRA or other account-based group health plan is integrated with individual health insurance coverage or Medicare Part A and B or Medicare Part C (and treated as complying with PHS Act sections 2711 and 2713) if the HRA or other account-based group health plan satisfies the requirements of § 54.9802-4(c) of this chapter (as modified by § 54.9802-4(e), for HRAs or other account-based group health plans integrated with Medicare Part A and B or Medicare Part C).

(5) *Integration with Medicare Part B and D.* For employers that are not required to offer their non-HRA group health plan coverage to employees who are Medicare beneficiaries, an HRA or other account-based group health plan that may be used to reimburse premiums under Medicare Part B or D may be integrated with Medicare (and deemed to comply with PHS Act sections 2711 and 2713) if the following requirements are satisfied with respect to employees who would be eligible for the employer's non-HRA group health plan but for their eligibility for Medicare (and the integration rules under paragraphs (d)(2)(i) and (ii) of this section continue to apply to employees who are not eligible for Medicare):

(i) The plan sponsor offers a group health plan (other than the HRA or other account-based group health plan and that does not consist solely of excepted benefits) to employees who are not eligible for Medicare;

(ii) The employee receiving the HRA or other account-based group health

plan is actually enrolled in Medicare Part B or D;

(iii) The HRA or other account-based group health plan is available only to employees who are enrolled in Medicare Part B or D; and

(iv) The HRA or other account-based group health plan complies with paragraphs (d)(2)(i)(E) and (d)(2)(ii)(D) of this section.

(6) *Definitions.* The following definitions apply for purposes of this section.

(i) *Account-based group health plan.* An account-based group health plan is 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. An HRA is a type of account-based group health plan. An account-based group health plan does not include a qualified small employer health reimbursement arrangement, as defined in section 9831(d)(2).

(ii) *Medical care expenses.* Medical care expenses means expenses for medical care as defined under section 213(d).

(e) *Applicability date.* The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning on or after January 1, 2020. Until the applicability date for this section, plans and issuers are required to continue to comply with the corresponding sections of 26 CFR part 54, contained in the 26 CFR, subchapter D, revised as of April 1, 2018.

■ **Par. 8.** Section 54.9831-1 is amended by revising paragraph (c)(3)(i) and adding paragraph (c)(3)(viii) to read as follows:

**§ 54.9831-1 Special rules relating to group health plans.**

\* \* \* \* \*

(c) \* \* \*

(3) \* \* \*

(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement (health FSA) are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section; benefits provided under an employee assistance program are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vi) of this section; benefits provided under limited

wraparound coverage are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vii) of this section; and benefits provided under a health reimbursement arrangement or other account-based group health plan, other than a health FSA, are excepted benefits if they satisfy the requirements of paragraph (c)(3)(viii) of this section.

\* \* \* \* \*

(viii) *Health reimbursement arrangements (HRAs) and other account-based group health plans.* Benefits provided under an HRA or other account-based group health plan, other than a health FSA, are excepted if they satisfy all of the requirements of this paragraph (c)(3)(viii). See paragraph (c)(3)(v) of this section for the circumstances in which benefits provided under a health FSA are excepted benefits. For purposes of this paragraph (c)(3)(viii), the term "HRA or other account-based group health plan" has the same meaning as "account-based group health plan" set forth in § 54.9815-2711(d)(6)(i) of this part, except that the term does not include health FSAs. For ease of reference, an HRA or other account-based group health plan that satisfies the requirements of this paragraph (c)(3)(viii) is referred to as an excepted benefit HRA.

(A) *Otherwise not an integral part of the plan.* 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 must be made available by the same plan sponsor for the plan year to the participant.

(B) *Benefits are limited in amount—*  
(1) *Limit on annual amounts made available.* The amounts newly made available for each plan year under the HRA or other account-based group health plan do not exceed \$1,800. In the case of any plan year beginning after December 31, 2020, the dollar amount in the preceding sentence shall be increased by an amount equal to such dollar amount multiplied by the cost-of-living adjustment. The cost of living adjustment is the percentage (if any) by which the C-CPI-U for the preceding calendar year exceeds the C-CPI-U for calendar year 2019. The term "C-CPI-U" means the Chained Consumer Price Index for All Urban Consumers as published by the Bureau of Labor Statistics of the Department of Labor. The C-CPI-U for any calendar year is the average of the C-CPI-U as of the close of the 12-month period ending on March 31 of such calendar year. The values of the C-CPI-U used for any calendar year shall be the latest values

so published as of the date on which the Bureau publishes the initial value of the C–CPI–U for the month of March for the preceding calendar year. Any such increase that is not a multiple of \$50 shall be rounded down to the next lowest multiple of \$50. The Department of the Treasury and the Internal Revenue Service will publish the adjusted amount for plan years beginning in any calendar year no later than June 1 of the preceding calendar year.

(2) *Carryover amounts.* If the terms of the HRA or other account-based group health plan allow unused amounts to be made available to participants and dependents in later plan years, such carryover amounts are disregarded for purposes of determining whether benefits are limited in amount.

(3) *Multiple HRAs or other account-based group health plans.* 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 to determine whether the benefits are limited in amount, except that HRAs or other account-based group health plans that reimburse only excepted benefits are not included in determining whether the benefits are limited in amount.

(C) *Prohibition on reimbursement of certain health insurance premiums.* The HRA or other account-based group health plan must not reimburse premiums for individual health insurance coverage, group health plan coverage (other than COBRA continuation coverage or other continuation coverage), or Medicare Part A, B, C, or D, except that the HRA or other account-based group health plan may reimburse premiums for such coverage that consists solely of excepted benefits. See also, paragraph (c)(3)(viii)(F) of this section.

(D) *Uniform availability.* The HRA or other account-based group health plan is made available under the same terms to all similarly situated individuals, as defined in § 54.9802–1(d) of this part, regardless of any health factor (as described in § 54.9802–1(a)).

(E) *Notice requirement.* See 29 CFR 2520.102–3(j)(2) and (3) and 29 CFR 2520.104b–2(a) for rules regarding the time, manner, and content for summary plan descriptions (including a description of conditions pertaining to eligibility to receive benefits; annual or lifetime caps or other limits on benefits under the plan; and a description or summary of the benefits) applicable to plans subject to Title I of the Employee

Retirement Income Security Act of 1974, as amended.

(F) *Special rule.* The HRA or other account-based group health plan must not reimburse premiums for short-term, limited-duration insurance (as defined in § 54.9801–2 of this part) if the conditions of this paragraph (c)(3)(viii)(F) are satisfied.

(1) The HRA or other account-based group health plan is offered by a small employer (as defined in PHS Act section 2791(e)(4)).

(2) The other group health plan coverage offered by the employer pursuant to paragraph (c)(3)(viii)(A) of this section is either fully-insured or partially-insured.

(3) The Secretary of Health and Human Services (HHS) makes a finding, in consultation with the Secretaries of Labor and the Treasury, that the reimbursement of premiums for short-term, limited-duration insurance by excepted benefit HRAs has caused significant harm to the small group market in the state that is the principal place of business of the small employer.

(4) The finding by the Secretary of HHS is made after submission of a written recommendation by the applicable state authority of such state, in a form and manner specified by HHS. The written recommendation must include evidence that the reimbursement of premiums for short-term, limited-duration insurance by excepted benefit HRAs established by insured or partially-insured small employers in the state has caused significant harm to the state's small group market, including with respect to premiums.

(5) The restriction shall be imposed or discontinued by publication by the Secretary of HHS of a notice in the **Federal Register** and shall apply only prospectively and with a reasonable time for plan sponsors to comply.

\* \* \* \* \*

## DEPARTMENT OF LABOR

### Employee Benefits Security Administration

#### 29 CFR Chapter XXV

For the reasons stated in the preamble, the Department of Labor amends 29 CFR parts 2510 and 2590 as set forth below:

#### **PART 2510—DEFINITION OF TERMS USED IN SUBCHAPTERS C, D, E, F, G, AND L OF THIS CHAPTER**

■ 9. The authority citation for part 2510 is revised to read as follows:

**Authority:** 29 U.S.C. 1002(1), 1002(3), 1002(2), 1002(5), 1002(16), 1002(21),

1002(37), 1002(38), 1002(40), 1002(42), 1031, and 1135; Secretary of Labor's Order No. 1–2011, 77 FR 1088 (Jan. 9, 2012); Secs. 2510.3–21, 2510.3–101 and 2510.3–102 also issued under sec. 102 of Reorganization Plan No. 4 of 1978, 5 U.S.C. App. at 237 (2012), E.O. 12108, 44 FR 1065 (Jan. 3, 1979) and 29 U.S.C. 1135 note. Sec. 2510.3–38 is also issued under sec. 1, Pub. L. 105–72, 111 Stat. 1457 (1997).

■ 10. Section 2510.3–1 is amended by adding paragraph (l) to read as follows:

#### **§ 2510.3–1 Employee welfare benefit plan.**

\* \* \* \* \*

(l) *Safe harbor for health reimbursement arrangements (HRAs) and certain other arrangements that reimburse individual health insurance coverage.* For purposes of title I of the Act and this chapter, the terms “employee welfare benefit plan” and “welfare plan” shall not include individual health insurance coverage the premiums of which are reimbursed by a health reimbursement arrangement (HRA) (or other account-based group health plan), including an HRA or other account-based group health plan integrated with individual health insurance coverage (as described in § 2590.702–2 of this chapter), an HRA that covers fewer than two current employees (as described in § 2590.732(b) of this chapter) and that reimburses premiums for individual health insurance coverage, a qualified small employer health reimbursement arrangement (QSEHRA), as defined in section 9831(d)(2) of the Code, or an arrangement under which an employer allows employees to pay the portion of the premium for individual health insurance coverage that is not covered by an HRA or other account-based group health plan with which the coverage is integrated by using a salary reduction arrangement in a cafeteria plan under section 125 of the Code (supplemental salary reduction arrangement), if all the conditions of this paragraph (l) are satisfied.

(1) The purchase of any individual health insurance coverage is completely voluntary for participants and beneficiaries. The fact that a plan sponsor requires such coverage to be purchased as a condition for participation in an HRA or supplemental salary reduction arrangement does not make the purchase involuntary.

(2) The employer, employee organization, or other plan sponsor does not select or endorse any particular issuer or insurance coverage. In contrast, providing general contact information regarding availability of health insurance in a state (such as

providing information regarding [www.HealthCare.gov](http://www.HealthCare.gov) or contact information for a state insurance commissioner's office) or providing general health insurance educational information (such as the uniform glossary of health coverage and medical terms available at: <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf>) is permitted.

(3) Reimbursement for non-group health insurance premiums is limited solely to individual health insurance coverage (as defined in § 2590.701–2 of this chapter) that does not consist solely of excepted benefits (as defined in § 2590.732(c) of this chapter).

(4) The employer, employee organization, or other plan sponsor receives no consideration in the form of cash or otherwise in connection with the employee's selection or renewal of any individual health insurance coverage.

(5) Each plan participant is notified annually that the individual health insurance coverage is not subject to title I of ERISA. For an HRA that is integrated with individual health insurance coverage, the notice must satisfy the notice requirement set forth in § 2590.702–2(c)(6) of this chapter. A QSEHRA or an HRA not subject to the notice requirement set forth in § 2590.702–2(c)(6) of this chapter may use the following language to satisfy this condition: “The individual health insurance coverage that is paid for by this plan, if any, is not subject to the rules and consumer protections of the Employee Retirement Income Security Act. You should contact your state insurance department for more information regarding your rights and responsibilities if you purchase individual health insurance coverage.” A supplemental salary reduction arrangement is not required to provide this notice as the notice will be provided by the HRA that such an arrangement supplements.

## PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS.

■ 11. The authority citation for part 2590 continues to read as follows:

**Authority:** 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L. 104–191, 110 Stat. 1936; sec. 401(b), Pub. L. 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111–148, 124 Stat. 119, as

amended by Pub. L. 111–152, 124 Stat. 1029; Division M, Pub. L. 113–235, 128 Stat. 2130; Secretary of Labor's Order 1–2011, 77 FR 1088 (Jan. 9, 2012).

■ 12. Section 2590.701–2 is amended by revising the definition of “group health insurance coverage” to read as follows:

### § 2590.701–2 Definitions.

\* \* \* \* \*

*Group health insurance coverage* means health insurance coverage offered in connection with a group health plan. Individual health insurance coverage reimbursed by the arrangements described in 29 CFR 2510.3–1(l) is not offered in connection with a group health plan, and is not group health insurance coverage, provided all the conditions in 29 CFR 2510.3–1(l) are satisfied.

\* \* \* \* \*

■ 13. Section 2590.702–2 is added to read as follows:

### § 2590.702–2 Special Rule Allowing Integration of Health Reimbursement Arrangements (HRAs) and Other Account-Based Group Health Plans with Individual Health Insurance Coverage and Medicare and Prohibiting Discrimination in HRAs and Other Account-Based Group Health Plans.

(a) *Scope.* This section applies to health reimbursement arrangements (HRAs) and other account-based group health plans, as defined in § 2590.715–2711(d)(6)(i) of this part. For ease of reference, the term “HRA” is used in this section to include other account-based group health plans. For related regulations, see 26 CFR 1.36B–2(c)(3)(i) and (c)(5), 29 CFR 2510.3–1(l), and 45 CFR 155.420.

(b) *Purpose.* This section provides the conditions that an HRA must satisfy in order to be integrated with individual health insurance coverage for purposes of Public Health Service Act (PHS Act) sections 2711 and 2713 and § 2590.715–2711(d)(4) of this part (referred to as an individual coverage HRA). This section also allows an individual coverage HRA to be integrated with Medicare for purposes of PHS Act sections 2711 and 2713 and § 2590.715–2711(d)(4), subject to the conditions provided in this section (see paragraph (e) of this section). Some of the conditions set forth in this section specifically relate to compliance with PHS Act sections 2711 and 2713 and some relate to the effect of having or being offered an individual coverage HRA on eligibility for the premium tax credit under section 36B of the Code. In addition, this section provides conditions that an individual coverage HRA must satisfy in order to comply with the nondiscrimination provisions in ERISA section 702 and

PHS Act section 2705 (which is incorporated in ERISA section 715) and that are consistent with the provisions of the Patient Protection and Affordable Care Act, Public Law 111–148 (124 Stat. 119 (2010)), and the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (124 Stat. 1029 (2010)), each as amended, that are designed to create a competitive individual market. These conditions are intended to prevent an HRA plan sponsor from intentionally or unintentionally, directly or indirectly, steering any participants or dependents with adverse health factors away from its traditional group health plan, if any, and toward individual health insurance coverage.

(c) *General rule.* An HRA will be considered to be integrated with individual health insurance coverage for purposes of PHS Act sections 2711 and 2713 and § 2590.715–2711(d)(4) of this part and will not be considered to discriminate in violation of ERISA section 702 and PHS Act section 2705 solely because it is integrated with individual health insurance coverage, provided that the conditions of this paragraph (c) are satisfied. See paragraph (e) of this section for how these conditions apply to an individual coverage HRA integrated with Medicare. For purposes of this section, medical care expenses means medical care expenses as defined in § 2590.715–2711(d)(6)(ii) of this part and Exchange means Exchange as defined in 45 CFR 155.20.

(1) *Enrollment in individual health insurance coverage—(i) In general.* The HRA must require that the participant and any dependent(s) are enrolled in individual health insurance coverage that is subject to and complies with the requirements in PHS Act sections 2711 (and § 2590.715–2711(a)(2) of this part) and PHS Act section 2713 (and § 2590.715–2713(a)(1) of this part), for each month that the individual(s) are covered by the HRA. For purposes of this paragraph (c), all individual health insurance coverage, except for individual health insurance coverage that consists solely of excepted benefits, is treated as being subject to and complying with PHS Act sections 2711 and 2713. References to individual health insurance coverage in this paragraph (c) do not include individual health insurance coverage that consists solely of excepted benefits.

(ii) *Forfeiture.* The HRA must provide that if any individual covered by the HRA ceases to be covered by individual health insurance coverage, the HRA will not reimburse medical care expenses that are incurred by that individual after

the individual health insurance coverage ceases. In addition, if the participant and all dependents covered by the participant's HRA cease to be covered by individual health insurance coverage, the participant must forfeit the HRA. In either case, the HRA must reimburse medical care expenses incurred by the individual prior to the cessation of individual health insurance coverage to the extent the medical care expenses are otherwise covered by the HRA, but the HRA may limit the period to submit medical care expenses for reimbursement to a reasonable specified time period. If a participant or dependent loses coverage under the HRA for a reason other than cessation of individual health insurance coverage, COBRA and other continuation coverage requirements may apply.

(iii) *Grace periods and retroactive termination of individual health insurance coverage.* In the event an individual is initially enrolled in individual health insurance coverage and subsequently timely fails to pay premiums for the coverage, with the result that the individual is in a grace period, the individual is considered to be enrolled in individual health insurance coverage for purposes of this paragraph (c)(1) and the individual coverage HRA must reimburse medical care expenses incurred by the individual during that time period to the extent the medical care expenses are otherwise covered by the HRA. If the individual fails to pay the applicable premium(s) by the end of the grace period and the coverage is cancelled or terminated, including retroactively, or if the individual health insurance coverage is cancelled or terminated retroactively for some other reason (for example, a rescission), an individual coverage HRA must require that a participant notify the HRA that coverage has been cancelled or terminated and the date on which the cancellation or termination is effective. After the individual coverage HRA has received the notice of cancellation or termination, the HRA may not reimburse medical care expenses incurred on and after the date the individual health insurance coverage was cancelled or terminated, which is considered to be the date of termination of coverage under the HRA.

(2) *No traditional group health plan may be offered to same participants.* To the extent a plan sponsor offers any class of employees (as defined in paragraph (d) of this section) an individual coverage HRA, the plan sponsor may not also offer a traditional group health plan to the same class of employees, except as provided in

paragraph (d)(5) of this section. For purposes of this section, a traditional group health plan is any group health plan other than either an account-based group health plan or a group health plan that consists solely of excepted benefits. Therefore, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any participant or dependent.

(3) *Same terms requirement—(i) In general.* If a plan sponsor offers an individual coverage HRA to a class of employees described in paragraph (d) of this section, the HRA must be offered on the same terms to all participants within the class, except as provided in paragraphs (c)(3)(ii) through (vi) and (d)(5) of this section.

(ii) *Carryover amounts, salary reduction arrangements, and transfer amounts.* Amounts that are not used to reimburse medical care expenses for any plan year that are made available to participants in later plan years are disregarded for purposes of determining whether an HRA is offered on the same terms, provided that the method for determining whether participants have access to unused amounts in future years, and the methodology and formula for determining the amounts of unused funds which they may access in future years, is the same for all participants in a class of employees. In addition, the ability to pay the portion of the premium for individual health insurance coverage that is not covered by the HRA, if any, by using a salary reduction arrangement under section 125 of the Code is considered to be a term of the HRA for purposes of this paragraph (c)(3). Therefore, an HRA is not provided on the same terms unless the salary reduction arrangement, if made available to any participant in a class of employees, is made available on the same terms to all participants (other than former employees, as defined in paragraph (c)(3)(iv) of this section) in the class of employees. Further, to the extent that a participant in an individual coverage HRA was previously covered by another HRA and the current individual coverage HRA makes available amounts that were not used to reimburse medical care expenses under the prior HRA (transferred amounts), the transferred amounts are disregarded for purposes of determining whether the HRA is offered on the same terms, provided that if the HRA makes available transferred amounts, it does so on the same terms for all participants in the class of employees.

(iii) *Permitted variation.* An HRA does not fail to be provided on the same terms solely because the maximum

dollar amount made available to participants in a class of employees to reimburse medical care expenses for any plan year increases in accordance with paragraph (c)(3)(iii)(A) or (B) of this section.

(A) *Variation due to number of dependents.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available to those participants to reimburse medical care expenses for any plan year increases as the number of the participant's dependents who are covered under the HRA increases, so long as the same maximum dollar amount attributable to the increase in family size is made available to all participants in that class of employees with the same number of dependents covered by the HRA.

(B) *Variation due to age.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available under the terms of the HRA to those participants to reimburse medical care expenses for any plan year increases as the age of the participant increases, so long as the requirements in paragraphs (c)(3)(iii)(B)(1) and (2) of this section are satisfied. For the purpose of this paragraph (c)(3)(iii)(B), the plan sponsor may determine the age of the participant using any reasonable method for a plan year, so long as the plan sponsor determines each participant's age for the purpose of this paragraph (c)(3)(iii)(B) using the same method for all participants in the class of employees for the plan year and the method is determined prior to the plan year.

(1) The same maximum dollar amount attributable to the increase in age is made available to all participants who are the same age.

(2) The maximum dollar amount made available to the oldest participant(s) is not more than three times the maximum dollar amount made available to the youngest participant(s).

(iv) *Former employees.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers the HRA to some, but not all, former employees within a class of employees. However, if a plan sponsor offers the HRA to one or more former employees within a class of employees, the HRA must be offered to the former employee(s) on the same terms as to all other employees within the class, except as provided in paragraph (c)(3)(ii) of this section. For purposes of this section, a former employee is an employee who is

no longer performing services for the employer.

(v) *New employees or new dependents.* For a participant whose coverage under the HRA becomes effective later than the first day of the plan year, the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees whose coverage became effective as of the first day of the plan year, or is pro-rated consistent with the portion of the plan year in which the participant is covered by the HRA. Similarly, if the HRA provides for variation in the maximum amount made available to participants in a class of employees based on the number of a participant's dependents covered by the HRA, and the number of a participant's dependents covered by the HRA changes during a plan year (either increasing or decreasing), the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees who had the same number of dependents covered by the HRA on the first day of the plan year or is pro-rated for the remainder of the plan year after the change in the number of the participant's dependents covered by the HRA consistent with the portion of the plan year in which that number of dependents are covered by the HRA. The method the HRA uses to determine amounts made available for participants whose coverage under the HRA is effective later than the first day of the plan year or who have changes in the number of dependents covered by the HRA during a plan year must be the same for all participants in the class of employees and the method must be determined prior to the beginning of the plan year.

(vi) *HSA-compatible HRAs.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers participants in a class of employees a choice between an HSA-compatible individual coverage HRA and an individual coverage HRA that is not HSA compatible, provided both types of HRAs are offered to all participants in the class of employees on the same terms. For the purpose of this paragraph (c)(3)(vi), an HSA-compatible individual coverage HRA is an individual coverage HRA that is limited in accordance with applicable

guidance under section 223 of the Code such that an individual covered by such an HRA is not disqualified from being an eligible individual under section 223 of the Code.

(vii) *Examples.* The following examples illustrate the provisions of this paragraph (c)(3), without taking into account the provisions of paragraph (d) of this section. In each example, the HRA is an individual coverage HRA that has a calendar year plan year and may reimburse any medical care expenses, including premiums for individual health insurance coverage (except as provided in paragraph (c)(3)(vii)(E) of this section (*Example 5*)). Further, in each example, assume the HRA is offered on the same terms, except as otherwise specified in the example and that no participants or dependents are Medicare beneficiaries.

(A) *Example 1: Carryover amounts permitted—(1) Facts.* For 2020 and again for 2021, Plan Sponsor A offers all employees \$7,000 each in an HRA, and the HRA provides that amounts that are unused at the end of a plan year may be carried over to the next plan year, with no restrictions on the use of the carryover amounts compared to the use of newly available amounts. At the end of 2020, some employees have used all of the funds in their HRAs, while other employees have balances remaining that range from \$500 to \$1,750 that are carried over to 2021 for those employees.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(A) (*Example 1*) for 2020 because Plan Sponsor A offers all employees the same amount, \$7,000, in an HRA for that year. The same terms requirement is also satisfied for 2021 because Plan Sponsor A again offers all employees the same amount for that year, and the carryover amounts that some employees have are disregarded in applying the same terms requirement because the amount of the carryover for each employee (that employee's balance) and each employee's access to the carryover amounts is based on the same terms.

(B) *Example 2: Employees hired after the first day of the plan year—(1)*

*Facts.* For 2020, Plan Sponsor B offers all employees employed on January 1, 2020, \$7,000 each in an HRA for the plan year. Employees hired after January 1, 2020, are eligible to enroll in the HRA with an effective date of the first day of the month following their date of hire, as long as they have enrolled in individual health insurance coverage effective on or before that date, and the amount offered to these employees is pro-rated based on the number of months remaining in the plan year, including the month which includes their coverage effective date.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(B) (*Example 2*) for 2020 because Plan Sponsor B offers all employees employed on the first

day of the plan year the same amount, \$7,000, in an HRA for that plan year and all employees hired after January 1, 2020, a pro-rata amount based on the portion of the plan year during which they are enrolled in the HRA.

(C) *Example 3: HRA amounts offered vary based on number of dependents—(1) Facts.* For 2020, Plan Sponsor C offers its employees the following amounts in an HRA: \$1,500, if the employee is the only individual covered by the HRA; \$3,500, if the employee and one dependent are covered by the HRA; and \$5,000, if the employee and more than one dependent are covered by the HRA.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(C) (*Example 3*) because paragraph (c)(3)(iii)(A) of this section allows the maximum dollar amount made available in an HRA to increase as the number of the participant's dependents covered by the HRA increases and Plan Sponsor C makes the same amount available to each employee with the same number of dependents covered by the HRA.

(D) *Example 4: HRA amounts offered vary based on increases in employees' ages—(1) Facts.* For 2020, Plan Sponsor D offers its employees the following amounts in an HRA: \$1,000 each for employees age 25 to 35; \$2,000 each for employees age 36 to 45; \$2,500 each for employees age 46 to 55; and \$4,000 each for employees over age 55.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is not satisfied in this paragraph (c)(3)(vii)(D) (*Example 4*) because the terms of the HRA provide the oldest participants (those over age 55) with more than three times the amount made available to the youngest participants (those ages 25 to 35), in violation of paragraph (c)(3)(iii)(B)(2) of this section.

(E) *Example 5: Application of same terms requirement to premium only HRA—(1) Facts.* For 2020, Plan Sponsor E offers its employees an HRA that reimburses only premiums for individual health insurance coverage, up to \$10,000 for the year. Employee A enrolls in individual health insurance coverage with a \$5,000 premium for the year and is reimbursed \$5,000 from the HRA. Employee B enrolls in individual health insurance coverage with an \$8,000 premium for the year and is reimbursed \$8,000 from the HRA.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(E) (*Example 5*) because Plan Sponsor E offers the HRA on the same terms to all employees, notwithstanding that some employees receive a greater amount of reimbursement than others based on the cost of the individual health insurance coverage selected by the employee.

(4) *Opt out.* Under the terms of the HRA, a participant who is otherwise eligible for coverage must be permitted to opt out of and waive future reimbursements on behalf of the participant and all dependents eligible for the HRA from the HRA once, and only once, with respect to each plan year. The HRA may establish

timeframes for enrollment in (and opting out of) the HRA but, in general, the opportunity to opt out must be provided in advance of the first day of the plan year. For participants who become eligible to participate in the HRA on a date other than the first day of the plan year (or who become eligible fewer than 90 days prior to the plan year or for whom the notice under paragraph (c)(6) of this section is required to be provided as set forth in paragraph (c)(6)(i)(C) of this section), or for a dependent who newly becomes eligible during the plan year, this opportunity must be provided during the applicable HRA enrollment period(s) established by the HRA for these individuals. Further, under the terms of the HRA, upon termination of employment, for a participant who is covered by the HRA, either the remaining amounts in the HRA must be forfeited or the participant must be permitted to permanently opt out of and waive future reimbursements from the HRA on behalf of the participant and all dependents covered by the HRA.

(5) *Reasonable procedures for coverage substantiation*—(i) *Substantiation of individual health insurance coverage for the plan year.* The HRA must implement, and comply with, reasonable procedures to substantiate that participants and each dependent covered by the HRA are, or will be, enrolled in individual health insurance coverage for the plan year (or for the portion of the plan year the individual is covered by the HRA, if applicable). The HRA may establish the date by which this substantiation must be provided, but, in general, the date may be no later than the first day of the plan year. However, for a participant who is not eligible to participate in the HRA on the first day of the plan year (or who becomes eligible fewer than 90 days prior to the plan year or for whom the notice under paragraph (c)(6) of this section is required to be provided as set forth in paragraph (c)(6)(i)(C) of this section), the HRA may establish the date by which this substantiation must be provided, but that date may be no later than the date the HRA coverage begins. Similarly, for a participant who adds a new dependent during the plan year, the HRA may establish the date by which this substantiation must be provided, but the date may be no later than the date the HRA coverage for the new dependent begins; however, to the extent the dependent's coverage under the HRA is effective retroactively, the HRA may establish a reasonable time by which this substantiation is required, but must require it be provided before

the HRA will reimburse any medical care expense for the newly added dependent. The reasonable procedures an HRA may use to implement the substantiation requirement set forth in this paragraph (c)(5)(i) may include a requirement that a participant substantiate enrollment by providing either:

(A) A document from a third party (for example, the issuer or an Exchange) showing that the participant and any dependents covered by the HRA are, or will be, enrolled in individual health insurance coverage (for example, an insurance card or an explanation of benefits document pertaining to the relevant time period or documentation from the Exchange showing that the individual has completed the application and plan selection); or

(B) An attestation by the participant stating that the participant and dependent(s) covered by the HRA are, or will be, enrolled in individual health insurance coverage, the date coverage began or will begin, and the name of the provider of the coverage.

(ii) *Coverage substantiation with each request for reimbursement of medical care expenses.* Following the initial substantiation of coverage, with each new request for reimbursement of an incurred medical care expense for the same plan year, the HRA may not reimburse a participant for any medical care expenses unless, prior to each reimbursement, the participant substantiates that the individual on whose behalf medical care expenses are requested to be reimbursed continues to be enrolled in individual health insurance coverage for the month during which the medical care expenses were incurred. The HRA must implement, and comply with, reasonable procedures to satisfy this requirement. This substantiation may be in the form of a written attestation by the participant, which may be part of the form used to request reimbursement, or a document from a third party (for example, a health insurance issuer) showing that the participant or the dependent, if applicable, are or were enrolled in individual health insurance coverage for the applicable month.

(iii) *Reliance on substantiation.* For purposes of this paragraph (c)(5), an HRA may rely on the participant's documentation or attestation unless the HRA, its plan sponsor, or any other entity acting in an official capacity on behalf of the HRA has actual knowledge that any individual covered by the HRA is not, or will not be, enrolled in individual health insurance coverage for the plan year (or applicable portion of

the plan year) or the month, as applicable.

(6) *Notice requirement*—(i) *Timing.* The HRA must provide a written notice to each participant:

(A) At least 90 calendar days before the beginning of each plan year for any participant who is not described in either paragraph (c)(6)(i)(B) or (C) of this section;

(B) No later than the date on which the HRA may first take effect for the participant, for any participant who is not eligible to participate at the beginning of the plan year (or is not eligible to participate at the time the notice is provided at least 90 calendar days before the beginning of the plan year pursuant to paragraph (c)(6)(i)(A) of this section); or

(C) No later than the date on which the HRA may first take effect for the participant, for any participant who is employed by an employer that is first established less than 120 days before the beginning of the first plan year of the HRA; this paragraph (c)(6)(i)(C) applies only with respect to the first plan year of the HRA.

(ii) *Content.* The notice must include all the information described in this paragraph (c)(6)(ii) (and may include any additional information that does not conflict with that information). To the extent that the Departments of the Treasury, Labor and Health and Human Services provide model notice language for certain elements of this required notice, HRAs are permitted, but not required, to use the model language.

(A) A description of the terms of the HRA, including the maximum dollar amount available for each participant (including the self-only HRA amount available for the plan year (or the maximum dollar amount available for the plan year if the HRA provides for reimbursements up to a single dollar amount regardless of whether a participant has self-only or other than self-only coverage)), any rules regarding the proration of the maximum dollar amount applicable to any participant (or dependent, if applicable) who is not eligible to participate in the HRA for the entire plan year, whether (and which of) the participant's dependents are eligible for the HRA, a statement that there are different kinds of HRAs (including a qualified small employer health reimbursement arrangement) and the HRA being offered is an individual coverage HRA, a statement that the HRA requires the participant and any covered dependents to be enrolled in individual health insurance coverage (or Medicare Part A and B or Medicare Part C, if applicable), a statement that the coverage in which the participant and

any covered dependents must be enrolled cannot be short-term, limited-duration insurance or consist solely of excepted benefits, a statement that individual health insurance coverage in which the participant and any covered dependents are enrolled is not subject to the Employee Retirement Income Security Act if the conditions under § 2510.3–1(l) of this chapter are satisfied, the date as of which coverage under the HRA may first become effective (both for participants whose coverage will become effective on the first day of the plan year and for participants whose HRA coverage may become effective at a later date), the dates on which the HRA plan year begins and ends, and the dates on which the amounts newly made available under the HRA will be made available.

(B) A statement of the right of the participant to opt out of and waive future reimbursements from the HRA, as set forth under paragraph (c)(4) of this section.

(C) A description of the potential availability of the premium tax credit if the participant opts out of and waives future reimbursements from the HRA and the HRA is not affordable for one or more months under 26 CFR 1.36B–2(c)(5), a statement that even if the participant opts out of and waives future reimbursements from an HRA, the offer will prohibit the participant (and, potentially, the participant's dependents) from receiving a premium tax credit for the participant's coverage (or the dependent's coverage, if applicable) on an Exchange for any month that the HRA is affordable under 26 CFR 1.36B–2(c)(5), a statement describing how the participant may find assistance with determining affordability, a statement that, if the participant is a former employee, the offer of the HRA does not render the participant (or the participant's dependents, if applicable) ineligible for the premium tax credit regardless of whether it is affordable under 26 CFR 1.36B–2(c)(5), and a statement that if the participant or dependent is enrolled in Medicare, he or she is ineligible for the premium tax credit without regard to the offer or acceptance of the HRA;

(D) A statement that if the participant accepts the HRA, the participant may not claim a premium tax credit for the participant's Exchange coverage for any month the HRA may be used to reimburse medical care expenses of the participant, and a premium tax credit may not be claimed for the Exchange coverage of the participant's dependents for any month the HRA may be used to reimburse medical care expenses of the dependents.

(E) A statement that the participant must inform any Exchange to which the participant applies for advance payments of the premium tax credit of the availability of the HRA; the self-only HRA amount available for the HRA plan year (or the maximum dollar amount available for the plan year if the HRA provides for reimbursements up to a single dollar amount regardless of whether a participant has self-only or other than self-only coverage) as set forth in the written notice in accordance with paragraph (c)(6)(ii)(A) of this section; whether the HRA is also available to the participant's dependents and if so, which ones; the date as of which coverage under the HRA may first become effective; the date on which the plan year begins and the date on which it ends; and whether the participant is a current employee or former employee.

(F) A statement that the participant should retain the written notice because it may be needed to determine whether the participant is allowed a premium tax credit on the participant's individual income tax return.

(G) A statement that the HRA may not reimburse any medical care expense unless the substantiation requirement set forth in paragraph (c)(5)(ii) of this section is satisfied and a statement that the participant must also provide the substantiation required by paragraph (c)(5)(i) of this section.

(H) A statement that if the individual health insurance coverage (or coverage under Medicare Part A and B or Medicare Part C) of a participant or dependent ceases, the HRA will not reimburse any medical care expenses that are incurred by the participant or dependent, as applicable, after the coverage ceases, and a statement that the participant must inform the HRA if the participant's or dependent's individual health insurance coverage (or coverage under Medicare Part A and B or Medicare Part C) is cancelled or terminated retroactively and the date on which the cancellation or termination is effective.

(I) The contact information (including a phone number) for an individual or a group of individuals who participants may contact in order to receive additional information regarding the HRA. The plan sponsor may determine which individual or group of individuals is best suited to be the specified contact.

(J) A statement of availability of a special enrollment period to enroll in or change individual health insurance coverage, through or outside of an Exchange, for the participant and any dependents who newly gain access to

the HRA and are not already covered by the HRA.

(d) *Classes of employees*—(1) *In general.* This paragraph (d) sets forth the rules for determining classes of employees. Paragraph (d)(2) of this section sets forth the specific classes of employees; paragraph (d)(3) of this section sets forth a minimum class size requirement that applies in certain circumstances; paragraph (d)(4) of this section sets forth rules regarding the definition of “full-time employees,” “part-time employees,” and “seasonal employees”; paragraph (d)(5) of this section sets forth a special rule for new hires; and paragraph (d)(6) of this section addresses student premium reduction arrangements. For purposes of this section, including determining classes under this paragraph (d), the employer is the common law employer and is determined without regard to the rules under sections 414(b), (c), (m), and (o) of the Code that would treat the common law employer as a single employer with certain other entities.

(2) *List of classes.* Participants may be treated as belonging to a class of employees based on whether they are, or are not, included in the classes described in this paragraph (d)(2). If the individual coverage HRA is offered to former employees, former employees are considered to be in the same class in which they were included immediately before separation from service. Before each plan year, a plan sponsor must determine for the plan year which classes of employees it intends to treat separately and the definition of the relevant class(es) it will apply, to the extent these regulations permit a choice. After the classes and the definitions of the classes are established for a plan year, a plan sponsor may not make changes to the classes of employees or the definitions of those relevant classes with respect to that plan year.

(i) Full-time employees, defined at the election of the plan sponsor to mean either full-time employees under section 4980H of the Code (and 26 CFR 54.4980H–1(a)(21)) or employees who are not part-time employees (as described in 26 CFR 1.105–11(c)(2)(iii)(C));

(ii) Part-time employees, defined at the election of the plan sponsor to mean either employees who are not full-time employees under section 4980H of the Code (and under 26 CFR 54.4980H–1(a)(21) (which defines full-time employee)) or employees who are part-time employees as described in 26 CFR 1.105–11(c)(2)(iii)(C);

(iii) Employees who are paid on a salary basis;

(iv) Non-salaried employees (such as, for example, hourly employees);

(v) Employees whose primary site of employment is in the same rating area as defined in 45 CFR 147.102(b);

(vi) Seasonal employees, defined at the election of the plan sponsor to mean seasonal employees as described in either 26 CFR 54.4980H-1(a)(38) or 26 CFR 1.105-11(c)(2)(iii)(C);

(vii) Employees included in a unit of employees covered by a particular collective bargaining agreement (or an appropriate related participation agreement) in which the plan sponsor participates (as described in 26 CFR 1.105-11(c)(2)(iii)(D));

(viii) Employees who have not satisfied a waiting period for coverage (if the waiting period complies with § 2590.715-2708 of this part);

(ix) Non-resident aliens with no U.S.-based income (as described in 26 CFR 1.105-11(c)(2)(iii)(E));

(x) Employees who, under all the facts and circumstances, are employees of an entity that hired the employees for temporary placement at an entity that is not the common law employer of the employees and that is not treated as a single employer with the entity that hired the employees for temporary placement under section 414(b), (c), (m), or (o) of the Code; or

(xi) A group of participants described as a combination of two or more of the classes of employees set forth in paragraphs (d)(2)(i) through (x) of this section.

(3) *Minimum class size requirement—*

(i) *In general.* If a class of employees is subject to the minimum class size requirement as set forth in this paragraph (d)(3), the class must consist of at least a minimum number of employees (as described in paragraphs (d)(3)(iii) and (iv) of this section), otherwise, the plan sponsor may not treat that class as a separate class of employees. Paragraph (d)(3)(ii) of this section sets forth the circumstances in which the minimum class size requirement applies to a class of employees, paragraph (d)(3)(iii) of this section sets forth the rules for determining the applicable class size minimum, and paragraph (d)(3)(iv) of this section sets forth the rules for a plan sponsor to determine if it satisfies the minimum class size requirement with respect to a class of employees.

(ii) *Circumstances in which minimum class size requirement applies—*(A) The minimum class size requirement applies only if a plan sponsor offers a traditional group health plan to one or more classes of employees and offers an individual coverage HRA to one or more other classes of employees.

(B) The minimum class size requirement does not apply to a class of employees offered a traditional group health plan or a class of employees offered no coverage.

(C) The minimum class size requirement applies to a class of employees offered an individual coverage HRA if the class is full-time employees, part-time employees, salaried employees, non-salaried employees, or employees whose primary site of employment is in the same rating area (described in paragraph (d)(2)(i), (ii), (iii), (iv), or (v) of this section, respectively, and referred to collectively as the applicable classes or individually as an applicable class), except that:

(1) In the case of the class of employees whose primary site of employment is in the same rating area (as described in paragraph (d)(2)(v) of this section), the minimum class size requirement does not apply if the geographic area defining the class is a State or a combination of two or more entire States; and

(2) In the case of the classes of employees that are full-time employees and part-time employees (as described in paragraphs (d)(2)(i) and (ii) of this section, respectively), the minimum class size requirement applies only to those classes (and the classes are only applicable classes) if the employees in one such class are offered a traditional group health plan while the employees in the other such class are offered an individual coverage HRA. In such a case, the minimum class size requirement applies only to the class offered an individual coverage HRA.

(D) A class of employees offered an individual coverage HRA is also subject to the minimum class size requirement if the class is a class of employees created by combining at least one of the applicable classes (as defined in paragraph (d)(3)(ii)(C) of this section) with any other class, except that the minimum class size requirement shall not apply to a class that is the result of a combination of one of the applicable classes and a class of employees who have not satisfied a waiting period (as described in paragraph (d)(2)(viii) of this section).

(iii) *Determination of the applicable class size minimum—*(A) *In general.* The minimum number of employees that must be in a class of employees that is subject to the minimum class size requirement (the applicable class size minimum) is determined prior to the beginning of the plan year for each plan year of the individual coverage HRA and is:

(1) 10, for an employer with fewer than 100 employees;

(2) A number, rounded down to a whole number, equal to 10 percent of the total number of employees, for an employer with 100 to 200 employees; and

(3) 20, for an employer with more than 200 employees.

(B) *Determining employer size.* For purposes of this paragraph (d)(3), the number of employees of an employer is determined in advance of the plan year of the HRA based on the number of employees that the employer reasonably expects to employ on the first day of the plan year.

(iv) *Determining if a class satisfies the applicable class size minimum.* For purposes of this paragraph (d)(3), whether a class of employees satisfies the applicable class size minimum for a plan year of the individual coverage HRA is based on the number of employees in the class offered the individual coverage HRA as of the first day of the plan year. Therefore, this determination is not based on the number of employees that actually enroll in the individual coverage HRA, and this determination is not affected by changes in the number of employees in the class during the plan year.

(4) *Consistency requirement.* For any plan year, a plan sponsor may define “full-time employee,” “part-time employee,” and “seasonal employee” in accordance with the relevant provisions of sections 105(h) or 4980H of the Code, as set forth in paragraphs (d)(2)(i), (ii), and (vi) of this section, if:

(i) To the extent applicable under the HRA for the plan year, each of the three classes of employees are defined in accordance with section 105(h) of the Code or each of the three classes of employees are defined in accordance with section 4980H of the Code for the plan year; and

(ii) The HRA plan document sets forth the applicable definitions prior to the beginning of the plan year to which the definitions will apply.

(5) *Special rule for new hires—*(i) *In general.* Notwithstanding paragraphs (c)(2) and (3) of this section, a plan sponsor that offers a traditional group health plan to a class of employees may prospectively offer the employees in that class of employees who are hired on or after a certain future date (the new hire date) an individual coverage HRA (with this group of employees referred to as the new hire subclass), while continuing to offer employees in that class of employees who are hired before the new hire date a traditional group health plan (with the rule set forth in this sentence referred to as the special

rule for new hires). For the new hire subclass, the individual coverage HRA must be offered on the same terms to all participants within the subclass, in accordance with paragraph (c)(3) of this section. In accordance with paragraph (c)(2) of this section, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any employee in the new hire subclass or to any employee in the class who is not a member of the new hire subclass.

(ii) *New hire date.* A plan sponsor may set the new hire date for a class of employees prospectively as any date on or after January 1, 2020. A plan sponsor may set different new hire dates prospectively for separate classes of employees.

(iii) *Discontinuation of use of special rule for new hires and multiple applications of the special rule for new hires.* A plan sponsor may discontinue use of the special rule for new hires at any time for any class of employees. In that case, the new hire subclass is no longer treated as a separate subclass of employees. In the event a plan sponsor applies the special rule for new hires to a class of employees and later discontinues use of the rule to the class of employees, the plan sponsor may later apply the rule if the application of the rule would be permitted under the rules for initial application of the special rule for new hires. If a plan sponsor, in accordance with the requirements for the special rule for new hires, applies the rule to a class of employees subsequent to any prior application and discontinuance of the rule to that class, the new hire date must be prospective.

(iv) *Application of the minimum class size requirement under the special rule for new hires.* The minimum class size requirement set forth in paragraph (d)(3) of this section does not apply to the new hire subclass. However, if a plan sponsor subdivides the new hire subclass subsequent to creating the new hire subclass, the minimum class size requirement set forth in paragraph (d)(3) of this section applies to any class of employees created by subdividing the new hire subclass, if the minimum class size requirement otherwise applies.

(6) *Student employees offered student premium reduction arrangements.* For purposes of this section, if an institution of higher education (as defined in the Higher Education Act of 1965) offers a student employee a student premium reduction arrangement, the employee is not considered to be part of the class of employees to which the employee would otherwise belong. For the purpose of this paragraph (d)(6) and

paragraph (f)(1) of this section, a student premium reduction arrangement is defined as any program offered by an institution of higher education under which the cost of insured or self-insured student health coverage is reduced for certain students through a credit, offset, reimbursement, stipend or similar arrangement. A student employee offered a student premium reduction arrangement is also not counted for purposes of determining the applicable class size minimum under paragraph (d)(3)(iii) of this section. If a student employee is not offered a student premium reduction arrangement (including if the student employee is offered an individual coverage HRA instead), the student employee is considered to be part of the class of employees to which the employee otherwise belongs and is counted for purposes of determining the applicable class size minimum under paragraph (d)(3)(iii) of this section.

(e) *Integration of Individual Coverage HRAs with Medicare—(1) General rule.* An individual coverage HRA will be considered to be integrated with Medicare (and deemed to comply with PHS Act sections 2711 and 2713 and § 2590.715–2711(d)(4) of this part), provided that the conditions of paragraph (c) of this section are satisfied, subject to paragraph (e)(2) of this section. Nothing in this section requires that a participant and his or her dependents all have the same type of coverage; therefore, an individual coverage HRA may be integrated with Medicare for some individuals and with individual health insurance coverage for others, including, for example, a participant enrolled in Medicare Part A and B or Part C and his or her dependents enrolled in individual health insurance coverage.

(2) *Application of conditions in paragraph (c) of this section—(i) In general.* Except as provided in paragraph (e)(2)(ii) of this section, in applying the conditions of paragraph (c) of this section with respect to integration with Medicare, a reference to “individual health insurance coverage” is deemed to refer to coverage under Medicare Part A and B or Part C. References in this section to integration of an HRA with Medicare refer to integration of an individual coverage HRA with Medicare Part A and B or Part C.

(ii) *Exceptions.* For purposes of the statement regarding ERISA under the notice content element under paragraph (c)(6)(ii)(A) of this section and the statement regarding the availability of a special enrollment period under the notice content element under paragraph

(c)(6)(ii)(I) of this section, the term individual health insurance coverage means only individual health insurance coverage and does not also mean coverage under Medicare Part A and B or Part C.

(f) *Examples—(1) Examples regarding classes and the minimum class size requirement.* The following examples illustrate the provisions of paragraph (c)(3) of this section, taking into account the provisions of paragraphs (d)(1) through (4) and (d)(6) of this section. In each example, the HRA is an individual coverage HRA that may reimburse any medical care expenses, including premiums for individual health insurance coverage and it is assumed that no participants or dependents are Medicare beneficiaries.

(i) *Example 1: Collectively bargained employees offered traditional group health plan; non-collectively bargained employees offered HRA—(A) Facts.* For 2020, Plan Sponsor A offers its employees covered by a collective bargaining agreement a traditional group health plan (as required by the collective bargaining agreement) and all other employees (non-collectively bargained employees) each an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(i) (*Example 1*) because collectively bargained and non-collectively bargained employees may be treated as different classes of employees, one of which may be offered a traditional group health plan and the other of which may be offered an individual coverage HRA, and Plan Sponsor A offers the HRA on the same terms to all participants who are non-collectively bargained employees. The minimum class size requirement does not apply to this paragraph (f)(1)(i) (*Example 1*) even though Plan Sponsor A offers one class a traditional group health plan and one class the HRA because collectively bargained and non-collectively bargained employees are not applicable classes that are subject to the minimum class size requirement.

(ii) *Example 2: Collectively bargained employees in one unit offered traditional group health plan and in another unit offered HRA—(A)*

*Facts.* For 2020, Plan Sponsor B offers its employees covered by a collective bargaining agreement with Local 100 a traditional group health plan (as required by the collective bargaining agreement), and its employees covered by a collective bargaining agreement with Local 200 each an HRA on the same terms (as required by the collective bargaining agreement).

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(ii) (*Example 2*) because the employees covered by the collective bargaining agreements with the two separate bargaining units (Local 100 and Local 200) may be treated as two different classes of employees and Plan Sponsor B offers an HRA on the same terms to the participants covered by the agreement with Local 200. The minimum class size

requirement does not apply to this paragraph (f)(1)(ii) (*Example 2*) even though Plan Sponsor B offers the Local 100 employees a traditional group health plan and the Local 200 employees an HRA because collectively bargained employees are not applicable classes that are subject to the minimum class size requirement.

(iii) *Example 3: Employees in a waiting period offered no coverage; other employees offered an HRA—(A) Facts.* For 2020, Plan Sponsor C offers its employees who have completed a waiting period that complies with the requirements for waiting periods in § 2590.715–2708 of this part each an HRA on the same terms and does not offer coverage to its employees who have not completed the waiting period.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(iii) (*Example 3*) because employees who have completed a waiting period and employees who have not completed a waiting period may be treated as different classes and Plan Sponsor C offers the HRA on the same terms to all participants who have completed the waiting period. The minimum class size requirement does not apply to this paragraph (f)(1)(iii) (*Example 3*) because Plan Sponsor C does not offer at least one class of employees a traditional group health plan and because the class of employees who have not completed a waiting period and the class of employees who have completed a waiting period are not applicable classes that are subject to the minimum class size requirement.

(iv) *Example 4: Employees in a waiting period offered an HRA; other employees offered a traditional group health plan—(A) Facts.* For 2020, Plan Sponsor D offers its employees who have completed a waiting period that complies with the requirements for waiting periods in § 2590.715–2708 of this part a traditional group health plan and offers its employees who have not completed the waiting period each an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(iv) (*Example 4*) because employees who have completed a waiting period and employees who have not completed a waiting period may be treated as different classes and Plan Sponsor D offers an HRA on the same terms to all participants who have not completed the waiting period. The minimum class size requirement does not apply to this paragraph (f)(1)(iv) (*Example 4*) even though Plan Sponsor D offers employees who have completed a waiting period a traditional group health plan and employees who have not completed a waiting period an HRA because the class of employees who have not completed a waiting period is not an applicable class that is subject to the minimum class size requirement (nor is the class made up of employees who have completed the waiting period).

(v) *Example 5: Staffing firm employees temporarily placed with customers offered an HRA; other employees offered a traditional group health plan—(A) Facts.* Plan Sponsor E is a staffing firm that places certain of its

employees on temporary assignments with customers that are not the common law employers of Plan Sponsor E's employees or treated as a single employer with Plan Sponsor E under section 414(b), (c), (m), or (o) of the Code (unrelated entities); other employees work in Plan Sponsor E's office managing the staffing business (non-temporary employees). For 2020, Plan Sponsor E offers its employees who are on temporary assignments with customers each an HRA on the same terms. All other employees are offered a traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(v) (*Example 5*) because the employees who are hired for temporary placement at an unrelated entity and non-temporary employees of Plan Sponsor E may be treated as different classes of employees and Plan Sponsor E offers an HRA on the same terms to all participants temporarily placed with customers. The minimum class size requirement does not apply to this paragraph (f)(1)(v) (*Example 5*) even though Plan Sponsor E offers one class a traditional group health plan and one class the HRA because the class of employees hired for temporary placement is not an applicable class that is subject to the minimum class size requirement (nor is the class made up of non-temporary employees).

(vi) *Example 6: Staffing firm employees temporarily placed with customers in rating area 1 offered an HRA; other employees offered a traditional group health plan—(A) Facts.* The facts are the same as in paragraph (f)(1)(v) of this section (*Example 5*), except that Plan Sponsor E has work sites in rating area 1 and rating area 2, and it offers its 10 employees on temporary assignments with a work site in rating area 1 an HRA on the same terms. Plan Sponsor E has 200 other employees in rating areas 1 and 2, including its non-temporary employees in rating areas 1 and 2 and its employees on temporary assignments with a work site in rating area 2, all of whom are offered a traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(vi) (*Example 6*) because, even though the employees who are temporarily placed with customers generally may be treated as employees of a different class, because Plan Sponsor E is also using a rating area to identify the class offered the HRA (which is an applicable class for the minimum class size requirement) and is offering one class the HRA and another class the traditional group health plan, the minimum class size requirement applies to the class offered the HRA, and the class offered the HRA fails to satisfy the minimum class size requirement. Because Plan Sponsor E employs 210 employees, the applicable class size minimum is 20, and the HRA is offered to only 10 employees.

(vii) *Example 7: Employees in State 1 offered traditional group health plan; employees in State 2 offered HRA—(A) Facts.* Plan Sponsor F employs 45 employees whose work site is in State 1 and 7 employees

whose primary site of employment is in State 2. For 2020, Plan Sponsor F offers its 45 employees in State 1 a traditional group health plan, and each of its 7 employees in State 2 an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(vii) (*Example 7*) because Plan Sponsor F offers the HRA on the same terms to all employees with a work site in State 2 and that class is a permissible class under paragraph (d) of this section. This is because employees whose work sites are in different rating areas may be considered different classes and a plan sponsor may create a class of employees by combining classes of employees, including by combining employees whose work site is in one rating area with employees whose work site is in a different rating area, or by combining all employees whose work site is in a state. The minimum class size requirement does not apply to this paragraph (f)(1)(vii) (*Example 7*) because the minimum class size requirement does not apply if the geographic area defining a class of employees is a state or a combination of two or more entire states.

(viii) *Example 8: Full-time seasonal employees offered HRA; all other full-time employees offered traditional group health plan; part-time employees offered no coverage—(A) Facts.* Plan Sponsor G employs 6 full-time seasonal employees, 75 full-time employees who are not seasonal employees, and 5 part-time employees. For 2020, Plan Sponsor G offers each of its 6 full-time seasonal employees an HRA on the same terms, its 75 full-time employees who are not seasonal employees a traditional group health plan, and offers no coverage to its 5 part-time employees.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(viii) (*Example 8*) because full-time seasonal employees and full-time employees who are not seasonal employees may be considered different classes and Plan Sponsor G offers the HRA on the same terms to all full-time seasonal employees. The minimum class size requirement does not apply to the class offered the HRA in this paragraph (f)(1)(viii) (*Example 8*) because part-time employees are not offered coverage and full-time employees are not an applicable class subject to the minimum class size requirement if part-time employees are not offered coverage.

(ix) *Example 9: Full-time employees in rating area 1 offered traditional group health plan; full-time employees in rating area 2 offered HRA; part-time employees offered no coverage—(A) Facts.* Plan Sponsor H employs 17 full-time employees and 10 part-time employees whose work site is in rating area 1 and 552 full-time employees whose work site is in rating area 2. For 2020, Plan Sponsor H offers its 17 full-time employees in rating area 1 a traditional group health plan and each of its 552 full-time employees in rating area 2 an HRA on the same terms. Plan Sponsor H offers no coverage to its 10 part-time employees in rating area 1. Plan Sponsor H reasonably expects to employ 569 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(ix) (*Example 9*) because employees whose work sites are in different rating areas may be considered different classes and Plan Sponsor H offers the HRA on the same terms to all full-time employees in rating area 2. The minimum class size requirement applies to the class offered the HRA in this paragraph (f)(1)(ix) (*Example 9*) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. However, the minimum class size requirement applies only to the class offered the HRA, and Plan Sponsor H offers the HRA to the 552 full-time employees in rating area 2 on the first day of the plan year, satisfying the minimum class size requirement (because the applicable class size minimum for Plan Sponsor H is 20).

(x) *Example 10: Employees in rating area 1 offered HRA; employees in rating area 2 offered traditional group health plan—(A) Facts.* The facts are the same as in paragraph (f)(1)(ix) of this section (*Example 9*) except that Plan Sponsor H offers its 17 full-time employees in rating area 1 the HRA and offers its 552 full-time employees in rating area 2 the traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(x) (*Example 10*) because, even though employees whose work sites are in different rating areas generally may be considered different classes and Plan Sponsor H offers the HRA on the same terms to all participants in rating area 1, the HRA fails to satisfy the minimum class size requirement. Specifically, the minimum class size requirement applies to this paragraph (f)(1)(x) (*Example 10*) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. Further, the applicable class size minimum for Plan Sponsor H is 20 employees, and the HRA is only offered to the 17 full-time employees in rating area 1 on the first day of the HRA plan year.

(xi) *Example 11: Employees in State 1 and rating area 1 of State 2 offered HRA; employees in all other rating areas of State 2 offered traditional group health plan—(A) Facts.* For 2020, Plan Sponsor I offers an HRA on the same terms to a total of 200 employees it employs with work sites in State 1 and in rating area 1 of State 2. Plan Sponsor I offers a traditional group health plan to its 150 employees with work sites in other rating areas in State 2. Plan Sponsor I reasonably expects to employ 350 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xi) (*Example 11*). Plan Sponsor I may treat all of the employees with a work site in State 1 and rating area 1 of State 2 as a class of employees because employees whose work sites are in different rating areas may be considered different classes and a plan sponsor may create a class of employees by

combining classes of employees, including by combining employees whose work site is in one rating area with a class of employees whose work site is in a different rating area. The minimum class size requirement applies to the class of employees offered the HRA (made up of employees in State 1 and in rating area 1 of State 2) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. In this case, the class is made up of a state plus a rating area which is not the entire state. However, this class satisfies the minimum class size requirement because the applicable class size minimum for Plan Sponsor I is 20, and Plan Sponsor I offered the HRA to 200 employees on the first day of the plan year.

(xii) *Example 12: Salaried employees offered a traditional group health plan; hourly employees offered an HRA—(A) Facts.* Plan Sponsor J has 163 salaried employees and 14 hourly employees. For 2020, Plan Sponsor J offers its 163 salaried employees a traditional group health plan and each of its 14 hourly employees an HRA on the same terms. Plan Sponsor J reasonably expects to employ 177 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xii) (*Example 12*) because, even though salaried and hourly employees generally may be considered different classes and Plan Sponsor J offers the HRA on the same terms to all hourly employees, the HRA fails to satisfy the minimum class size requirement. Specifically, the minimum class size requirement applies in this paragraph (f)(1)(xii) (*Example 12*) because employees who are paid on a salaried basis and employees who are not paid on a salaried basis are applicable classes subject to the minimum class size requirement. Because Plan Sponsor J reasonably expects to employ between 100 and 200 employees on the first day of the plan year, the applicable class size minimum is 10 percent, rounded down to a whole number. Ten percent of 177 total employees, rounded down to a whole number is 17, and the HRA is offered to only 14 hourly employees.

(xiii) *Example 13: Part-time employees and full-time employees offered different HRAs; no traditional group health plan offered—(A) Facts.* Plan Sponsor K has 50 full-time employees and 7 part-time employees. For 2020, Plan Sponsor K offers its 50 full-time employees \$2,000 each in an HRA otherwise provided on the same terms and each of its 7 part-time employees \$500 in an HRA otherwise provided on the same terms. Plan Sponsor K reasonably expects to employ 57 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xiii) (*Example 13*) because full-time employees and part-time employees may be treated as different classes and Plan Sponsor K offers an HRA on the same terms to all the participants in each class. The minimum class size requirement does not apply to

either the full-time class or the part-time class because (although in certain circumstances the minimum class size requirement applies to a class of full-time employees and a class of part-time employees) Plan Sponsor K does not offer any class of employees a traditional group health plan, and the minimum class size requirement applies only when, among other things, at least one class of employees is offered a traditional group health plan while another class is offered an HRA.

(xiv) *Example 14: No employees offered an HRA—(A) Facts.* The facts are the same facts as in paragraph (f)(1)(xiii) of this section (*Example 13*), except that Plan Sponsor K offers its full-time employees a traditional group health plan and does not offer any group health plan (either a traditional group health plan or an HRA) to its part-time employees.

(B) *Conclusion.* The regulations set forth under this section do not apply to Plan Sponsor K because Plan Sponsor K does not offer an individual coverage HRA to any employee.

(xv) *Example 15: Full-time employees offered traditional group health plan; part-time employees offered HRA—(A) Facts.* The facts are the same as in paragraph (f)(1)(xiii) of this section (*Example 13*), except that Plan Sponsor K offers its full-time employees a traditional group health plan and offers each of its part-time employees \$500 in an HRA and otherwise on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xv) (*Example 15*) because, even though the full-time employees and the part-time employees generally may be treated as different classes, in this paragraph (f)(1)(xv) (*Example 15*), the minimum class size requirement applies to the part-time employees, and it is not satisfied. Specifically, the minimum class size requirement applies to the part-time employees because that requirement applies to an applicable class offered an HRA when one class is offered a traditional group health plan while another class is offered an HRA, and to the part-time and full-time employee classes when one of those classes is offered a traditional group health plan while the other is offered an HRA. Because Plan Sponsor K reasonably expects to employ fewer than 100 employees on the first day of the HRA plan year, the applicable class size minimum for Plan Sponsor K is 10 employees, but Plan Sponsor K offered the HRA only to its 7 part-time employees.

(xvi) *Example 16: Satisfying minimum class size requirement based on employees offered HRA—(A) Facts.* Plan Sponsor L employs 78 full-time employees and 12 part-time employees. For 2020, Plan Sponsor L offers its 78 full-time employees a traditional group health plan and each of its 12 part-time employees an HRA on the same terms. Only 6 part-time employees enroll in the HRA. Plan Sponsor L reasonably expects to employ fewer than 100 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph

(f)(1)(xvi) (*Example 16*) because full-time employees and part-time employees may be treated as different classes, Plan Sponsor L offers an HRA on the same terms to all the participants in the part-time class, and the minimum class size requirement is satisfied. Specifically, whether a class of employees satisfies the applicable class size minimum is determined as of the first day of the plan year based on the number of employees in a class that is offered an HRA, not on the number of employees who enroll in the HRA. The applicable class size minimum for Plan Sponsor L is 10 employees, and Plan Sponsor L offered the HRA to its 12 part-time employees.

(xvii) *Example 17: Student employees offered student premium reduction arrangements and same terms requirement—*

(A) *Facts.* Plan Sponsor M is an institution of higher education that offers each of its part-time employees an HRA on the same terms, except that it offers its part-time employees who are student employees a student premium reduction arrangement, and the student premium reduction arrangement provides different amounts to different part-time student employees.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xvii) (*Example 17*) because Plan Sponsor M offers the HRA on the same terms to its part-time employees who are not students and because the part-time student employees offered a student premium reduction arrangement (and their varying HRAs) are not taken into account as part-time employees for purposes of determining whether a class of employees is offered an HRA on the same terms.

(xiii) *Example 18: Student employees offered student premium reduction arrangements and minimum class size requirement—*(A) *Facts.* Plan Sponsor N is an institution of higher education with 25 hourly employees. Plan Sponsor N offers 15 of its hourly employees, who are student employees, a student premium reduction arrangement and it wants to offer its other 10 hourly employees an HRA for 2022. Plan Sponsor N offers its salaried employees a traditional group health plan. Plan Sponsor N reasonably expects to have 250 employees on the first day of the 2022 HRA plan year, 15 of which will have offers of student premium reduction arrangements.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xviii) (*Example 18*). The minimum class size requirement will apply to the class of hourly employees to which Plan Sponsor N wants to offer the HRA because Plan Sponsor N offers a class of employees a traditional group health plan and another class the HRA, and the minimum class size requirement generally applies to a class of hourly employees offered an HRA. Plan Sponsor N's applicable class size minimum is 20 because Plan Sponsor N reasonably expects to employ 235 employees on the first day of the plan year (250 employees minus 15 employees receiving a student premium reduction arrangement). Plan Sponsor N may not offer the HRA to its hourly employees

because the 10 employees offered the HRA as of the first day of the plan year does not satisfy the applicable class size minimum.

(2) *Examples regarding special rule for new hires.* The following examples illustrate the provisions of paragraph (c)(3) of this section, taking into account the provisions of paragraph (d) of this section, in particular the special rule for new hires under paragraph (d)(5) of this section. In each example, the HRA is an individual coverage HRA that has a calendar year plan year and may reimburse any medical care expenses, including premiums for individual health insurance coverage. The examples also assume that no participants or dependents are Medicare beneficiaries.

(i) *Example 1: Application of special rule for new hires to all employees—*(A) *Facts.* For 2021, Plan Sponsor A offers all employees a traditional group health plan. For 2022, Plan Sponsor A offers all employees hired on or after January 1, 2022, an HRA on the same terms and continues to offer the traditional group health plan to employees hired before that date. On the first day of the 2022 plan year, Plan Sponsor A has 2 new hires who are offered the HRA.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(i) (*Example 1*) because, under the special rule for new hires in paragraph (d)(5) of this section, the employees newly hired on and after January 1, 2022, may be treated as a new hire subclass. Plan Sponsor A offers the HRA on the same terms to all participants in the new hire subclass, and the minimum class size requirement does not apply to the new hire subclass.

(ii) *Example 2: Application of special rule for new hires to full-time employees—*(A) *Facts.* For 2021, Plan Sponsor B offers a traditional group health plan to its full-time employees and does not offer any coverage to its part-time employees. For 2022, Plan Sponsor B offers full-time employees hired on or after January 1, 2022, an HRA on the same terms, continues to offer its full-time employees hired before that date a traditional group health plan, and continues to offer no coverage to its part-time employees. On the first day of the 2022 plan year, Plan Sponsor B has 2 new hire, full-time employees who are offered the HRA.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(ii) (*Example 2*) because, under the special rule for new hires in paragraph (d)(5) of this section, the full-time employees newly hired on and after January 1, 2022, may be treated as a new hire subclass and Plan Sponsor B offers the HRA on the same terms to all participants in the new hire subclass. The minimum class size requirement does not apply to the new hire subclass.

(iii) *Example 3: Special rule for new hires impermissibly applied retroactively—*(A) *Facts.* For 2025, Plan Sponsor C offers a traditional group health plan to its full-time employees. For 2026, Plan Sponsor C wants

to offer an HRA to its full-time employees hired on and after January 1, 2023, while continuing to offer a traditional group health plan to its full-time employees hired before January 1, 2023.

(B) *Conclusion.* The special rule for new hires under paragraph (d)(5) of this section does not apply in this paragraph (f)(2)(iii) (*Example 3*) because the rule must be applied prospectively. That is, Plan Sponsor C may not, in 2026, choose to apply the special rule for new hires retroactive to 2023. If Plan Sponsor C were to offer an HRA in this way, it would fail to satisfy the conditions under paragraphs (c)(2) and (3) of this section because the new hire subclass would not be treated as a subclass for purposes of applying those rules and, therefore, all full-time employees would be treated as one class to which either a traditional group health plan or an HRA could be offered, but not both.

(iv) *Example 4: Permissible second application of the special rule for new hires to the same class of employees—*(A) *Facts.* For 2021, Plan Sponsor D offers all of its full-time employees a traditional group health plan. For 2022, Plan Sponsor D applies the special rule for new hires and offers an HRA on the same terms to all employees hired on and after January 1, 2022, and continues to offer a traditional group health plan to full-time employees hired before that date. For 2025, Plan Sponsor D discontinues use of the special rule for new hires, and again offers all full-time employees a traditional group health plan. In 2030, Plan Sponsor D decides to apply the special rule for new hires to the full-time employee class again, offering an HRA to all full-time employees hired on and after January 1, 2030, on the same terms, while continuing to offer employees hired before that date a traditional group health plan.

(B) *Conclusion.* Plan Sponsor D has permissibly applied the special rule for new hires and is in compliance with the requirements of paragraphs (c)(2) and (3) of this section.

(v) *Example 5: Impermissible second application of the special rule for new hires to the same class of employees—*(A) *Facts.* The facts are the same as in paragraph (f)(2)(iv) of this section (*Example 4*), except that for 2025, Plan Sponsor D discontinues use of the special rule for new hires by offering all full-time employees an HRA on the same terms. Further, for 2030, Plan Sponsor D wants to continue to offer an HRA on the same terms to all full-time employees hired before January 1, 2030, and to offer all full-time employees hired on or after January 1, 2030, an HRA in a different amount.

(B) *Conclusion.* Plan Sponsor D may not apply the special rule for new hires for 2030 to the class of full-time employees being offered an HRA because the special rule for new hires may only be applied to a class that is being offered a traditional group health plan.

(vi) *Example 6: New full-time employees offered different HRAs in different rating areas—*(A) *Facts.* Plan Sponsor E has work sites in rating area 1, rating area 2, and rating area 3. For 2021, Plan Sponsor E offers its full-time employees a traditional group health plan. For 2022, Plan Sponsor E offers

its full-time employees hired on or after January 1, 2022, in rating area 1 an HRA of \$3,000, its full-time employees hired on or after January 1, 2022, in rating area 2 an HRA of \$5,000, and its full-time employees hired on or after January 1, 2022, in rating area 3 an HRA of \$7,000. Within each class offered an HRA, Plan Sponsor E offers the HRA on the same terms. Plan Sponsor E offers its full-time employees hired prior to January 1, 2022, in each of those classes a traditional group health plan. On the first day of the 2022 plan year, there is one new hire, full-time employee in rating area 1, three new hire, full-time employees in rating area 2, and 10 new hire-full-time employees in rating area 3.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(vi) (*Example 6*) because, under the special rule for new hires in paragraph (d)(5) of this section, the full-time employees in each of the three rating areas newly hired on and after January 1, 2022, may be treated as three new hire subclasses and Plan Sponsor E offers the HRA on the same terms to all participants in the new hire subclasses. Further, the minimum class size requirement does not apply to the new hire subclasses.

(vii) *Example 7: New full-time employee class subdivided based on rating area—(A) Facts.* Plan Sponsor F offers its full-time employees hired on or after January 1, 2022, an HRA on the same terms and it continues to offer its full-time employees hired before that date a traditional group health plan. Plan Sponsor F offers no coverage to its part-time employees. For the 2025 plan year, Plan Sponsor F wants to subdivide the full-time new hire subclass so that those whose work site is in rating area 1 will be offered the traditional group health plan and those whose work site is in rating area 2 will continue to receive the HRA. Plan Sponsor F reasonably expects to employ 219 employees on January 1, 2025. As of January 1, 2025, Plan Sponsor F has 15 full-time employees whose work site is in rating area 2 and who were hired between January 1, 2022, and January 1, 2025.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(2)(vii) (*Example 7*) because the new hire subclass has been subdivided in a manner that is subject to the minimum class size requirement, and the class offered the HRA fails to satisfy the minimum class size requirement. Specifically, once the new hire subclass is subdivided the general rules for applying the minimum class size requirement apply to the employees offered the HRA in the new hire subclass. In this case, because the subdivision of the new hire full-time subclass is based on rating areas; a class based on rating areas is an applicable class subject to the minimum class size requirement; and the employees in one rating area are to be offered the HRA, while the employees in the other rating area are offered the traditional group health plan, the minimum class size requirement would apply on and after the date of the subdivision. Further, the minimum class size requirement would not be satisfied, because

the applicable class size minimum for Plan Sponsor F would be 20, and only 15 employees in rating area 2 would be offered the HRA.

(viii) *Example 8: New full-time employee class subdivided based on state—(A) Facts.* The facts are the same as in paragraph (f)(2)(vii) of this section (*Example 7*), except that for the 2025 plan year, Plan Sponsor F intends to subdivide the new hire, full-time class so that those in State 1 will be offered the traditional group health plan and those in State 2 will each be offered an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(viii) (*Example 8*) because even though the new hire subclass has been subdivided, it has been subdivided in a manner that is not subject to the minimum class size requirement as the subdivision is based on the entire state.

(ix) *Example 9: New full-time employees and part-time employees offered HRA—(A) Facts.* In 2021, Plan Sponsor G offers its full-time employees a traditional group health plan and does not offer coverage to its part-time employees. For the 2022 plan year, Plan Sponsor G offers its full-time employees hired on or after January 1, 2022, and all of its part-time employees, including those hired before January 1, 2022, and those hired on and after January 1, 2022, an HRA on the same terms, and it continues to offer its full-time employees hired before January 1, 2022, a traditional group health plan.

(B) *Conclusion.* The minimum class size requirement applies to the part-time employees offered the HRA in 2022 because the class is being offered an HRA; the special rule for new hires does not apply (because this class was not previously offered a traditional group health plan) and so it is not a new hire subclass exempt from the minimum class size requirement; another class of employees (that is, full-time hired before January 1, 2022) are being offered a traditional group health plan; and the part-time employee class is generally an applicable classes that is subject to the minimum class size requirement. However, because the full-time, new hire subclass is based on the special rule for new hires, the minimum class size requirement does not apply to full-time new hires offered an HRA in 2022.

(g) *Applicability date.* This section applies to plan years beginning on or after January 1, 2020.

■ 14. Section 2590.715–2711 is amended by revising paragraphs (c), (d), and (e) to read as follows:

**§ 2590.715–2711 No lifetime or annual limits.**

\* \* \* \* \*

(c) *Definition of essential health benefits.* The term “essential health benefits” means essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. For the purpose of this section, a group health

plan or a health insurance issuer that is not required to provide essential health benefits under section 1302(b) must define “essential health benefits” in a manner that is consistent with the following:

(1) For plan years beginning before January 1, 2020, one of the EHB-benchmark plans applicable in a State under 45 CFR 156.110, and including coverage of any additional required benefits that are considered essential health benefits consistent with 45 CFR 155.170(a)(2), or one of the three Federal Employees Health Benefits Program (FEHBP) plan options as defined by 45 CFR 156.100(a)(3), supplemented as necessary, to satisfy the standards in 45 CFR 156.110; or

(2) For plan years beginning on or after January 1, 2020, an EHB-benchmark plan selected by a State in accordance with the available options and requirements for EHB-benchmark plan selection at 45 CFR 156.111, including an EHB-benchmark plan in a State that takes no action to change its EHB-benchmark plan and thus retains the EHB-benchmark plan applicable in that State for the prior year in accordance with 45 CFR 156.111(d)(1), and including coverage of any additional required benefits that are considered essential health benefits consistent with 45 CFR 155.170(a)(2).

(d) *Health reimbursement arrangements (HRAs) and other account-based group health plans—(1) In general.* If an HRA or other account-based group health plan is integrated with another group health plan or individual health insurance coverage and the other group health plan or individual health insurance coverage, as applicable, separately is subject to and satisfies the requirements in PHS Act section 2711 and paragraph (a)(2) of this section, the fact that the benefits under the HRA or other account-based group health plan are limited does not cause the HRA or other account-based group health plan to fail to satisfy the requirements of PHS Act section 2711 and paragraph (a)(2) of this section. Similarly, if an HRA or other account-based group health plan is integrated with another group health plan or individual health insurance coverage and the other group health plan or individual health insurance coverage, as applicable, separately is subject to and satisfies the requirements in PHS Act section 2713 and § 2590.715–2713(a)(1) of this part, the fact that the benefits under the HRA or other account-based group health plan are limited does not cause the HRA or other account-based group health plan to fail to satisfy the requirements of PHS Act section 2713

and § 2590.715–2713(a)(1) of this part. For the purpose of this paragraph (d), all individual health insurance coverage, except for coverage that consists solely of excepted benefits, is treated as being subject to and complying with PHS Act sections 2711 and 2713.

(2) *Requirements for an HRA or other account-based group health plan to be integrated with another group health plan.* An HRA or other account-based group health plan is integrated with another group health plan for purposes of PHS Act section 2711 and paragraph (a)(2) of this section if it satisfies the requirements under one of the integration methods set forth in paragraph (d)(2)(i) or (ii) of this section. For purposes of the integration methods under which an HRA or other account-based group health plan is integrated with another group health plan, integration does not require that the HRA or other account-based group health plan and the other group health plan with which it is integrated share the same plan sponsor, the same plan document or governing instruments, or file a single Form 5500, if applicable. An HRA or other account-based group health plan integrated with another group health plan for purposes of PHS Act section 2711 and paragraph (a)(2) of this section may not be used to purchase individual health insurance coverage unless that coverage consists solely of excepted benefits, as defined in 45 CFR 148.220.

(i) *Method for integration with a group health plan: Minimum value not required.* An HRA or other account-based group health plan is integrated with another group health plan for purposes of this paragraph (d) if:

(A) The plan sponsor offers a group health plan (other than the HRA or other account-based group health plan) to the employee that does not consist solely of excepted benefits;

(B) The employee receiving the HRA or other account-based group health plan is actually enrolled in a group health plan (other than the HRA or other account-based group health plan) that does not consist solely of excepted benefits, regardless of whether the plan is offered by the same plan sponsor (referred to as non-HRA group coverage);

(C) The HRA or other account-based group health plan is available only to employees who are enrolled in non-HRA group coverage, regardless of whether the non-HRA group coverage is offered by the plan sponsor of the HRA or other account-based group health plan (for example, the HRA may be offered only to employees who do not enroll in an employer's group health

plan but are enrolled in other non-HRA group coverage, such as a group health plan maintained by the employer of the employee's spouse);

(D) The benefits under the HRA or other account-based group health plan are limited to reimbursement of one or more of the following—co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care expenses that do not constitute essential health benefits as defined in paragraph (c) of this section; and

(E) Under the terms of the HRA or other account-based group health plan, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan at least annually and, upon termination of employment, either the remaining amounts in the HRA or other account-based group health plan are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan (see paragraph (d)(3) of this section for additional rules regarding forfeiture and waiver).

(ii) *Method for integration with another group health plan: Minimum value required.* An HRA or other account-based group health plan is integrated with another group health plan for purposes of this paragraph (d) if:

(A) The plan sponsor offers a group health plan (other than the HRA or other account-based group health plan) to the employee that provides minimum value pursuant to Code section 36B(c)(2)(C)(ii) (and its implementing regulations and applicable guidance);

(B) The employee receiving the HRA or other account-based group health plan is actually enrolled in a group health plan (other than the HRA or other account-based group health plan) that provides minimum value pursuant to Code section 36B(c)(2)(C)(ii) (and applicable guidance), regardless of whether the plan is offered by the plan sponsor of the HRA or other account-based group health plan (referred to as non-HRA MV group coverage);

(C) The HRA or other account-based group health plan is available only to employees who are actually enrolled in non-HRA MV group coverage, regardless of whether the non-HRA MV group coverage is offered by the plan sponsor of the HRA or other account-based group health plan (for example, the HRA may be offered only to employees who do not enroll in an employer's group health plan but are enrolled in other non-HRA MV group coverage,

such as a group health plan maintained by an employer of the employee's spouse); and

(D) Under the terms of the HRA or other account-based group health plan, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan at least annually, and, upon termination of employment, either the remaining amounts in the HRA or other account-based group health plan are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan (see paragraph (d)(3) of this section for additional rules regarding forfeiture and waiver).

(3) *Forfeiture.* For purposes of integration under paragraphs (d)(2)(i)(E) and (d)(2)(ii)(D) of this section, forfeiture or waiver occurs even if the forfeited or waived amounts may be reinstated upon a fixed date, a participant's death, or the earlier of the two events (the reinstatement event). For the purpose of this paragraph (d)(3), coverage under an HRA or other account-based group health plan is considered forfeited or waived prior to a reinstatement event only if the participant's election to forfeit or waive is irrevocable, meaning that, beginning on the effective date of the election and through the date of the reinstatement event, the participant and the participant's beneficiaries have no access to amounts credited to the HRA or other account-based group health plan. This means that upon and after reinstatement, the reinstated amounts under the HRA or other account-based group health plan may not be used to reimburse or pay medical care expenses incurred during the period after forfeiture and prior to reinstatement.

(4) *Requirements for an HRA or other account-based group health plan to be integrated with individual health insurance coverage or Medicare Part A and B or Medicare Part C.* An HRA or other account-based group health plan is integrated with individual health insurance coverage or Medicare Part A and B or Medicare Part C (and treated as complying with PHS Act sections 2711 and 2713) if the HRA or other account-based group health plan satisfies the requirements of § 2590.702–2(c) of this part (as modified by § 2590.702–2(e), for HRAs or other account-based group health plans integrated with Medicare Part A and B or Medicare Part C).

(5) *Integration with Medicare Part B and D.* For employers that are not required to offer their non-HRA group

health plan coverage to employees who are Medicare beneficiaries, an HRA or other account-based group health plan that may be used to reimburse premiums under Medicare Part B or D may be integrated with Medicare (and deemed to comply with PHS Act sections 2711 and 2713) if the following requirements are satisfied with respect to employees who would be eligible for the employer's non-HRA group health plan but for their eligibility for Medicare (and the integration rules under paragraphs (d)(2)(i) and (ii) of this section continue to apply to employees who are not eligible for Medicare):

(i) The plan sponsor offers a group health plan (other than the HRA or other account-based group health plan and that does not consist solely of excepted benefits) to employees who are not eligible for Medicare;

(ii) The employee receiving the HRA or other account-based group health plan is actually enrolled in Medicare Part B or D;

(iii) The HRA or other account-based group health plan is available only to employees who are enrolled in Medicare Part B or D; and

(iv) The HRA or other account-based group health plan complies with paragraphs (d)(2)(i)(E) and (d)(2)(ii)(D) of this section.

(6) *Definitions.* The following definitions apply for purposes of this section.

(i) *Account-based group health plan.* An account-based group health plan is 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. An HRA is a type of account-based group health plan. An account-based group health plan does not include a qualified small employer health reimbursement arrangement, as defined in Code section 9831(d)(2).

(ii) *Medical care expenses.* Medical care expenses means expenses for medical care as defined under Code section 213(d).

(e) *Applicability date.* The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning on or after January 1, 2020. Until the applicability date for this section, plans and issuers are required to continue to comply with the corresponding sections of this part, contained in the 29 CFR parts 1927 to end edition, revised as of July 1, 2018.

■ 15. Section 2590.732 is amended by revising paragraph (c)(3)(i) and adding paragraph (c)(3)(viii) to read as follows:

**§ 2590.732 Special rules relating to group health plans.**

\* \* \* \* \*

(c) \* \* \*

(3) \* \* \*

(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement (health FSA) are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section; benefits provided under an employee assistance program are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vi) of this section; benefits provided under limited wraparound coverage are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vii) of this section; and benefits provided under a health reimbursement arrangement or other account-based group health plan, other than a health FSA, are excepted benefits if they satisfy the requirements of paragraph (c)(3)(viii) of this section.

\* \* \* \* \*

(viii) *Health reimbursement arrangements (HRAs) and other account-based group health plans.* Benefits provided under an HRA or other account-based group health plan, other than a health FSA, are excepted if they satisfy all of the requirements of this paragraph (c)(3)(viii). See paragraph (c)(3)(v) of this section for the circumstances in which benefits provided under a health FSA are excepted benefits. For purposes of this paragraph (c)(3)(viii), the term "HRA or other account-based group health plan" has the same meaning as "account-based group health plan" set forth in § 2590.715–2711(d)(6)(i) of this part, except that the term does not include health FSAs. For ease of reference, an HRA or other account-based group health plan that satisfies the requirements of this paragraph (c)(3)(viii) is referred to as an excepted benefit HRA.

(A) *Otherwise not an integral part of the plan.* 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 must be made available by the same plan sponsor for the plan year to the participant.

(B) *Benefits are limited in amount—*  
(1) *Limit on annual amounts made available.* The amounts newly made

available for each plan year under the HRA or other account-based group health plan do not exceed \$1,800. In the case of any plan year beginning after December 31, 2020, the dollar amount in the preceding sentence shall be increased by an amount equal to such dollar amount multiplied by the cost-of-living adjustment. The cost of living adjustment is the percentage (if any) by which the C–CPI–U for the preceding calendar year exceeds the C–CPI–U for calendar year 2019. The term "C–CPI–U" means the Chained Consumer Price Index for All Urban Consumers as published by the Bureau of Labor Statistics of the Department of Labor. The C–CPI–U for any calendar year is the average of the C–CPI–U as of the close of the 12-month period ending on March 31 of such calendar year. The values of the C–CPI–U used for any calendar year shall be the latest values so published as of the date on which the Bureau publishes the initial value of the C–CPI–U for the month of March for the preceding calendar year. Any such increase that is not a multiple of \$50 shall be rounded down to the next lowest multiple of \$50. The Department of the Treasury and the Internal Revenue Service will publish the adjusted amount for plan years beginning in any calendar year no later than June 1 of the preceding calendar year.

(2) *Carryover amounts.* If the terms of the HRA or other account-based group health plan allow unused amounts to be made available to participants and dependents in later plan years, such carryover amounts are disregarded for purposes of determining whether benefits are limited in amount.

(3) *Multiple HRAs or other account-based group health plans.* 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 to determine whether the benefits are limited in amount, except that HRAs or other account-based group health plans that reimburse only excepted benefits are not included in determining whether the benefits are limited in amount.

(C) *Prohibition on reimbursement of certain health insurance premiums.* The HRA or other account-based group health plan must not reimburse premiums for individual health insurance coverage, group health plan coverage (other than COBRA continuation coverage or other continuation coverage), or Medicare Part A, B, C, or D, except that the HRA or other account-based group health plan

may reimburse premiums for such coverage that consists solely of excepted benefits. See also, paragraph (c)(3)(viii)(F) of this section.

(D) *Uniform availability.* The HRA or other account-based group health plan is made available under the same terms to all similarly situated individuals, as defined in § 2590.702(d) of this part, regardless of any health factor (as described in § 2590.702(a)).

(E) *Notice requirement.* See sections 2520.102–3(j)(2) and (3) and 2520.104b–2(a) of this chapter regarding the time, manner, and content for summary plan descriptions (including a description of conditions pertaining to eligibility to receive benefits; annual or lifetime caps or other limits on benefits under the plan; and a description or summary of the benefits).

(F) *Special rule.* The HRA or other account-based group health plan must not reimburse premiums for short-term, limited-duration insurance (as defined in § 2590.701–2 of this part) if the conditions of this paragraph (c)(3)(viii)(F) are satisfied.

(1) The HRA or other account-based group health plan is offered by a small employer (as defined in PHS Act section 2791(e)(4)).

(2) The other group health plan coverage offered by the employer pursuant to paragraph (c)(3)(viii)(A) of this section is either fully-insured or partially-insured.

(3) The Secretary of Health and Human Services (HHS) makes a finding, in consultation with the Secretaries of Labor and the Treasury, that the reimbursement of premiums for short-term, limited-duration insurance by excepted benefit HRAs has caused significant harm to the small group market in the state that is the principal place of business of the small employer.

(4) The finding by the Secretary of HHS is made after submission of a written recommendation by the applicable state authority of such state, in a form and manner specified by HHS. The written recommendation must include evidence that the reimbursement of premiums for short-term, limited-duration insurance by excepted benefit HRAs established by insured or partially-insured small employers in the state has caused significant harm to the state’s small group market, including with respect to premiums.

(5) The restriction shall be imposed or discontinued by publication by the Secretary of HHS of a notice in the **Federal Register** and shall apply only prospectively and with a reasonable time for plan sponsors to comply.

\* \* \* \* \*

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**45 CFR Chapter 1**

For the reasons stated in the preamble, the Department of Health and Human Services amends 45 CFR parts 144, 146, 147, and 155 as set forth below:

**PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE**

■ 16. The authority for part 144 is revised to read as follows:

**Authority:** 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92.

■ 17. Section 144.103 is amended by revising the definition of “Group health insurance coverage” to read as follows:

**§ 144.103 Definitions.**

\* \* \* \* \*

*Group health insurance coverage* means health insurance coverage offered in connection with a group health plan. Individual health insurance coverage reimbursed by the arrangements described in 29 CFR 2510.3–1(l) is not offered in connection with a group health plan, and is not group health insurance coverage, provided all the conditions in 29 CFR 2510.3–1(l) are satisfied.

\* \* \* \* \*

**PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET**

18. The authority citation for part 146 continues to read as follows:

**Authority:** 42 U.S.C. 300gg–1 through 300gg–5, 300gg–11 through 300gg–23, 300gg–91, and 300gg–92.

■ 19. Section 146.123 is added to read as follows:

**§ 146.123 Special rule allowing integration of Health Reimbursement Arrangements (HRAs) and other account-based group health plans with individual health insurance coverage and medicare and prohibiting discrimination in HRAs and other account-based group health plans.**

(a) *Scope.* This section applies to health reimbursement arrangements (HRAs) and other account-based group health plans, as defined in § 147.126(d)(6)(i) of this subchapter. For ease of reference, the term “HRA” is used in this section to include other account-based group health plans. For related regulations, see 26 CFR 1.36B–2(c)(3)(i) and (c)(5), 29 CFR 2510.3–1(l), and 45 CFR 155.420.

(b) *Purpose.* This section provides the conditions that an HRA must satisfy in order to be integrated with individual

health insurance coverage for purposes of Public Health Service Act (PHS Act) sections 2711 and 2713 and § 147.126(d)(4) of this subchapter (referred to as an individual coverage HRA). This section also allows an individual coverage HRA to be integrated with Medicare for purposes of PHS Act sections 2711 and 2713 and § 147.126(d)(4) of this subchapter, subject to the conditions provided in this section (see paragraph (e) of this section). Some of the conditions set forth in this section specifically relate to compliance with PHS Act sections 2711 and 2713 and some relate to the effect of having or being offered an individual coverage HRA on eligibility for the premium tax credit under section 36B of the Internal Revenue Code (Code). In addition, this section provides conditions that an individual coverage HRA must satisfy in order to comply with the nondiscrimination provisions in PHS Act section 2705 and that are consistent with the provisions of the Patient Protection and Affordable Care Act, Public Law 111–148 (124 Stat. 119 (2010)), and the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (124 Stat. 1029 (2010)), each as amended, that are designed to create a competitive individual market. These conditions are intended to prevent an HRA plan sponsor from intentionally or unintentionally, directly or indirectly, steering any participants or dependents with adverse health factors away from its traditional group health plan, if any, and toward individual health insurance coverage.

(c) *General rule.* An HRA will be considered to be integrated with individual health insurance coverage for purposes of PHS Act sections 2711 and 2713 and § 147.126(d)(4) of this subchapter and will not be considered to discriminate in violation of PHS Act section 2705 solely because it is integrated with individual health insurance coverage, provided that the conditions of this paragraph (c) are satisfied. See paragraph (e) of this section for how these conditions apply to an individual coverage HRA integrated with Medicare. For purposes of this section, medical care expenses means medical care expenses as defined in § 147.126(d)(6)(ii) of this subchapter and Exchange means Exchange as defined in § 155.20 of this subchapter.

(1) *Enrollment in individual health insurance coverage—(i) In general.* The HRA must require that the participant and any dependent(s) are enrolled in individual health insurance coverage that is subject to and complies with the requirements in PHS Act sections 2711

(and § 147.126(a)(2) of this subchapter) and PHS Act section 2713 (and § 147.130(a)(1) of this subchapter), for each month that the individual(s) are covered by the HRA. For purposes of this paragraph (c), all individual health insurance coverage, except for individual health insurance coverage that consists solely of excepted benefits, is treated as being subject to and complying with PHS Act sections 2711 and 2713. References to individual health insurance coverage in this paragraph (c) do not include individual health insurance coverage that consists solely of excepted benefits.

(ii) *Forfeiture.* The HRA must provide that if any individual covered by the HRA ceases to be covered by individual health insurance coverage, the HRA will not reimburse medical care expenses that are incurred by that individual after the individual health insurance coverage ceases. In addition, if the participant and all dependents covered by the participant's HRA cease to be covered by individual health insurance coverage, the participant must forfeit the HRA. In either case, the HRA must reimburse medical care expenses incurred by the individual prior to the cessation of individual health insurance coverage to the extent the medical care expenses are otherwise covered by the HRA, but the HRA may limit the period to submit medical care expenses for reimbursement to a reasonable specified time period. If a participant or dependent loses coverage under the HRA for a reason other than cessation of individual health insurance coverage, COBRA and other continuation coverage requirements may apply.

(iii) *Grace periods and retroactive termination of individual health insurance coverage.* In the event an individual is initially enrolled in individual health insurance coverage and subsequently timely fails to pay premiums for the coverage, with the result that the individual is in a grace period, the individual is considered to be enrolled in individual health insurance coverage for purposes of this paragraph (c)(1) and the individual coverage HRA must reimburse medical care expenses incurred by the individual during that time period to the extent the medical care expenses are otherwise covered by the HRA. If the individual fails to pay the applicable premium(s) by the end of the grace period and the coverage is cancelled or terminated, including retroactively, or if the individual health insurance coverage is cancelled or terminated retroactively for some other reason (for example, a rescission), an individual coverage HRA must require that a

participant notify the HRA that coverage has been cancelled or terminated and the date on which the cancellation or termination is effective. After the individual coverage HRA has received the notice of cancellation or termination, the HRA may not reimburse medical care expenses incurred on and after the date the individual health insurance coverage was cancelled or terminated, which is considered to be the date of termination of coverage under the HRA.

(2) *No traditional group health plan may be offered to same participants.* To the extent a plan sponsor offers any class of employees (as defined in paragraph (d) of this section) an individual coverage HRA, the plan sponsor may not also offer a traditional group health plan to the same class of employees, except as provided in paragraph (d)(5) of this section. For purposes of this section, a traditional group health plan is any group health plan other than either an account-based group health plan or a group health plan that consists solely of excepted benefits. Therefore, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any participant or dependent.

(3) *Same terms requirement—(i) In general.* If a plan sponsor offers an individual coverage HRA to a class of employees described in paragraph (d) of this section, the HRA must be offered on the same terms to all participants within the class, except as provided in paragraphs (c)(3)(ii) through (vi) and (d)(5) of this section.

(ii) *Carryover amounts, salary reduction arrangements, and transfer amounts.* Amounts that are not used to reimburse medical care expenses for any plan year that are made available to participants in later plan years are disregarded for purposes of determining whether an HRA is offered on the same terms, provided that the method for determining whether participants have access to unused amounts in future years, and the methodology and formula for determining the amounts of unused funds which they may access in future years, is the same for all participants in a class of employees. In addition, the ability to pay the portion of the premium for individual health insurance coverage that is not covered by the HRA, if any, by using a salary reduction arrangement under section 125 of the Code is considered to be a term of the HRA for purposes of this paragraph (c)(3). Therefore, an HRA is not provided on the same terms unless the salary reduction arrangement, if made available to any participant in a class of employees, is made available on

the same terms to all participants (other than former employees, as defined in paragraph (c)(3)(iv) of this section) in the class of employees. Further, to the extent that a participant in an individual coverage HRA was previously covered by another HRA and the current individual coverage HRA makes available amounts that were not used to reimburse medical care expenses under the prior HRA (transferred amounts), the transferred amounts are disregarded for purposes of determining whether the HRA is offered on the same terms, provided that if the HRA makes available transferred amounts, it does so on the same terms for all participants in the class of employees.

(iii) *Permitted variation.* An HRA does not fail to be provided on the same terms solely because the maximum dollar amount made available to participants in a class of employees to reimburse medical care expenses for any plan year increases in accordance with paragraph (c)(3)(iii)(A) or (B) of this section.

(A) *Variation due to number of dependents.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available to those participants to reimburse medical care expenses for any plan year increases as the number of the participant's dependents who are covered under the HRA increases, so long as the same maximum dollar amount attributable to the increase in family size is made available to all participants in that class of employees with the same number of dependents covered by the HRA.

(B) *Variation due to age.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available under the terms of the HRA to those participants to reimburse medical care expenses for any plan year increases as the age of the participant increases, so long as the requirements in paragraphs (c)(3)(iii)(B)(1) and (2) of this section are satisfied. For the purpose of this paragraph (c)(3)(iii)(B), the plan sponsor may determine the age of the participant using any reasonable method for a plan year, so long as the plan sponsor determines each participant's age for the purpose of this paragraph (c)(3)(iii)(B) using the same method for all participants in the class of employees for the plan year and the method is determined prior to the plan year.

(1) The same maximum dollar amount attributable to the increase in age is

made available to all participants who are the same age.

(2) The maximum dollar amount made available to the oldest participant(s) is not more than three times the maximum dollar amount made available to the youngest participant(s).

(iv) *Former employees.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers the HRA to some, but not all, former employees within a class of employees. However, if a plan sponsor offers the HRA to one or more former employees within a class of employees, the HRA must be offered to the former employee(s) on the same terms as to all other employees within the class, except as provided in paragraph (c)(3)(ii) of this section. For purposes of this section, a former employee is an employee who is no longer performing services for the employer.

(v) *New employees or new dependents.* For a participant whose coverage under the HRA becomes effective later than the first day of the plan year, the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees whose coverage became effective as of the first day of the plan year, or is pro-rated consistent with the portion of the plan year in which the participant is covered by the HRA. Similarly, if the HRA provides for variation in the maximum amount made available to participants in a class of employees based on the number of a participant's dependents covered by the HRA, and the number of a participant's dependents covered by the HRA changes during a plan year (either increasing or decreasing), the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees who had the same number of dependents covered by the HRA on the first day of the plan year or is pro-rated for the remainder of the plan year after the change in the number of the participant's dependents covered by the HRA consistent with the portion of the plan year in which that number of dependents are covered by the HRA. The method the HRA uses to determine amounts made available for participants whose coverage under the HRA is effective later than the first day of the

plan year or who have changes in the number of dependents covered by the HRA during a plan year must be the same for all participants in the class of employees and the method must be determined prior to the beginning of the plan year.

(vi) *HSA-compatible HRAs.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers participants in a class of employees a choice between an HSA-compatible individual coverage HRA and an individual coverage HRA that is not HSA compatible, provided both types of HRAs are offered to all participants in the class of employees on the same terms. For the purpose of this paragraph (c)(3)(vi), an HSA-compatible individual coverage HRA is an individual coverage HRA that is limited in accordance with applicable guidance under section 223 of the Code such that an individual covered by such an HRA is not disqualified from being an eligible individual under section 223 of the Code.

(vii) *Examples.* The following examples illustrate the provisions of this paragraph (c)(3), without taking into account the provisions of paragraph (d) of this section. In each example, the HRA is an individual coverage HRA that has a calendar year plan year and may reimburse any medical care expenses, including premiums for individual health insurance coverage (except as provided in paragraph (c)(3)(vii)(E) of this section (*Example 5*)). Further, in each example, assume the HRA is offered on the same terms, except as otherwise specified in the example and that no participants or dependents are Medicare beneficiaries.

(A) *Example 1: Carryover amounts permitted—(1) Facts.* For 2020 and again for 2021, Plan Sponsor A offers all employees \$7,000 each in an HRA, and the HRA provides that amounts that are unused at the end of a plan year may be carried over to the next plan year, with no restrictions on the use of the carryover amounts compared to the use of newly available amounts. At the end of 2020, some employees have used all of the funds in their HRAs, while other employees have balances remaining that range from \$500 to \$1,750 that are carried over to 2021 for those employees.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(A) (*Example 1*) for 2020 because Plan Sponsor A offers all employees the same amount, \$7,000, in an HRA for that year. The same terms requirement is also satisfied for 2021 because Plan Sponsor A again offers all employees the same amount for that year, and the carryover amounts that some employees have are disregarded in applying the same terms requirement because the amount of the carryover for each employee

(that employee's balance) and each employee's access to the carryover amounts is based on the same terms.

(B) *Example 2: Employees hired after the first day of the plan year—(1) Facts.* For 2020, Plan Sponsor B offers all employees employed on January 1, 2020, \$7,000 each in an HRA for the plan year. Employees hired after January 1, 2020, are eligible to enroll in the HRA with an effective date of the first day of the month following their date of hire, as long as they have enrolled in individual health insurance coverage effective on or before that date, and the amount offered to these employees is pro-rated based on the number of months remaining in the plan year, including the month which includes their coverage effective date.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(B) (*Example 2*) for 2020 because Plan Sponsor B offers all employees employed on the first day of the plan year the same amount, \$7,000, in an HRA for that plan year and all employees hired after January 1, 2020, a pro-rata amount based on the portion of the plan year during which they are enrolled in the HRA.

(C) *Example 3: HRA amounts offered vary based on number of dependents—(1) Facts.* For 2020, Plan Sponsor C offers its employees the following amounts in an HRA: \$1,500, if the employee is the only individual covered by the HRA; \$3,500, if the employee and one dependent are covered by the HRA; and \$5,000, if the employee and more than one dependent are covered by the HRA.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(C) (*Example 3*) because paragraph (c)(3)(iii)(A) of this section allows the maximum dollar amount made available in an HRA to increase as the number of the participant's dependents covered by the HRA increases and Plan Sponsor C makes the same amount available to each employee with the same number of dependents covered by the HRA.

(D) *Example 4: HRA amounts offered vary based on increases in employees' ages—(1) Facts.* For 2020, Plan Sponsor D offers its employees the following amounts in an HRA: \$1,000 each for employees age 25 to 35; \$2,000 each for employees age 36 to 45; \$2,500 each for employees age 46 to 55; and \$4,000 each for employees over age 55.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is not satisfied in this paragraph (c)(3)(vii)(D) (*Example 4*) because the terms of the HRA provide the oldest participants (those over age 55) with more than three times the amount made available to the youngest participants (those ages 25 to 35), in violation of paragraph (c)(3)(iii)(B)(2) of this section.

(E) *Example 5: Application of same terms requirement to premium only HRA—(1) Facts.* For 2020, Plan Sponsor E offers its employees an HRA that reimburses only premiums for individual health insurance coverage, up to \$10,000 for the year. Employee A enrolls in individual health insurance coverage with a \$5,000 premium for the year and is reimbursed \$5,000 from the HRA. Employee B enrolls in individual

health insurance coverage with an \$8,000 premium for the year and is reimbursed \$8,000 from the HRA.

*Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(E) (*Example 5*) because Plan Sponsor E offers the HRA on the same terms to all employees, notwithstanding that some employees receive a greater amount of reimbursement than others based on the cost of the individual health insurance coverage selected by the employee.

(4) *Opt out.* Under the terms of the HRA, a participant who is otherwise eligible for coverage must be permitted to opt out of and waive future reimbursements on behalf of the participant and all dependents eligible for the HRA from the HRA once, and only once, with respect to each plan year. The HRA may establish timeframes for enrollment in (and opting out of) the HRA but, in general, the opportunity to opt out must be provided in advance of the first day of the plan year. For participants who become eligible to participate in the HRA on a date other than the first day of the plan year (or who become eligible fewer than 90 days prior to the plan year or for whom the notice under paragraph (c)(6) of this section is required to be provided as set forth in paragraph (c)(6)(i)(C) of this section), or for a dependent who newly becomes eligible during the plan year, this opportunity must be provided during the applicable HRA enrollment period(s) established by the HRA for these individuals. Further, under the terms of the HRA, upon termination of employment, for a participant who is covered by the HRA, either the remaining amounts in the HRA must be forfeited or the participant must be permitted to permanently opt out of and waive future reimbursements from the HRA on behalf of the participant and all dependents covered by the HRA.

(5) *Reasonable procedures for coverage substantiation—(i) Substantiation of individual health insurance coverage for the plan year.* The HRA must implement, and comply with, reasonable procedures to substantiate that participants and each dependent covered by the HRA are, or will be, enrolled in individual health insurance coverage for the plan year (or for the portion of the plan year the individual is covered by the HRA, if applicable). The HRA may establish the date by which this substantiation must be provided, but, in general, the date may be no later than the first day of the plan year. However, for a participant who is not eligible to participate in the HRA on the first day of the plan year (or who becomes eligible fewer than 90

days prior to the plan year or for whom the notice under paragraph (c)(6) of this section is required to be provided as set forth in paragraph (c)(6)(i)(C) of this section), the HRA may establish the date by which this substantiation must be provided, but that date may be no later than the date the HRA coverage begins. Similarly, for a participant who adds a new dependent during the plan year, the HRA may establish the date by which this substantiation must be provided, but the date may be no later than the date the HRA coverage for the new dependent begins; however, to the extent the dependent's coverage under the HRA is effective retroactively, the HRA may establish a reasonable time by which this substantiation is required, but must require it be provided before the HRA will reimburse any medical care expense for the newly added dependent. The reasonable procedures an HRA may use to implement the substantiation requirement set forth in this paragraph (c)(5)(i) may include a requirement that a participant substantiate enrollment by providing either:

(A) A document from a third party (for example, the issuer or an Exchange) showing that the participant and any dependents covered by the HRA are, or will be, enrolled in individual health insurance coverage (for example, an insurance card or an explanation of benefits document pertaining to the relevant time period or documentation from the Exchange showing that the individual has completed the application and plan selection); or

(B) An attestation by the participant stating that the participant and dependent(s) covered by the HRA are, or will be, enrolled in individual health insurance coverage, the date coverage began or will begin, and the name of the provider of the coverage.

(ii) *Coverage substantiation with each request for reimbursement of medical care expenses.* Following the initial substantiation of coverage, with each new request for reimbursement of an incurred medical care expense for the same plan year, the HRA may not reimburse a participant for any medical care expenses unless, prior to each reimbursement, the participant substantiates that the individual on whose behalf medical care expenses are requested to be reimbursed continues to be enrolled in individual health insurance coverage for the month during which the medical care expenses were incurred. The HRA must implement, and comply with, reasonable procedures to satisfy this requirement. This substantiation may be in the form of a written attestation by the participant,

which may be part of the form used to request reimbursement, or a document from a third party (for example, a health insurance issuer) showing that the participant or the dependent, if applicable, are or were enrolled in individual health insurance coverage for the applicable month.

(iii) *Reliance on substantiation.* For purposes of this paragraph (c)(5), an HRA may rely on the participant's documentation or attestation unless the HRA, its plan sponsor, or any other entity acting in an official capacity on behalf of the HRA has actual knowledge that any individual covered by the HRA is not, or will not be, enrolled in individual health insurance coverage for the plan year (or applicable portion of the plan year) or the month, as applicable.

(6) *Notice requirement—(i) Timing.* The HRA must provide a written notice to each participant:

(A) At least 90 calendar days before the beginning of each plan year for any participant who is not described in either paragraph (c)(6)(i)(B) or (C) of this section;

(B) No later than the date on which the HRA may first take effect for the participant, for any participant who is not eligible to participate at the beginning of the plan year (or is not eligible to participate at the time the notice is provided at least 90 calendar days before the beginning of the plan year pursuant to paragraph (c)(6)(i)(A) of this section); or

(C) No later than the date on which the HRA may first take effect for the participant, for any participant who is employed by an employer that is first established less than 120 days before the beginning of the first plan year of the HRA; this paragraph (c)(6)(i)(C) applies only with respect to the first plan year of the HRA.

(ii) *Content.* The notice must include all the information described in this paragraph (c)(6)(ii) (and may include any additional information that does not conflict with that information). To the extent that the Departments of the Treasury, Labor and Health and Human Services provide model notice language for certain elements of this required notice, HRAs are permitted, but not required, to use the model language.

(A) A description of the terms of the HRA, including the maximum dollar amount available for each participant (including the self-only HRA amount available for the plan year (or the maximum dollar amount available for the plan year if the HRA provides for reimbursements up to a single dollar amount regardless of whether a participant has self-only or other than

self-only coverage)), any rules regarding the proration of the maximum dollar amount applicable to any participant (or dependent, if applicable) who is not eligible to participate in the HRA for the entire plan year, whether (and which of) the participant's dependents are eligible for the HRA, a statement that there are different kinds of HRAs (including a qualified small employer health reimbursement arrangement) and the HRA being offered is an individual coverage HRA, a statement that the HRA requires the participant and any covered dependents to be enrolled in individual health insurance coverage (or Medicare Part A and B or Medicare Part C, if applicable), a statement that the coverage in which the participant and any covered dependents must be enrolled cannot be short-term, limited-duration insurance or consist solely of excepted benefits, if the HRA is subject to the Employee Retirement Income Security Act (ERISA), a statement that individual health insurance coverage in which the participant and any covered dependents are enrolled is not subject to ERISA, if the conditions under 29 CFR 2510.3-1(l) are satisfied, the date as of which coverage under the HRA may first become effective (both for participants whose coverage will become effective on the first day of the plan year and for participants whose HRA coverage may become effective at a later date), the dates on which the HRA plan year begins and ends, and the dates on which the amounts newly made available under the HRA will be made available.

(B) A statement of the right of the participant to opt out of and waive future reimbursements from the HRA, as set forth under paragraph (c)(4) of this section.

(C) A description of the potential availability of the premium tax credit if the participant opts out of and waives future reimbursements from the HRA and the HRA is not affordable for one or more months under 26 CFR 1.36B-2(c)(5), a statement that even if the participant opts out of and waives future reimbursements from an HRA, the offer will prohibit the participant (and, potentially, the participant's dependents) from receiving a premium tax credit for the participant's coverage (or the dependent's coverage, if applicable) on an Exchange for any month that the HRA is affordable under 26 CFR 1.36B-2(c)(5), a statement describing how the participant may find assistance with determining affordability, a statement that, if the participant is a former employee, the offer of the HRA does not render the participant (or the participant's

dependents, if applicable) ineligible for the premium tax credit regardless of whether it is affordable under 26 CFR 1.36B-2(c)(5), and a statement that if the participant or dependent is enrolled in Medicare, he or she is ineligible for the premium tax credit without regard to the offer or acceptance of the HRA;

(D) A statement that if the participant accepts the HRA, the participant may not claim a premium tax credit for the participant's Exchange coverage for any month the HRA may be used to reimburse medical care expenses of the participant, and a premium tax credit may not be claimed for the Exchange coverage of the participant's dependents for any month the HRA may be used to reimburse medical care expenses of the dependents.

(E) A statement that the participant must inform any Exchange to which the participant applies for advance payments of the premium tax credit of the availability of the HRA; the self-only HRA amount available for the HRA plan year (or the maximum dollar amount available for the plan year if the HRA provides for reimbursements up to a single dollar amount regardless of whether a participant has self-only or other than self-only coverage) as set forth in the written notice in accordance with paragraph (c)(6)(ii)(A) of this section; whether the HRA is also available to the participant's dependents and if so, which ones; the date as of which coverage under the HRA may first become effective; the date on which the plan year begins and the date on which it ends; and whether the participant is a current employee or former employee.

(F) A statement that the participant should retain the written notice because it may be needed to determine whether the participant is allowed a premium tax credit on the participant's individual income tax return.

(G) A statement that the HRA may not reimburse any medical care expense unless the substantiation requirement set forth in paragraph (c)(5)(ii) of this section is satisfied and a statement that the participant must also provide the substantiation required by paragraph (c)(5)(i) of this section.

(H) A statement that if the individual health insurance coverage (or coverage under Medicare Part A and B or Medicare Part C) of a participant or dependent ceases, the HRA will not reimburse any medical care expenses that are incurred by the participant or dependent, as applicable, after the coverage ceases, and a statement that the participant must inform the HRA if the participant's or dependent's individual health insurance coverage (or

coverage under Medicare Part A and B or Medicare Part C) is cancelled or terminated retroactively and the date on which the cancellation or termination is effective.

(I) The contact information (including a phone number) for an individual or a group of individuals who participants may contact in order to receive additional information regarding the HRA. The plan sponsor may determine which individual or group of individuals is best suited to be the specified contact.

(J) A statement of availability of a special enrollment period to enroll in or change individual health insurance coverage, through or outside of an Exchange, for the participant and any dependents who newly gain access to the HRA and are not already covered by the HRA.

(d) *Classes of employees*—(1) *In general.* This paragraph (d) sets forth the rules for determining classes of employees. Paragraph (d)(2) of this section sets forth the specific classes of employees; paragraph (d)(3) of this section sets forth a minimum class size requirement that applies in certain circumstances; paragraph (d)(4) of this section sets forth rules regarding the definition of “full-time employees,” “part-time employees,” and “seasonal employees”; paragraph (d)(5) of this section sets forth a special rule for new hires; and paragraph (d)(6) of this section addresses student premium reduction arrangements. For purposes of this section, including determining classes under this paragraph (d), the employer is the common law employer and is determined without regard to the rules under sections 414(b), (c), (m), and (o) of the Code that would treat the common law employer as a single employer with certain other entities.

(2) *List of classes.* Participants may be treated as belonging to a class of employees based on whether they are, or are not, included in the classes described in this paragraph (d)(2). If the individual coverage HRA is offered to former employees, former employees are considered to be in the same class in which they were included immediately before separation from service. Before each plan year, a plan sponsor must determine for the plan year which classes of employees it intends to treat separately and the definition of the relevant class(es) it will apply, to the extent these regulations permit a choice. After the classes and the definitions of the classes are established for a plan year, a plan sponsor may not make changes to the classes of employees or the definitions of those relevant classes with respect to that plan year.

(i) Full-time employees, defined at the election of the plan sponsor to mean either full-time employees under section 4980H of the Code (and 26 CFR 54.4980H-1(a)(21)) or employees who are not part-time employees (as described in 26 CFR 1.105-11(c)(2)(iii)(C));

(ii) Part-time employees, defined at the election of the plan sponsor to mean either employees who are not full-time employees under section 4980H of the Code (and under 26 CFR 54.4980H-1(a)(21) (which defines full-time employee)) or employees who are part-time employees as described in 26 CFR 1.105-11(c)(2)(iii)(C);

(iii) Employees who are paid on a salary basis;

(iv) Non-salaried employees (such as, for example, hourly employees);

(v) Employees whose primary site of employment is in the same rating area as defined in § 147.102(b) of this subchapter;

(vi) Seasonal employees, defined at the election of the plan sponsor to mean seasonal employees as described in either 26 CFR 54.4980H-1(a)(38) or 26 CFR 1.105-11(c)(2)(iii)(C);

(vii) Employees included in a unit of employees covered by a particular collective bargaining agreement (or an appropriate related participation agreement) in which the plan sponsor participates (as described in 26 CFR 1.105-11(c)(2)(iii)(D));

(viii) Employees who have not satisfied a waiting period for coverage (if the waiting period complies with § 147.116 of this subchapter);

(ix) Non-resident aliens with no U.S.-based income (as described in 26 CFR 1.105-11(c)(2)(iii)(E));

(x) Employees who, under all the facts and circumstances, are employees of an entity that hired the employees for temporary placement at an entity that is not the common law employer of the employees and that is not treated as a single employer with the entity that hired the employees for temporary placement under section 414(b), (c), (m), or (o) of the Code; or

(xi) A group of participants described as a combination of two or more of the classes of employees set forth in paragraphs (d)(2)(i) through (x) of this section.

(3) *Minimum class size requirement—*  
(i) *In general.* If a class of employees is subject to the minimum class size requirement as set forth in this paragraph (d)(3), the class must consist of at least a minimum number of employees (as described in paragraphs (d)(3)(iii) and (iv) of this section), otherwise, the plan sponsor may not treat that class as a separate class of

employees. Paragraph (d)(3)(ii) of this section sets forth the circumstances in which the minimum class size requirement applies to a class of employees, paragraph (d)(3)(iii) of this section sets forth the rules for determining the applicable class size minimum, and paragraph (d)(3)(iv) of this section sets forth the rules for a plan sponsor to determine if it satisfies the minimum class size requirement with respect to a class of employees.

(ii) *Circumstances in which minimum class size requirement applies—*(A) The minimum class size requirement applies only if a plan sponsor offers a traditional group health plan to one or more classes of employees and offers an individual coverage HRA to one or more other classes of employees.

(B) The minimum class size requirement does not apply to a class of employees offered a traditional group health plan or a class of employees offered no coverage.

(C) The minimum class size requirement applies to a class of employees offered an individual coverage HRA if the class is full-time employees, part-time employees, salaried employees, non-salaried employees, or employees whose primary site of employment is in the same rating area (described in paragraph (d)(2)(i), (ii), (iii), (iv), or (v) of this section, respectively, and referred to collectively as the applicable classes or individually as an applicable class), except that:

(1) In the case of the class of employees whose primary site of employment is in the same rating area (as described in paragraph (d)(2)(v) of this section), the minimum class size requirement does not apply if the geographic area defining the class is a State or a combination of two or more entire States; and

(2) In the case of the classes of employees that are full-time employees and part-time employees (as described in paragraphs (d)(2)(i) and (ii) of this section, respectively), the minimum class size requirement applies only to those classes (and the classes are only applicable classes) if the employees in one such class are offered a traditional group health plan while the employees in the other such class are offered an individual coverage HRA. In such a case, the minimum class size requirement applies only to the class offered an individual coverage HRA.

(D) A class of employees offered an individual coverage HRA is also subject to the minimum class size requirement if the class is a class of employees created by combining at least one of the applicable classes (as defined in

paragraph (d)(3)(ii)(C) of this section) with any other class, except that the minimum class size requirement shall not apply to a class that is the result of a combination of one of the applicable classes and a class of employees who have not satisfied a waiting period (as described in paragraph (d)(2)(viii) of this section).

(iii) *Determination of the applicable class size minimum—*(A) *In general.* The minimum number of employees that must be in a class of employees that is subject to the minimum class size requirement (the applicable class size minimum) is determined prior to the beginning of the plan year for each plan year of the individual coverage HRA and is:

(1) 10, for an employer with fewer than 100 employees;

(2) A number, rounded down to a whole number, equal to 10 percent of the total number of employees, for an employer with 100 to 200 employees; and

(3) 20, for an employer with more than 200 employees.

(B) *Determining employer size.* For purposes of this paragraph (d)(3), the number of employees of an employer is determined in advance of the plan year of the HRA based on the number of employees that the employer reasonably expects to employ on the first day of the plan year.

(iv) *Determining if a class satisfies the applicable class size minimum.* For purposes of this paragraph (d)(3), whether a class of employees satisfies the applicable class size minimum for a plan year of the individual coverage HRA is based on the number of employees in the class offered the individual coverage HRA as of the first day of the plan year. Therefore, this determination is not based on the number of employees that actually enroll in the individual coverage HRA, and this determination is not affected by changes in the number of employees in the class during the plan year.

(4) *Consistency requirement.* For any plan year, a plan sponsor may define “full-time employee,” “part-time employee,” and “seasonal employee” in accordance with the relevant provisions of sections 105(h) or 4980H of the Code, as set forth in paragraphs (d)(2)(i), (ii), and (vi) of this section, if:

(i) To the extent applicable under the HRA for the plan year, each of the three classes of employees are defined in accordance with section 105(h) of the Code or each of the three classes of employees are defined in accordance with section 4980H of the Code for the plan year; and

(ii) The HRA plan document sets forth the applicable definitions prior to the beginning of the plan year to which the definitions will apply.

(5) *Special rule for new hires*—(i) *In general*. Notwithstanding paragraphs (c)(2) and (3) of this section, a plan sponsor that offers a traditional group health plan to a class of employees may prospectively offer the employees in that class of employees who are hired on or after a certain future date (the new hire date) an individual coverage HRA (with this group of employees referred to as the new hire subclass), while continuing to offer employees in that class of employees who are hired before the new hire date a traditional group health plan (with the rule set forth in this sentence referred to as the special rule for new hires). For the new hire subclass, the individual coverage HRA must be offered on the same terms to all participants within the subclass, in accordance with paragraph (c)(3) of this section. In accordance with paragraph (c)(2) of this section, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any employee in the new hire subclass or to any employee in the class who is not a member of the new hire subclass.

(ii) *New hire date*. A plan sponsor may set the new hire date for a class of employees prospectively as any date on or after January 1, 2020. A plan sponsor may set different new hire dates prospectively for separate classes of employees.

(iii) *Discontinuation of use of special rule for new hires and multiple applications of the special rule for new hires*. A plan sponsor may discontinue use of the special rule for new hires at any time for any class of employees. In that case, the new hire subclass is no longer treated as a separate subclass of employees. In the event a plan sponsor applies the special rule for new hires to a class of employees and later discontinues use of the rule to the class of employees, the plan sponsor may later apply the rule if the application of the rule would be permitted under the rules for initial application of the special rule for new hires. If a plan sponsor, in accordance with the requirements for the special rule for new hires, applies the rule to a class of employees subsequent to any prior application and discontinuance of the rule to that class, the new hire date must be prospective.

(iv) *Application of the minimum class size requirement under the special rule for new hires*. The minimum class size requirement set forth in paragraph (d)(3) of this section does not apply to the new

hire subclass. However, if a plan sponsor subdivides the new hire subclass subsequent to creating the new hire subclass, the minimum class size requirement set forth in paragraph (d)(3) of this section applies to any class of employees created by subdividing the new hire subclass, if the minimum class size requirement otherwise applies.

(6) *Student employees offered student premium reduction arrangements*. For purposes of this section, if an institution of higher education (as defined in the Higher Education Act of 1965) offers a student employee a student premium reduction arrangement, the employee is not considered to be part of the class of employees to which the employee would otherwise belong. For the purpose of this paragraph (d)(6) and paragraph (f)(1) of this section, a student premium reduction arrangement is defined as any program offered by an institution of higher education under which the cost of insured or self-insured student health coverage is reduced for certain students through a credit, offset, reimbursement, stipend or similar arrangement. A student employee offered a student premium reduction arrangement is also not counted for purposes of determining the applicable class size minimum under paragraph (d)(3)(iii) of this section. If a student employee is not offered a student premium reduction arrangement (including if the student employee is offered an individual coverage HRA instead), the student employee is considered to be part of the class of employees to which the employee otherwise belongs and is counted for purposes of determining the applicable class size minimum under paragraph (d)(3)(iii) of this section.

(e) *Integration of Individual Coverage HRAs with Medicare*—(1) *General rule*. An individual coverage HRA will be considered to be integrated with Medicare (and deemed to comply with PHS Act sections 2711 and 2713 and § 147.126(d)(4) of this subchapter), provided that the conditions of paragraph (c) of this section are satisfied, subject to paragraph (e)(2) of this section. Nothing in this section requires that a participant and his or her dependents all have the same type of coverage; therefore, an individual coverage HRA may be integrated with Medicare for some individuals and with individual health insurance coverage for others, including, for example, a participant enrolled in Medicare Part A and B or Part C and his or her dependents enrolled in individual health insurance coverage.

(2) *Application of conditions in paragraph (c) of this section*—(i) *In*

*general*. Except as provided in paragraph (e)(2)(ii) of this section, in applying the conditions of paragraph (c) of this section with respect to integration with Medicare, a reference to “individual health insurance coverage” is deemed to refer to coverage under Medicare Part A and B or Part C. References in this section to integration of an HRA with Medicare refer to integration of an individual coverage HRA with Medicare Part A and B or Part C.

(ii) *Exceptions*. For purposes of the statement regarding ERISA under the notice content element under paragraph (c)(6)(ii)(A) of this section and the statement regarding the availability of a special enrollment period under the notice content element under paragraph (c)(6)(ii)(J) of this section, the term individual health insurance coverage means only individual health insurance coverage and does not also mean coverage under Medicare Part A and B or Part C.

(f) *Examples*—(1) *Examples regarding classes and the minimum class size requirement*. The following examples illustrate the provisions of paragraph (c)(3) of this section, taking into account the provisions of paragraphs (d)(1) through (4) and (d)(6) of this section. In each example, the HRA is an individual coverage HRA that may reimburse any medical care expenses, including premiums for individual health insurance coverage and it is assumed that no participants or dependents are Medicare beneficiaries.

(i) *Example 1: Collectively bargained employees offered traditional group health plan; non-collectively bargained employees offered HRA*—(A) *Facts*. For 2020, Plan Sponsor A offers its employees covered by a collective bargaining agreement a traditional group health plan (as required by the collective bargaining agreement) and all other employees (non-collectively bargained employees) each an HRA on the same terms.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(i) (*Example 1*) because collectively bargained and non-collectively bargained employees may be treated as different classes of employees, one of which may be offered a traditional group health plan and the other of which may be offered an individual coverage HRA, and Plan Sponsor A offers the HRA on the same terms to all participants who are non-collectively bargained employees. The minimum class size requirement does not apply to this paragraph (f)(1)(i) (*Example 1*) even though Plan Sponsor A offers one class the HRA because collectively bargained and non-collectively bargained employees are not applicable classes that are subject to the minimum class size requirement.

(ii) *Example 2: Collectively bargained employees in one unit offered traditional*

group health plan and in another unit offered HRA—(A) *Facts*. For 2020, Plan Sponsor B offers its employees covered by a collective bargaining agreement with Local 100 a traditional group health plan (as required by the collective bargaining agreement), and its employees covered by a collective bargaining agreement with Local 200 each an HRA on the same terms (as required by the collective bargaining agreement).

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(ii) (*Example 2*) because the employees covered by the collective bargaining agreements with the two separate bargaining units (Local 100 and Local 200) may be treated as two different classes of employees and Plan Sponsor B offers an HRA on the same terms to the participants covered by the agreement with Local 200. The minimum class size requirement does not apply to this paragraph (f)(1)(ii) (*Example 2*) even though Plan Sponsor B offers the Local 100 employees a traditional group health plan and the Local 200 employees an HRA because collectively bargained employees are not applicable classes that are subject to the minimum class size requirement.

(iii) *Example 3: Employees in a waiting period offered no coverage; other employees offered an HRA—(A) Facts*. For 2020, Plan Sponsor C offers its employees who have completed a waiting period that complies with the requirements for waiting periods in § 147.116 of this subchapter each an HRA on the same terms and does not offer coverage to its employees who have not completed the waiting period.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(iii) (*Example 3*) because employees who have completed a waiting period and employees who have not completed a waiting period may be treated as different classes and Plan Sponsor C offers the HRA on the same terms to all participants who have completed the waiting period. The minimum class size requirement does not apply to this paragraph (f)(1)(iii) (*Example 3*) because Plan Sponsor C does not offer at least one class of employees a traditional group health plan and because the class of employees who have not completed a waiting period and the class of employees who have completed a waiting period are not applicable classes that are subject to the minimum class size requirement.

(iv) *Example 4: Employees in a waiting period offered an HRA; other employees offered a traditional group health plan—(A) Facts*. For 2020, Plan Sponsor D offers its employees who have completed a waiting period that complies with the requirements for waiting periods in § 147.116 of this subchapter a traditional group health plan and offers its employees who have not completed the waiting period each an HRA on the same terms.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(iv) (*Example 4*) because employees who have completed a waiting period and employees who have not completed a waiting period

may be treated as different classes and Plan Sponsor D offers an HRA on the same terms to all participants who have not completed the waiting period. The minimum class size requirement does not apply to this paragraph (f)(1)(iv) (*Example 4*) even though Plan Sponsor D offers employees who have completed a waiting period a traditional group health plan and employees who have not completed a waiting period an HRA because the class of employees who have not completed a waiting period is not an applicable class that is subject to the minimum class size requirement (nor is the class made up of employees who have completed the waiting period).

(v) *Example 5: Staffing firm employees temporarily placed with customers offered an HRA; other employees offered a traditional group health plan—(A) Facts*. Plan Sponsor E is a staffing firm that places certain of its employees on temporary assignments with customers that are not the common law employers of Plan Sponsor E's employees or treated as a single employer with Plan Sponsor E under section 414(b), (c), (m), or (o) of the Code (unrelated entities); other employees work in Plan Sponsor E's office managing the staffing business (non-temporary employees). For 2020, Plan Sponsor E offers its employees who are on temporary assignments with customers each an HRA on the same terms. All other employees are offered a traditional group health plan.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(v) (*Example 5*) because the employees who are hired for temporary placement at an unrelated entity and non-temporary employees of Plan Sponsor E may be treated as different classes of employees and Plan Sponsor E offers an HRA on the same terms to all participants temporarily placed with customers. The minimum class size requirement does not apply to this paragraph (f)(1)(v) (*Example 5*) even though Plan Sponsor E offers one class a traditional group health plan and one class the HRA because the class of employees hired for temporary placement is not an applicable class that is subject to the minimum class size requirement (nor is the class made up of non-temporary employees).

(vi) *Example 6: Staffing firm employees temporarily placed with customers in rating area 1 offered an HRA; other employees offered a traditional group health plan—(A) Facts*. The facts are the same as in paragraph (f)(1)(v) of this section (*Example 5*), except that Plan Sponsor E has work sites in rating area 1 and rating area 2, and it offers its 10 employees on temporary assignments with a work site in rating area 1 an HRA on the same terms. Plan Sponsor E has 200 other employees in rating areas 1 and 2, including its non-temporary employees in rating areas 1 and 2 and its employees on temporary assignments with a work site in rating area 2, all of whom are offered a traditional group health plan.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(vi) (*Example 6*) because, even though

the employees who are temporarily placed with customers generally may be treated as employees of a different class, because Plan Sponsor E is also using a rating area to identify the class offered the HRA (which is an applicable class for the minimum class size requirement) and is offering one class the HRA and another class the traditional group health plan, the minimum class size requirement applies to the class offered the HRA, and the class offered the HRA fails to satisfy the minimum class size requirement. Because Plan Sponsor E employs 210 employees, the applicable class size minimum is 20, and the HRA is offered to only 10 employees.

(vii) *Example 7: Employees in State 1 offered traditional group health plan; employees in State 2 offered HRA—(A) Facts*. Plan Sponsor F employs 45 employees whose work site is in State 1 and 7 employees whose primary site of employment is in State 2. For 2020, Plan Sponsor F offers its 45 employees in State 1 a traditional group health plan, and each of its 7 employees in State 2 an HRA on the same terms.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(vii) (*Example 7*) because Plan Sponsor F offers the HRA on the same terms to all employees with a work site in State 2 and that class is a permissible class under paragraph (d) of this section. This is because employees whose work sites are in different rating areas may be considered different classes and a plan sponsor may create a class of employees by combining classes of employees, including by combining employees whose work site is in one rating area with employees whose work site is in a different rating area, or by combining all employees whose work site is in a state. The minimum class size requirement does not apply to this paragraph (f)(1)(vii) (*Example 7*) because the minimum class size requirement does not apply if the geographic area defining a class of employees is a state or a combination of two or more entire states.

(viii) *Example 8: Full-time seasonal employees offered HRA; all other full-time employees offered traditional group health plan; part-time employees offered no coverage—(A) Facts*. Plan Sponsor G employs 6 full-time seasonal employees, 75 full-time employees who are not seasonal employees, and 5 part-time employees. For 2020, Plan Sponsor G offers each of its 6 full-time seasonal employees an HRA on the same terms, its 75 full-time employees who are not seasonal employees a traditional group health plan, and offers no coverage to its 5 part-time employees.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(viii) (*Example 8*) because full-time seasonal employees and full-time employees who are not seasonal employees may be considered different classes and Plan Sponsor G offers the HRA on the same terms to all full-time seasonal employees. The minimum class size requirement does not apply to the class offered the HRA in this paragraph (f)(1)(viii) (*Example 8*) because part-time employees are not offered coverage

and full-time employees are not an applicable class subject to the minimum class size requirement if part-time employees are not offered coverage.

(ix) *Example 9: Full-time employees in rating area 1 offered traditional group health plan; full-time employees in rating area 2 offered HRA; part-time employees offered no coverage—(A) Facts.* Plan Sponsor H employs 17 full-time employees and 10 part-time employees whose work site is in rating area 1 and 552 full-time employees whose work site is in rating area 2. For 2020, Plan Sponsor H offers its 17 full-time employees in rating area 1 a traditional group health plan and each of its 552 full-time employees in rating area 2 an HRA on the same terms. Plan Sponsor H offers no coverage to its 10 part-time employees in rating area 1. Plan Sponsor H reasonably expects to employ 569 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(ix) (*Example 9*) because employees whose work sites are in different rating areas may be considered different classes and Plan Sponsor H offers the HRA on the same terms to all full-time employees in rating area 2. The minimum class size requirement applies to the class offered the HRA in this paragraph (f)(1)(ix) (*Example 9*) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. However, the minimum class size requirement applies only to the class offered the HRA, and Plan Sponsor H offers the HRA to the 552 full-time employees in rating area 2 on the first day of the plan year, satisfying the minimum class size requirement (because the applicable class size minimum for Plan Sponsor H is 20).

(x) *Example 10: Employees in rating area 1 offered HRA; employees in rating area 2 offered traditional group health plan—(A) Facts.* The facts are the same as in paragraph (f)(1)(ix) of this section (*Example 9*) except that Plan Sponsor H offers its 17 full-time employees in rating area 1 the HRA and offers its 552 full-time employees in rating area 2 the traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(x) (*Example 10*) because, even though employees whose work sites are in different rating areas generally may be considered different classes and Plan Sponsor H offers the HRA on the same terms to all participants in rating area 1, the HRA fails to satisfy the minimum class size requirement. Specifically, the minimum class size requirement applies to this paragraph (f)(1)(x) (*Example 10*) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. Further, the applicable class size minimum for Plan Sponsor H is 20 employees, and the HRA is only offered to the 17 full-time employees in rating area 1 on the first day of the HRA plan year.

(xi) *Example 11: Employees in State 1 and rating area 1 of State 2 offered HRA;*

*employees in all other rating areas of State 2 offered traditional group health plan—(A) Facts.* For 2020, Plan Sponsor I offers an HRA on the same terms to a total of 200 employees it employs with work sites in State 1 and in rating area 1 of State 2. Plan Sponsor I offers a traditional group health plan to its 150 employees with work sites in other rating areas in State 2. Plan Sponsor I reasonably expects to employ 350 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xi) (*Example 11*). Plan Sponsor I may treat all of the employees with a work site in State 1 and rating area 1 of State 2 as a class of employees because employees whose work sites are in different rating areas may be considered different classes and a plan sponsor may create a class of employees by combining classes of employees, including by combining employees whose work site is in one rating area with a class of employees whose work site is in a different rating area. The minimum class size requirement applies to the class of employees offered the HRA (made up of employees in State 1 and in rating area 1 of State 2) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. In this case, the class is made up of a state plus a rating area which is not the entire state. However, this class satisfies the minimum class size requirement because the applicable class size minimum for Plan Sponsor I is 20, and Plan Sponsor I offered the HRA to 200 employees on the first day of the plan year.

(xii) *Example 12: Salaried employees offered a traditional group health plan; hourly employees offered an HRA—(A) Facts.* Plan Sponsor J has 163 salaried employees and 14 hourly employees. For 2020, Plan Sponsor J offers its 163 salaried employees a traditional group health plan and each of its 14 hourly employees an HRA on the same terms. Plan Sponsor J reasonably expects to employ 177 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xii) (*Example 12*) because, even though salaried and hourly employees generally may be considered different classes and Plan Sponsor J offers the HRA on the same terms to all hourly employees, the HRA fails to satisfy the minimum class size requirement. Specifically, the minimum class size requirement applies in this paragraph (f)(1)(xii) (*Example 12*) because employees who are paid on a salaried basis and employees who are not paid on a salaried basis are applicable classes subject to the minimum class size requirement. Because Plan Sponsor J reasonably expects to employ between 100 and 200 employees on the first day of the plan year, the applicable class size minimum is 10 percent, rounded down to a whole number. Ten percent of 177 total employees, rounded down to a whole number is 17, and the HRA is offered to only 14 hourly employees.

(xiii) *Example 13: Part-time employees and full-time employees offered different HRAs;*

*no traditional group health plan offered—(A) Facts.* Plan Sponsor K has 50 full-time employees and 7 part-time employees. For 2020, Plan Sponsor K offers its 50 full-time employees \$2,000 each in an HRA otherwise provided on the same terms and each of its 7 part-time employees \$500 in an HRA otherwise provided on the same terms. Plan Sponsor K reasonably expects to employ 57 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xiii) (*Example 13*) because full-time employees and part-time employees may be treated as different classes and Plan Sponsor K offers an HRA on the same terms to all the participants in each class. The minimum class size requirement does not apply to either the full-time class or the part-time class because (although in certain circumstances the minimum class size requirement applies to a class of full-time employees and a class of part-time employees) Plan Sponsor K does not offer any class of employees a traditional group health plan, and the minimum class size requirement applies only when, among other things, at least one class of employees is offered a traditional group health plan while another class is offered an HRA.

(xiv) *Example 14: No employees offered an HRA—(A) Facts.* The facts are the same facts as in paragraph (f)(1)(xiii) of this section (*Example 13*), except that Plan Sponsor K offers its full-time employees a traditional group health plan and does not offer any group health plan (either a traditional group health plan or an HRA) to its part-time employees.

(B) *Conclusion.* The regulations set forth under this section do not apply to Plan Sponsor K because Plan Sponsor K does not offer an individual coverage HRA to any employee.

(xv) *Example 15: Full-time employees offered traditional group health plan; part-time employees offered HRA—(A) Facts.* The facts are the same as in paragraph (f)(1)(xiii) of this section (*Example 13*), except that Plan Sponsor K offers its full-time employees a traditional group health plan and offers each of its part-time employees \$500 in an HRA and otherwise on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xv) (*Example 15*) because, even though the full-time employees and the part-time employees generally may be treated as different classes, in this paragraph (f)(1)(xv) (*Example 15*), the minimum class size requirement applies to the part-time employees, and it is not satisfied. Specifically, the minimum class size requirement applies to the part-time employees because that requirement applies to an applicable class offered an HRA when one class is offered a traditional group health plan while another class is offered an HRA, and to the part-time and full-time employee classes when one of those classes is offered a traditional group health plan while the other is offered an HRA. Because Plan Sponsor K reasonably expects to employ

fewer than 100 employees on the first day of the HRA plan year, the applicable class size minimum for Plan Sponsor K is 10 employees, but Plan Sponsor K offered the HRA only to its 7 part-time employees.

(xvi) *Example 16: Satisfying minimum class size requirement based on employees offered HRA—(A) Facts.* Plan Sponsor L employs 78 full-time employees and 12 part-time employees. For 2020, Plan Sponsor L offers its 78 full-time employees a traditional group health plan and each of its 12 part-time employees an HRA on the same terms. Only 6 part-time employees enroll in the HRA. Plan Sponsor L reasonably expects to employ fewer than 100 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xvi) (*Example 16*) because full-time employees and part-time employees may be treated as different classes, Plan Sponsor L offers an HRA on the same terms to all the participants in the part-time class, and the minimum class size requirement is satisfied. Specifically, whether a class of employees satisfies the applicable class size minimum is determined as of the first day of the plan year based on the number of employees in a class that is offered an HRA, not on the number of employees who enroll in the HRA. The applicable class size minimum for Plan Sponsor L is 10 employees, and Plan Sponsor L offered the HRA to its 12 part-time employees.

(xvii) *Example 17: Student employees offered student premium reduction arrangements and same terms requirement—(A) Facts.* Plan Sponsor M is an institution of higher education that offers each of its part-time employees an HRA on the same terms, except that it offers its part-time employees who are student employees a student premium reduction arrangement, and the student premium reduction arrangement provides different amounts to different part-time student employees.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xvii) (*Example 17*) because Plan Sponsor M offers the HRA on the same terms to its part-time employees who are not students and because the part-time student employees offered a student premium reduction arrangement (and their varying HRAs) are not taken into account as part-time employees for purposes of determining whether a class of employees is offered an HRA on the same terms.

(xiii) *Example 18: Student employees offered student premium reduction arrangements and minimum class size requirement—(A) Facts.* Plan Sponsor N is an institution of higher education with 25 hourly employees. Plan Sponsor N offers 15 of its hourly employees, who are student employees, a student premium reduction arrangement and it wants to offer its other 10 hourly employees an HRA for 2022. Plan Sponsor N offers its salaried employees a traditional group health plan. Plan Sponsor N reasonably expects to have 250 employees on the first day of the 2022 HRA plan year, 15 of which will have offers of student premium reduction arrangements.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xviii) (*Example 18*). The minimum class size requirement will apply to the class of hourly employees to which Plan Sponsor N wants to offer the HRA because Plan Sponsor N offers a class of employees a traditional group health plan and another class the HRA, and the minimum class size requirement generally applies to a class of hourly employees offered an HRA. Plan Sponsor N's applicable class size minimum is 20 because Plan Sponsor N reasonably expects to employ 235 employees on the first day of the plan year (250 employees minus 15 employees receiving a student premium reduction arrangement). Plan Sponsor N may not offer the HRA to its hourly employees because the 10 employees offered the HRA as of the first day of the plan year does not satisfy the applicable class size minimum.

(2) *Examples regarding special rule for new hires.* The following examples illustrate the provisions of paragraph (c)(3) of this section, taking into account the provisions of paragraph (d) of this section, in particular the special rule for new hires under paragraph (d)(5) of this section. In each example, the HRA is an individual coverage HRA that has a calendar year plan year and may reimburse any medical care expenses, including premiums for individual health insurance coverage. The examples also assume that no participants or dependents are Medicare beneficiaries.

(i) *Example 1: Application of special rule for new hires to all employees—(A) Facts.* For 2021, Plan Sponsor A offers all employees a traditional group health plan. For 2022, Plan Sponsor A offers all employees hired on or after January 1, 2022, an HRA on the same terms and continues to offer the traditional group health plan to employees hired before that date. On the first day of the 2022 plan year, Plan Sponsor A has 2 new hires who are offered the HRA.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(i) (*Example 1*) because, under the special rule for new hires in paragraph (d)(5) of this section, the employees newly hired on and after January 1, 2022, may be treated as a new hire subclass. Plan Sponsor A offers the HRA on the same terms to all participants in the new hire subclass, and the minimum class size requirement does not apply to the new hire subclass.

(ii) *Example 2: Application of special rule for new hires to full-time employees—(A) Facts.* For 2021, Plan Sponsor B offers a traditional group health plan to its full-time employees and does not offer any coverage to its part-time employees. For 2022, Plan Sponsor B offers full-time employees hired on or after January 1, 2022, an HRA on the same terms, continues to offer its full-time employees hired before that date a traditional group health plan, and continues to offer no coverage to its part-time employees. On the first day of the 2022 plan year, Plan Sponsor

B has 2 new hire, full-time employees who are offered the HRA.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(ii) (*Example 2*) because, under the special rule for new hires in paragraph (d)(5) of this section, the full-time employees newly hired on and after January 1, 2022, may be treated as a new hire subclass and Plan Sponsor B offers the HRA on the same terms to all participants in the new hire subclass. The minimum class size requirement does not apply to the new hire subclass.

(iii) *Example 3: Special rule for new hires impermissibly applied retroactively—(A) Facts.* For 2025, Plan Sponsor C offers a traditional group health plan to its full-time employees. For 2026, Plan Sponsor C wants to offer an HRA to its full-time employees hired on and after January 1, 2023, while continuing to offer a traditional group health plan to its full-time employees hired before January 1, 2023.

(B) *Conclusion.* The special rule for new hires under paragraph (d)(5) of this section does not apply in this paragraph (f)(2)(iii) (*Example 3*) because the rule must be applied prospectively. That is, Plan Sponsor C may not, in 2026, choose to apply the special rule for new hires retroactive to 2023. If Plan Sponsor C were to offer an HRA in this way, it would fail to satisfy the conditions under paragraphs (c)(2) and (3) of this section because the new hire subclass would not be treated as a subclass for purposes of applying those rules and, therefore, all full-time employees would be treated as one class to which either a traditional group health plan or an HRA could be offered, but not both.

(iv) *Example 4: Permissible second application of the special rule for new hires to the same class of employees—(A) Facts.* For 2021, Plan Sponsor D offers all of its full-time employees a traditional group health plan. For 2022, Plan Sponsor D applies the special rule for new hires and offers an HRA on the same terms to all employees hired on and after January 1, 2022, and continues to offer a traditional group health plan to full-time employees hired before that date. For 2025, Plan Sponsor D discontinues use of the special rule for new hires, and again offers all full-time employees a traditional group health plan. In 2030, Plan Sponsor D decides to apply the special rule for new hires to the full-time employee class again, offering an HRA to all full-time employees hired on and after January 1, 2030, on the same terms, while continuing to offer employees hired before that date a traditional group health plan.

(B) *Conclusion.* Plan Sponsor D has permissibly applied the special rule for new hires and is in compliance with the requirements of paragraphs (c)(2) and (3) of this section.

(v) *Example 5: Impermissible second application of the special rule for new hires to the same class of employees—(A) Facts.* The facts are the same as in paragraph (f)(2)(iv) of this section (*Example 4*), except that for 2025, Plan Sponsor D discontinues use of the special rule for new hires by offering all full-time employees an HRA on the same terms. Further, for 2030, Plan

Sponsor D wants to continue to offer an HRA on the same terms to all full-time employees hired before January 1, 2030, and to offer all full-time employees hired on or after January 1, 2030, an HRA in a different amount.

(B) *Conclusion.* Plan Sponsor D may not apply the special rule for new hires for 2030 to the class of full-time employees being offered an HRA because the special rule for new hires may only be applied to a class that is being offered a traditional group health plan.

(vi) *Example 6: New full-time employees offered different HRAs in different rating areas—(A) Facts.* Plan Sponsor E has work sites in rating area 1, rating area 2, and rating area 3. For 2021, Plan Sponsor E offers its full-time employees a traditional group health plan. For 2022, Plan Sponsor E offers its full-time employees hired on or after January 1, 2022, in rating area 1 an HRA of \$3,000, its full-time employees hired on or after January 1, 2022, in rating area 2 an HRA of \$5,000, and its full-time employees hired on or after January 1, 2022, in rating area 3 an HRA of \$7,000. Within each class offered an HRA, Plan Sponsor E offers the HRA on the same terms. Plan Sponsor E offers its full-time employees hired prior to January 1, 2022, in each of those classes a traditional group health plan. On the first day of the 2022 plan year, there is one new hire, full-time employee in rating area 1, three new hire, full-time employees in rating area 2, and 10 new hire-full-time employees in rating area 3.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(vi) (*Example 6*) because, under the special rule for new hires in paragraph (d)(5) of this section, the full-time employees in each of the three rating areas newly hired on and after January 1, 2022, may be treated as three new hire subclasses and Plan Sponsor E offers the HRA on the same terms to all participants in the new hire subclasses. Further, the minimum class size requirement does not apply to the new hire subclasses.

(vii) *Example 7: New full-time employee class subdivided based on rating area—(A) Facts.* Plan Sponsor F offers its full-time employees hired on or after January 1, 2022, an HRA on the same terms and it continues to offer its full-time employees hired before that date a traditional group health plan. Plan Sponsor F offers no coverage to its part-time employees. For the 2025 plan year, Plan Sponsor F wants to subdivide the full-time new hire subclass so that those whose work site is in rating area 1 will be offered the traditional group health plan and those whose work site is in rating area 2 will continue to receive the HRA. Plan Sponsor F reasonably expects to employ 219 employees on January 1, 2025. As of January 1, 2025, Plan Sponsor F has 15 full-time employees whose work site is in rating area 2 and who were hired between January 1, 2022, and January 1, 2025.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(2)(vii) (*Example 7*) because the new hire subclass has been subdivided in a manner that is subject to the minimum class size

requirement, and the class offered the HRA fails to satisfy the minimum class size requirement. Specifically, once the new hire subclass is subdivided the general rules for applying the minimum class size requirement apply to the employees offered the HRA in the new hire subclass. In this case, because the subdivision of the new hire full-time subclass is based on rating areas; a class based on rating areas is an applicable class subject to the minimum class size requirement; and the employees in one rating area are to be offered the HRA, while the employees in the other rating area are offered the traditional group health plan, the minimum class size requirement would apply on and after the date of the subdivision. Further, the minimum class size requirement would not be satisfied, because the applicable class size minimum for Plan Sponsor F would be 20, and only 15 employees in rating area 2 would be offered the HRA.

(viii) *Example 8: New full-time employee class subdivided based on state—(A) Facts.* The facts are the same as in paragraph (f)(2)(vii) of this section (*Example 7*), except that for the 2025 plan year, Plan Sponsor F intends to subdivide the new hire, full-time class so that those in State 1 will be offered the traditional group health plan and those in State 2 will each be offered an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(viii) (*Example 8*) because even though the new hire subclass has been subdivided, it has been subdivided in a manner that is not subject to the minimum class size requirement as the subdivision is based on the entire state.

(ix) *Example 9: New full-time employees and part-time employees offered HRA—(A) Facts.* In 2021, Plan Sponsor G offers its full-time employees a traditional group health plan and does not offer coverage to its part-time employees. For the 2022 plan year, Plan Sponsor G offers its full-time employees hired on or after January 1, 2022, and all of its part-time employees, including those hired before January 1, 2022, and those hired on and after January 1, 2022, an HRA on the same terms, and it continues to offer its full-time employees hired before January 1, 2022, a traditional group health plan.

(B) *Conclusion.* The minimum class size requirement applies to the part-time employees offered the HRA in 2022 because the class is being offered an HRA; the special rule for new hires does not apply (because this class was not previously offered a traditional group health plan) and so it is not a new hire subclass exempt from the minimum class size requirement; another class of employees (that is, full-time hired before January 1, 2022) are being offered a traditional group health plan; and the part-time employee class is generally an applicable classes that is subject to the minimum class size requirement. However, because the full-time, new hire subclass is based on the special rule for new hires, the minimum class size requirement does not apply to full-time new hires offered an HRA in 2022.

(g) *Applicability date.* This section applies to plan years beginning on or after January 1, 2020.

■ 20. Section 146.145 is amended by revising paragraph (b)(3)(i) and adding paragraph (b)(3)(viii) to read as follows:

**§ 146.145 Special rules relating to group health plans.**

\* \* \* \* \*

(b) \* \* \*

(3) \* \* \*

(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (b)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement (health FSA) are excepted benefits if they satisfy the requirements of paragraph (b)(3)(v) of this section; benefits provided under an employee assistance program are excepted benefits if they satisfy the requirements of paragraph (b)(3)(vi) of this section; benefits provided under limited wraparound coverage are excepted benefits if they satisfy the requirements of paragraph (b)(3)(vii) of this section; and benefits provided under a health reimbursement arrangement or other account-based group health plan, other than a health FSA, are excepted benefits if they satisfy the requirements of paragraph (b)(3)(viii) of this section.

\* \* \* \* \*

(viii) *Health reimbursement arrangements (HRAs) and other account-based group health plans.* Benefits provided under an HRA or other account-based group health plan, other than a health FSA, are excepted if they satisfy all of the requirements of this paragraph (b)(3)(viii). See paragraph (b)(3)(v) of this section for the circumstances in which benefits provided under a health FSA are excepted benefits. For purposes of this paragraph (b)(3)(viii), the term “HRA or other account-based group health plan” has the same meaning as “account-based group health plan” set forth in § 147.126(d)(6)(i) of this subchapter, except that the term does not include health FSAs. For ease of reference, an HRA or other account-based group health plan that satisfies the requirements of this paragraph (b)(3)(viii) is referred to as an excepted benefit HRA.

(A) *Otherwise not an integral part of the plan.* 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 must

be made available by the same plan sponsor for the plan year to the participant.

(B) *Benefits are limited in amount—*  
(1) *Limit on annual amounts made available.* The amounts newly made available for each plan year under the HRA or other account-based group health plan do not exceed \$1,800. In the case of any plan year beginning after December 31, 2020, the dollar amount in the preceding sentence shall be increased by an amount equal to such dollar amount multiplied by the cost-of-living adjustment. The cost of living adjustment is the percentage (if any) by which the C–CPI–U for the preceding calendar year exceeds the C–CPI–U for calendar year 2019. The term “C–CPI–U” means the Chained Consumer Price Index for All Urban Consumers as published by the Bureau of Labor Statistics of the Department of Labor. The C–CPI–U for any calendar year is the average of the C–CPI–U as of the close of the 12-month period ending on March 31 of such calendar year. The values of the C–CPI–U used for any calendar year shall be the latest values so published as of the date on which the Bureau publishes the initial value of the C–CPI–U for the month of March for the preceding calendar year. Any such increase that is not a multiple of \$50 shall be rounded down to the next lowest multiple of \$50. The Department of the Treasury and the Internal Revenue Service will publish the adjusted amount for plan years beginning in any calendar year no later than June 1 of the preceding calendar year.

(2) *Carryover amounts.* If the terms of the HRA or other account-based group health plan allow unused amounts to be made available to participants and dependents in later plan years, such carryover amounts are disregarded for purposes of determining whether benefits are limited in amount.

(3) *Multiple HRAs or other account-based group health plans.* 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 to determine whether the benefits are limited in amount, except that HRAs or other account-based group health plans that reimburse only excepted benefits are not included in determining whether the benefits are limited in amount.

(C) *Prohibition on reimbursement of certain health insurance premiums.* The HRA or other account-based group health plan must not reimburse premiums for individual health

insurance coverage, group health plan coverage (other than COBRA continuation coverage or other continuation coverage), or Medicare Part A, B, C, or D, except that the HRA or other account-based group health plan may reimburse premiums for such coverage that consists solely of excepted benefits. See also, paragraph (b)(3)(viii)(F) of this section.

(D) *Uniform availability.* The HRA or other account-based group health plan is made available under the same terms to all similarly situated individuals, as defined in § 146.121(d), regardless of any health factor (as described in § 146.121(a)).

(E) [Reserved]

(F) *Special rule.* The HRA or other account-based group health plan must not reimburse premiums for short-term, limited-duration insurance (as defined in § 144.103 of this subchapter) if the conditions of this paragraph (b)(3)(viii)(F) are satisfied.

(1) The HRA or other account-based group health plan is offered by a small employer (as defined in PHS Act section 2791(e)(4)).

(2) The other group health plan coverage offered by the employer pursuant to paragraph (b)(3)(viii)(A) of this section is either fully-insured or partially-insured.

(3) The Secretary makes a finding, in consultation with the Secretaries of Labor and the Treasury, that the reimbursement of premiums for short-term, limited-duration insurance by excepted benefit HRAs has caused significant harm to the small group market in the state that is the principal place of business of the small employer.

(4) The finding by the Secretary is made after submission of a written recommendation by the applicable state authority of such state, in a form and manner specified by HHS. The written recommendation must include evidence that the reimbursement of premiums for short-term, limited-duration insurance by excepted benefit HRAs established by insured or partially-insured small employers in the state has caused significant harm to the state’s small group market, including with respect to premiums.

(5) The restriction shall be imposed or discontinued by publication by the Secretary of a notice in the **Federal Register** and shall apply only prospectively and with a reasonable time for plan sponsors to comply.

\* \* \* \* \*

## PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

■ 21. The authority citation for part 147 is revised to read as follows:

**Authority:** 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92, as amended.

■ 22. Section 147.126 is amended by revising paragraphs (c), (d), and (e) to read as follows:

### § 147.126 No Lifetime or annual limits.

\* \* \* \* \*

(c) *Definition of essential health benefits.* The term “essential health benefits” means essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. For the purpose of this section, a group health plan or a health insurance issuer that is not required to provide essential health benefits under section 1302(b) must define “essential health benefits” in a manner that is consistent with the following:

(1) For plan years beginning before January 1, 2020, one of the EHB-benchmark plans applicable in a State under § 156.110 of this subchapter, and including coverage of any additional required benefits that are considered essential health benefits consistent with § 155.170(a)(2) of this subchapter, or one of the three Federal Employees Health Benefits Program (FEHBP) plan options as defined by § 156.100(a)(3) of this subchapter, supplemented as necessary, to satisfy the standards in § 156.110 of this subchapter; or

(2) For plan years beginning on or after January 1, 2020, an EHB-benchmark plan selected by a State in accordance with the available options and requirements for EHB-benchmark plan selection at § 156.111 of this subchapter, including an EHB-benchmark plan in a State that takes no action to change its EHB-benchmark plan and thus retains the EHB-benchmark plan applicable in that State for the prior year in accordance with § 156.111(d)(1) of this subchapter, and including coverage of any additional required benefits that are considered essential health benefits consistent with § 155.170(a)(2) of this subchapter.

(d) *Health reimbursement arrangements (HRAs) and other account-based group health plans—*(1) *In general.* If an HRA or other account-based group health plan is integrated with another group health plan or individual health insurance coverage and the other group health plan or individual health insurance coverage, as

applicable, separately is subject to and satisfies the requirements in PHS Act section 2711 and paragraph (a)(2) of this section, the fact that the benefits under the HRA or other account-based group health plan are limited does not cause the HRA or other account-based group health plan to fail to satisfy the requirements of PHS Act section 2711 and paragraph (a)(2) of this section. Similarly, if an HRA or other account-based group health plan is integrated with another group health plan or individual health insurance coverage and the other group health plan or individual health insurance coverage, as applicable, separately is subject to and satisfies the requirements in PHS Act section 2713 and § 147.130(a)(1) of this subchapter, the fact that the benefits under the HRA or other account-based group health plan are limited does not cause the HRA or other account-based group health plan to fail to satisfy the requirements of PHS Act section 2713 and § 147.130(a)(1) of this subchapter. For the purpose of this paragraph (d), all individual health insurance coverage, except for coverage that consists solely of excepted benefits, is treated as being subject to and complying with PHS Act sections 2711 and 2713.

(2) *Requirements for an HRA or other account-based group health plan to be integrated with another group health plan.* An HRA or other account-based group health plan is integrated with another group health plan for purposes of PHS Act section 2711 and paragraph (a)(2) of this section if it satisfies the requirements under one of the integration methods set forth in paragraph (d)(2)(i) or (ii) of this section. For purposes of the integration methods under which an HRA or other account-based group health plan is integrated with another group health plan, integration does not require that the HRA or other account-based group health plan and the other group health plan with which it is integrated share the same plan sponsor, the same plan document or governing instruments, or file a single Form 5500, if applicable. An HRA or other account-based group health plan integrated with another group health plan for purposes of PHS Act section 2711 and paragraph (a)(2) of this section may not be used to purchase individual health insurance coverage unless that coverage consists solely of excepted benefits, as defined in § 148.220 of this subchapter.

(i) *Method for integration with a group health plan: Minimum value not required.* An HRA or other account-based group health plan is integrated with another group health plan for purposes of this paragraph (d) if:

(A) The plan sponsor offers a group health plan (other than the HRA or other account-based group health plan) to the employee that does not consist solely of excepted benefits;

(B) The employee receiving the HRA or other account-based group health plan is actually enrolled in a group health plan (other than the HRA or other account-based group health plan) that does not consist solely of excepted benefits, regardless of whether the plan is offered by the same plan sponsor (referred to as non-HRA group coverage);

(C) The HRA or other account-based group health plan is available only to employees who are enrolled in non-HRA group coverage, regardless of whether the non-HRA group coverage is offered by the plan sponsor of the HRA or other account-based group health plan (for example, the HRA may be offered only to employees who do not enroll in an employer's group health plan but are enrolled in other non-HRA group coverage, such as a group health plan maintained by the employer of the employee's spouse);

(D) The benefits under the HRA or other account-based group health plan are limited to reimbursement of one or more of the following—co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care expenses that do not constitute essential health benefits as defined in paragraph (c) of this section; and

(E) Under the terms of the HRA or other account-based group health plan, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan at least annually and, upon termination of employment, either the remaining amounts in the HRA or other account-based group health plan are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan (see paragraph (d)(3) of this section for additional rules regarding forfeiture and waiver).

(ii) *Method for integration with another group health plan: Minimum value required.* An HRA or other account-based group health plan is integrated with another group health plan for purposes of this paragraph (d) if:

(A) The plan sponsor offers a group health plan (other than the HRA or other account-based group health plan) to the employee that provides minimum value pursuant to section 36B(c)(2)(C)(ii) of

the Code (and its implementing regulations and applicable guidance);

(B) The employee receiving the HRA or other account-based group health plan is actually enrolled in a group health plan (other than the HRA or other account-based group health plan) that provides minimum value pursuant to section 36B(c)(2)(C)(ii) of the Code (and applicable guidance), regardless of whether the plan is offered by the plan sponsor of the HRA or other account-based group health plan (referred to as non-HRA MV group coverage);

(C) The HRA or other account-based group health plan is available only to employees who are actually enrolled in non-HRA MV group coverage, regardless of whether the non-HRA MV group coverage is offered by the plan sponsor of the HRA or other account-based group health plan (for example, the HRA may be offered only to employees who do not enroll in an employer's group health plan but are enrolled in other non-HRA MV group coverage, such as a group health plan maintained by an employer of the employee's spouse); and

(D) Under the terms of the HRA or other account-based group health plan, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan at least annually, and, upon termination of employment, either the remaining amounts in the HRA or other account-based group health plan are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan (see paragraph (d)(3) of this section for additional rules regarding forfeiture and waiver).

(3) *Forfeiture.* For purposes of integration under paragraphs (d)(2)(i)(E) and (d)(2)(ii)(D) of this section, forfeiture or waiver occurs even if the forfeited or waived amounts may be reinstated upon a fixed date, a participant's death, or the earlier of the two events (the reinstatement event). For the purpose of this paragraph (d)(3), coverage under an HRA or other account-based group health plan is considered forfeited or waived prior to a reinstatement event only if the participant's election to forfeit or waive is irrevocable, meaning that, beginning on the effective date of the election and through the date of the reinstatement event, the participant and the participant's beneficiaries have no access to amounts credited to the HRA or other account-based group health plan. This means that upon and after reinstatement, the reinstated amounts

under the HRA or other account-based group health plan may not be used to reimburse or pay medical care expenses incurred during the period after forfeiture and prior to reinstatement.

(4) Requirements for an HRA or other account-based group health plan to be integrated with individual health insurance coverage or Medicare Part A and B or Medicare Part C. An HRA or other account-based group health plan is integrated with individual health insurance coverage or Medicare Part A and B or Medicare Part C (and treated as complying with PHS Act sections 2711 and 2713) if the HRA or other account-based group health plan satisfies the requirements of § 146.123(c) of this subchapter (as modified by § 146.123(e), for HRAs or other account-based group health plans integrated with Medicare Part A and B or Medicare Part C).

(5) Integration with Medicare Part B and D. For employers that are not required to offer their non-HRA group health plan coverage to employees who are Medicare beneficiaries, an HRA or other account-based group health plan that may be used to reimburse premiums under Medicare Part B or D may be integrated with Medicare (and deemed to comply with PHS Act sections 2711 and 2713) if the following requirements are satisfied with respect to employees who would be eligible for the employer's non-HRA group health plan but for their eligibility for Medicare (and the integration rules under paragraphs (d)(2)(i) and (ii) of this section continue to apply to employees who are not eligible for Medicare):

(i) The plan sponsor offers a group health plan (other than the HRA or other account-based group health plan and that does not consist solely of excepted benefits) to employees who are not eligible for Medicare;

(ii) The employee receiving the HRA or other account-based group health plan is actually enrolled in Medicare Part B or D;

(iii) The HRA or other account-based group health plan is available only to employees who are enrolled in Medicare Part B or D; and

(iv) The HRA or other account-based group health plan complies with paragraphs (d)(2)(i)(E) and (d)(2)(ii)(D) of this section.

(6) Definitions. The following definitions apply for purposes of this section.

(i) Account-based group health plan. An account-based group health plan is 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. An HRA is a type of account-based group health plan. An account-based group health plan does not include a qualified small employer health reimbursement arrangement, as defined in section 9831(d)(2) of the Code.

(ii) Medical care expenses. Medical care expenses means expenses for medical care as defined under section 213(d) of the Code.

(e) Applicability date. The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning on or after January 1, 2020. Until the applicability date for this section, plans and issuers are required to continue to comply with the corresponding sections of this subchapter B, contained in the 45 CFR, subtitle A, parts 1–199, revised as of October 1, 2018.

**PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT**

■ 23. The authority citation for part 155 is revised to read as follows:

**Authority:** 42 U.S.C. 18021–18024, 18031–18033, 18041–18042, 18051, 18054, 18071, and 18081–18083.

■ 24. Section 155.420 is amended

■ a. By revising paragraph (a)(4)(iii) introductory text;

■ b. By adding paragraph (b)(2)(vi);

■ c. By redesignating paragraph (c)(3) as paragraph (c)(4); By adding a new paragraph (c)(3);

■ d. In paragraph (d)(12) by removing “; or” and adding “;” in its place;

■ e. In paragraph (d)(13) by removing the period at the end of the paragraph and adding “; or” in its place; and

■ f. By adding paragraph (d)(14).

The revisions and additions read as follows:

**§ 155.420 Special enrollment periods.**

\* \* \* \* \*

(a) \* \* \*

(4) \* \* \*

(iii) For the other triggering events specified in paragraph (d) of this section, except for paragraphs (d)(2)(i), (d)(4), and (d)(6)(i) and (ii) of this section for becoming newly eligible for cost-sharing reductions, and paragraphs (d)(8), (9), (10), (12), and (14) of this section:

\* \* \* \* \*

(b) \* \* \*

(2) \* \* \*

(vi) If a qualified individual, enrollee, or dependent newly gains access to an individual coverage HRA or is newly provided a QSEHRA, each as described in paragraph (d)(14) of this section, and

if the plan selection is made before the day of the triggering event, the Exchange must ensure that coverage is effective on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the triggering event. If the plan selection is made on or after the day of the triggering event, the Exchange must ensure that coverage is effective on the first day of the month following plan selection.

\* \* \* \* \*

(c) \* \* \*

(3) Advanced availability for individuals with an individual coverage HRA or QSEHRA. A qualified individual, enrollee, or his or her dependent who is described in paragraph (d)(14) of this section has 60 days before the triggering event to select a QHP, unless the HRA or QSEHRA was not required to provide the notice setting forth its terms to such individual or enrollee at least 90 days before the beginning of the plan year, as specified in 45 CFR 146.123(c)(6), 26 CFR 54.9802–4(c)(6), and 29 CFR 2590.702–2(c)(6) or section 9831(d)(4) of the Internal Revenue Code, as applicable, in which case the qualified individual, enrollee, or his or her dependent has 60 days before or after the triggering event to select a QHP.

\* \* \* \* \*

(d) \* \* \*

(14) The qualified individual, enrollee, or dependent newly gains access to an individual coverage HRA (as defined in 45 CFR 146.123(b)) or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code). The triggering event is the first day on which coverage for the qualified individual, enrollee, or dependent under the individual coverage HRA can take effect, or the first day on which coverage under the QSEHRA takes effect. An individual, enrollee, or dependent will qualify for this special enrollment period regardless of whether they were previously offered or enrolled in an individual coverage HRA or previously provided a QSEHRA, so long as the individual, enrollee, or dependent is not enrolled in the individual coverage HRA or covered by the QSEHRA on the day immediately prior to the triggering event.

\* \* \* \* \*