

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

[REG–136724–17]

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–P]

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:** Notice of proposed rulemaking.

**SUMMARY:** This document sets forth proposed rules to expand opportunities for working men and women and their families to access affordable, quality healthcare through proposed changes to regulations 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. (For simplicity, this preamble generally refers only to HRAs, but references to HRAs should also be considered to include other account-based group health plans, unless indicated otherwise.) Specifically, these proposed rules allow integrating HRAs with individual health insurance coverage, if certain conditions are met. The proposed rules also set forth conditions under which certain HRAs would be recognized as limited excepted benefits. Also, the Department of the Treasury (Treasury Department) and the Internal Revenue Service (IRS) propose rules regarding premium tax credit (PTC) eligibility for individuals offered coverage under an HRA integrated with individual health

insurance coverage. In addition, the Department of Labor (DOL) proposes a clarification to provide plan sponsors with assurance that the individual health insurance coverage the premiums of which are reimbursed by an HRA or a qualified small employer health reimbursement arrangement (QSEHRA) does not become part of an ERISA plan, provided certain conditions are met. Finally, the Department of Health and Human Services (HHS) proposes rules that would provide a special enrollment period in the individual market for individuals who gain access to an HRA integrated with individual health insurance coverage or who are provided a QSEHRA. The goal of these proposed rules is to expand the flexibility and use of HRAs to provide more Americans with additional options to obtain quality, affordable healthcare. The proposed rules would 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:** Comments are due on or before December 28, 2018.

**ADDRESSES:** Written comments may be submitted to the addresses specified below. Any comment that is submitted will be shared with the DOL and HHS. Please do not submit duplicates.

All comments will be made available to the public. Warning: Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments are posted on the internet exactly as received, and can be retrieved by most internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records. Comments may be submitted anonymously.

Comments, identified by REG–136724–17, may be submitted by one of the following methods:

*Federal eRulemaking Portal:* <http://www.regulations.gov>. Follow the instructions for submitting comments.

*Mail:* CC:PA:LPD:PR (REG–136724–17), Room 5205, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044.

*Hand or courier delivery:* Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (REG–136724–17), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue NW, Washington, DC 20224.

Comments received will be posted without change to [www.regulations.gov](http://www.regulations.gov) and available for public inspection.

*Inspection of Public Comments:* All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable information that is included in a comment. All comments received before the close of the comment period will be posted on the following website as soon as possible after they have been received: <https://www.regulations.gov>. Follow the search instructions on that website to view public comments.

**FOR FURTHER INFORMATION CONTACT:**

Christopher Dellana, Internal Revenue Service, Department of the Treasury, at (202) 317–5500; Elizabeth Schumacher or Matthew Litton, Employee Benefits Security Administration, Department of Labor, at (202) 693–8335; David Mlawsky or Cam Clemmons, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at (410) 786–1565.

*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 nonfederal 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 13813*

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

<sup>1</sup> 82 FR 48385 (Oct. 17, 2017).

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 proposed rules have been developed in response to this Executive Order.<sup>2</sup>

### B. Health Reimbursement Arrangements 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 section 213(d) of the Code) (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>3</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 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, such as 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

<sup>2</sup> In response to Executive Order 13813, on June 21, 2018, DOL published the Definition of Employer under Section 3(5) of ERISA—Association Health Plans final rule and on August 3, 2018, DOL, HHS and the Treasury Department published the Short-Term, Limited-Duration Insurance final rule. See the Association Health Plan final rule at 83 FR 28912 and the Short-Term, Limited-Duration Insurance final rule at 83 FR 38212.

<sup>3</sup> See IRS Notice 2002–45, 2002–02 CB 93; Revenue Ruling 2002–41, 2002–2 CB 75; IRS Notice 2013–54, 2013–40 IRB 287.

the premium for individual health insurance coverage or other non-employer sponsored hospital or medical insurance covering the employee.<sup>4</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>5</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; the Health Care and Education Reconciliation Act of 2010, Public Law 111–152, was enacted on March 30, 2010 (collectively, PPACA). PPACA 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

<sup>4</sup> For more information about employer payment plans, see IRS Notice 2013–54, Q1 & Q3, and IRS Notice 2015–17, Q4 & Q5, 2015–14 IRB 845.

<sup>5</sup> A QSEHRA, as defined in section 9831(d) of the Code, is not a group health plan for purposes of the market requirements of the Code (except as provided in section 49801(f)(4) of the Code), parts 6 and 7 of ERISA, and title 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 these proposed regulations 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 section 2791(a)(1) of the PHS Act, as amended by section 18001(c) of the Cures Act. As previously noted, 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 these proposed rules, unless otherwise specified. This term does not include QSEHRAs, medical savings accounts (MSAs), or health savings accounts (HSAs). In addition, for purposes of these proposed 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 in a cafeteria plan under section 125 of the Code (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 HRA integrated with individual health insurance coverage in certain circumstances and see later in this preamble for a related comment solicitation.

accordance with section 9831(b) and (c) of the Code, section 732(b) and (c) of ERISA, and sections 2722(b), (c) and 2763 of the PHS Act, the market requirements do not apply to a group health plan or health insurance issuers in the group or individual markets in relation to their provision of excepted benefits described in section 9832(c) of the Code, section 733(c) of ERISA, and section 2791(c) of the PHS Act.<sup>6</sup> See the discussion later in this preamble for additional background on excepted benefits. In addition, in accordance with section 9831(a)(2) of the Code and section 732(a) of ERISA, 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>7</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>8</sup> from establishing for any individual any lifetime or annual limits on the dollar value of essential health benefits (EHBs), as defined in section 1302(b) of PPACA. 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>9</sup>

<sup>6</sup> While the PPACA amendments to PHS Act section 2722(b) and (c) (formerly section 2721(c) and (d)) could be read as restricting the exemption for excepted benefits so that 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 plans and encourages States to adopt a similar approach with respect to issuers of excepted benefits. See 75 FR 34537 at 34539–34540 (June 17, 2010).

<sup>7</sup> While the PPACA amendments to title XXVII of the PHS Act removed the parallel provision at section 2722(a) (formerly 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>8</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 regulations. See 26 CFR 54.9815–1251, 29 CFR 2590.715–1251, and 45 CFR 147.140.

<sup>9</sup> For information regarding EHBs, see HHS’s February 25, 2013 final regulations addressing EHBs under section 1302 of PPACA (78 FR 12834);

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.

As explained in prior guidance, however, the Treasury Department, DOL, and HHS (collectively, 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.<sup>10</sup> 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 section 125 of the Code (cafeteria plan) because section 9005 of PPACA specifically limits salary reduction contributions to health FSAs to \$2,500 (indexed for inflation) per year.<sup>11</sup> Similarly, although medical savings accounts (MSAs) under section 220 of the Code and health savings accounts (HSAs) under section 223 of the Code generally are not treated as group health plans subject to the market requirements,<sup>12</sup> the Departments have concluded that the annual dollar limit prohibition would not apply to an MSA or HSA even if a particular arrangement did meet the criteria to be a group health plan because both types of arrangements are subject to specific statutory provisions that limit the contributions.<sup>13</sup> Therefore, the proposed

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. 45 CFR 156.111 (83 FR 16930, Apr. 17, 2018). The current regulations under PHS Act section 2711 include a definition of EHBs that applies for plans that are not required to provide 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 proposed rules set forth in this document include proposed amendments to the definition of EHBs under the PHS Act section 2711 regulations to reflect the updated final EHB rules.

<sup>10</sup> See 80 FR 72192, 72201 (November 18, 2015).

<sup>11</sup> Notwithstanding this exclusion for certain health FSAs from the application of the annual dollar limit prohibition, regulations under section 125 of the Code provide that health FSAs are not permitted to reimburse employees for premiums for health coverage. See proposed 26 CFR 1.125–5(k)(4) (72 FR 43938, 43959 (Aug. 6, 2007)).

<sup>12</sup> See 75 FR 37188, 37190 (June 28, 2010) and IRS Notice 2004–2, Q1 & Q3, 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 Bulletins 2004–01 and 2006–02, providing guidance regarding HSAs not constituting “employee welfare benefit plans” covered by title I of ERISA where employer involvement with the HSA is limited.

<sup>13</sup> See 75 FR 37188, 37190 (June 28, 2010).

rules do not apply to MSAs, HSAs, or, in certain circumstances, health FSAs.

PHS Act section 2713, as added by PPACA, 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>14</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>15</sup>

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

The Departments have previously issued regulations and subregulatory guidance regarding the application of PHS Act sections 2711 and 2713 to HRAs.<sup>16</sup> The regulations and guidance

<sup>14</sup> See also 26 CFR 54.9815–2713; 29 CFR 2590.715–2713; and 45 CFR 147.130.

<sup>15</sup> Because MSAs and HSAs are generally 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 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 2013–03, Q&A–7; and 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>16</sup> Regulations 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 2013–03, issued on September 13, 2013, and 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>; (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/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-XXII-FINAL.pdf>; (6) IRS Notice 2015–17, issued on February 18, 2015, (as detailed in Notice

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 would be considered in compliance because the combined arrangement complies with PHS Act sections 2711 and 2713. The regulations and guidance also provide that HRAs may be integrated with Medicare and TRICARE coverage if certain conditions are met, but may not be integrated with individual health insurance coverage for purposes of complying with PHS Act sections 2711 and 2713.<sup>17</sup>

In the preamble to the 2010 interim final regulations 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>18</sup> The interim final regulations 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 regulations under PHS Act section 2711.

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>19</sup> This guidance stated that an HRA may not be integrated with individual health insurance coverage for purposes of PHS Act sections 2711 and 2713, but described methods for integrating an

2015–17, DOL and HHS reviewed and agreed with the guidance in Part II); (7) 80 FR 72192 (November 18, 2015); (8) Notice 2015–87, issued on December 16, 2015; (9) IRS Notice 2016–17, DOL Technical Release No. 2016–01, and Insurance Standards Bulletin, Application of the Market Reforms and Other Provisions of the Affordable Care Act to Student Health Coverage, each 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>; and (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>.

<sup>17</sup> 26 CFR 54.9815–2711(d)(4); 29 CFR 2590.715–2711(d)(4) and 45 CFR 147.126(d)(4).

<sup>18</sup> See 75 FR 37188, 37190–37191 (June 28, 2010).

<sup>19</sup> See 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>.

HRA with another group health plan.<sup>20</sup> The provisions in this guidance were later incorporated into the final regulations under PHS Act section 2711, 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>21</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 may not be integrated with individual health insurance coverage, and therefore will fail to comply with PHS Act sections 2711 and 2713.<sup>22</sup>

On February 18, 2015, the Treasury Department and the IRS issued Notice 2015–17. Q&A–3 of Notice 2015–17 provides 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 plan for integration purposes. However, Q&A–3 states 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. Notice 2015–17 also included a general reminder that to the extent such an arrangement is available to active employees it may be subject to restrictions under other laws that prohibit offering financial or other incentives for TRICARE-eligible employees to decline employer-provided group health plan coverage, similar to the Medicare secondary payer rules.

Q&A–3 of Notice 2015–17 also provides 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. But it provides that 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 parts 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 provisions. See later in this preamble for a discussion of the rules provided in the final regulations 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 regulations).<sup>23</sup> Consistent with the initial subregulatory guidance, the final regulations under PHS Act section 2711 provide two methods for integration of HRAs with other group health plan coverage.<sup>24</sup> The first method applies to HRAs integrated with other group health plan coverage that provides MV (the MV Integration Method).<sup>25</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>26</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>27</sup> and (3) the HRA is 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 methods, the non-HRA group coverage may not consist solely of excepted benefits and, for the MV

<sup>20</sup> In addition to describing the integration methods, IRS Notice 2013–54 and DOL Technical Release 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>21</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>22</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 sections 36B, 9801, 9802, 9815, 9831 and 9832 of the Code and PHS Act sections 2711 and 2713.

<sup>23</sup> See 80 FR 72192 (November 18, 2015). To the extent the final regulations did not incorporate or modify the prior subregulatory guidance, such guidance remains in effect.

<sup>24</sup> These two methods of integration were originally discussed in IRS Notice 2013–54, Q4, and DOL Technical Release 2013–03, available at <https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/13-03>.

<sup>25</sup> See 26 CFR 54.9815–2711(d)(2)(ii); 29 CFR 2590.715–2711(d)(2)(ii); 45 CFR 147.126(d)(2)(ii).

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

<sup>27</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>28</sup>

The 2015 regulations 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>29</sup> For these employers, an HRA that may be used to reimburse premiums under Medicare part B or D

<sup>28</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 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>29</sup> See 26 CFR 54.9815-2711(d)(5); 29 CFR 2590.715-2711(d)(5); 45 CFR 147.126(d)(5). The final regulations did not address the Medicare integration rules that apply to employers with 20 or more employees. For a discussion of those rules, see IRS Notice 2015-17 and the discussion elsewhere in this preamble.

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.

The 2015 regulations also incorporate prior subregulatory guidance that HRAs cannot be integrated with individual health insurance coverage for purposes of complying with PHS Act sections 2711 and 2713.<sup>30</sup>

### 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 section 9802 of the Code, section 702 of ERISA, and section 2702 of the PHS Act (HIPAA nondiscrimination provisions). The Departments published joint final regulations implementing the HIPAA nondiscrimination provisions on December 13, 2006.<sup>31</sup> Section 1201 of PPACA reorganized and amended the HIPAA nondiscrimination provisions of

<sup>30</sup> See 26 CFR 54.9815-2711(d)(4); 29 CFR 2590.715-2711(d)(4); 45 CFR 147.126(d)(4). Also see IRS Notice 2013-54, Q&A-1, and DOL Technical Release 2013-03, Q&A-1. This principle was also reiterated and clarified in the various other pieces of subregulatory guidance summarized elsewhere in this section of the preamble. See also IRS Notice 2015-87, Q&A-5, in which the Departments clarified that an HRA that by its terms may only be used to reimburse (or pay directly for) premiums for individual health insurance coverage consisting solely of excepted benefits will not fail to comply with PHS Act sections 2711 and 2713 because those provisions do not apply to a group health plan that is designed to provide only excepted benefits. For guidance on enforcement relief for certain premium reduction arrangements offered by institutions of higher education to students with respect to student health insurance coverage, which is a type of individual health insurance coverage, 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, 2016-9 IRB 358; DOL Technical Release 2016-1, available at <http://www.dol.gov/ebsa/newsroom/tr16-01.html>; and Insurance Standards Bulletin, Application of the Market Reforms and Other Provisions of the Affordable Care Act to Student Health Coverage, February 5, 2016, available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/student-health-bulletin.pdf>. See elsewhere in this preamble for additional discussion of student health insurance coverage.

<sup>31</sup> 71 FR 75014.

the PHS Act. (Although section 9802 of the Code and section 702 of ERISA were not amended, the requirements of section 2705 of the PHS Act are also incorporated by reference into section 9815 of the Code and section 715 of ERISA.)<sup>32</sup> As amended by PPACA, the nondiscrimination provisions of section 2705 of the PHS Act largely reflect the 2006 regulations 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>33</sup>

Q&A-2 of FAQs about Affordable Care Act Implementation (Part XXII)<sup>34</sup> provided that, if an employer offers 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 section 2705 of the PHS Act (which is incorporated by reference into section 9815 of the Code and section 715 of ERISA), as well as the HIPAA nondiscrimination provisions of section 9802 of the Code and section 702 of ERISA. The Q&A explained that such arrangements will 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, in the Departments' view, 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

<sup>32</sup> PPACA section 1201 moved the HIPAA nondiscrimination provisions from PHS Act section 2702 to PHS Act section 2705, with some modification.

<sup>33</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 health care, 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 (January 8, 2001).

<sup>34</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>.

health plan, in contravention of the HIPAA nondiscrimination provisions.

#### D. Excepted Benefits

Section 9831 of the Code, section 732 of ERISA, and sections 2722 and 2763 of the PHS Act 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 section 9832 of the Code, section 733 of ERISA, and section 2791 of the PHS Act.

There are four statutory categories of excepted benefits. One such category of excepted benefits is 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 health care, or community-based care, or any combination thereof, and “such other similar, limited benefits as are specified in regulations” by the Departments.<sup>35</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>36</sup> The 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>37</sup>

Coverage that consists of excepted benefits is not minimum essential coverage (MEC).<sup>38</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>39</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 section 4980H of the Code, the employer shared responsibility provisions; thus, an employer will not avoid a payment under section 4980H of

the Code by virtue of an offer of an excepted benefit.<sup>40</sup>

#### E. Premium Tax Credit

##### 1. In General

Section 36B of the Code 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>41</sup> Under section 36B(a) and (b)(1) of the Code 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.

An individual is eligible for the PTC for a month if the individual meets various requirements for the month (a coverage month). Among other things, under section 36B(c)(2) of the Code, 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>42</sup> An eligible employer-sponsored plan includes coverage under a self-insured (as well as an insured) group health plan<sup>43</sup> and is MEC unless it consists solely of excepted benefits.<sup>44</sup>

An HRA is a self-insured group health plan and therefore is an eligible employer-sponsored plan. Accordingly, an individual currently 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. Although Treasury Department and IRS guidance provides that an HRA is an eligible employer-sponsored plan and therefore individuals covered by an HRA are ineligible for the PTC,<sup>45</sup> to date, the Treasury Department and the IRS have not provided guidance as to the circumstances in which an HRA is considered to be affordable or to provide MV.<sup>46</sup>

##### 2. Affordability and Minimum Value

Section 36B(c)(2)(C) of the Code and 26 CFR 1.36B–2(c)(3)(v)(A)(1) and (2) provide that 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 an entire plan year if, at the time an individual enrolls in a qualified health plan offered through an Exchange, the Exchange determines that the eligible employer-sponsored plan is not affordable.<sup>47</sup> Thus, the employee safe harbor locks in the Exchange’s determination of affordability, 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 section 36B(c)(2)(C)(ii) of the Code, a 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. Section 1302(d)(2)(C) of PPACA provides that, in determining the percentage of the total allowed costs of benefits provided under a group health plan, the regulations promulgated by HHS under that paragraph apply. HHS regulations provide that an 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>48</sup>

#### F. Qualified Small Employer Health Reimbursement Arrangements

##### 1. In General

The 21st Century Cures Act (Cures Act), Public Law 114–255, was enacted on December 13, 2016. Section 18001 of

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. This document does not make substantive revisions to those rules.

<sup>47</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>48</sup> See 45 CFR 156.145. See also 80 FR 52678 (Sept. 1, 2015).

<sup>35</sup> See section 9832(c)(2) of the Code, section 733(c)(2) of ERISA, and section 2791(c)(2) of the PHS Act.

<sup>36</sup> See section 9831(c)(1) of the Code, ERISA section 732(c)(1), and PHS Act section 2722(c)(1) and 2763(b). See also the discussion in 2014 final regulations concerning the application of these requirements to benefits such as limited-scope dental and vision benefits and employee assistance programs at 79 FR 59130, 59131–59134 (Oct. 1, 2014).

<sup>37</sup> See 26 CFR 54.9831–1(c)(3)(v), (vi) and (vii); 29 CFR 2590.732(c)(3)(v), (vi) and (vii); 45 CFR 146.145(b)(3)(v), (vi) and (vii).

<sup>38</sup> See section 5000A(f)(3) of the Code.

<sup>39</sup> See section 36B(c)(2)(B) of the Code.

<sup>40</sup> See section 4980H(a)(1), (b)(1) of the Code. See also 26 CFR 54.4980H–1(a)(14).

<sup>41</sup> Exchanges are entities established under section 1311 of PPACA through which qualified individuals and qualified employers can purchase health insurance coverage.

<sup>42</sup> See section 36B(c)(2)(C)(iii) of the Code and 26 CFR 1.36B–2(c)(3)(vii)(A) and 1.36B–3(c).

<sup>43</sup> See 26 CFR 1.5000A–2(c).

<sup>44</sup> See section 5000A(f)(3) of the Code and 26 CFR 1.5000A–2(g).

<sup>45</sup> See IRS Notice 2013–54, Q&A 10.

<sup>46</sup> The Treasury Department and the IRS have provided guidance regarding when amounts newly made available under an HRA count toward the affordability or MV of another group health plan

the Cures Act amends 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>49</sup> For purposes of the proposed rules, QSEHRAs are not included in the term “HRA or other account-based group health plans.”

Pursuant to section 9831(d) of the Code, a QSEHRA is an arrangement that meets certain conditions, including the following:

- The arrangement provides, after the eligible employee provides proof of coverage,<sup>50</sup> for the payment or reimbursement of medical care expenses incurred by the employee or the employee’s family members (in accordance with the terms of the arrangement);
- The amount of payments for and reimbursements of medical care expenses incurred by the employee or the employee’s family members for any year does not exceed \$4,950 (\$10,000<sup>51</sup> for an arrangement that also provides for payments or reimbursements of medical care expenses of the eligible employee’s family members (family coverage)); and
- The arrangement generally is provided on the same terms to all eligible employees of the eligible employer.<sup>52</sup>

<sup>49</sup> See Section 9831(d)(1) of the Code, section 733(a)(1) of ERISA, and section 2791(a)(1) of the PHS Act. 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 section 2791(a)(1) of the PHS Act, as amended by section 18001(c) of the Cures Act. In addition, QSEHRAs were not excluded from ERISA’s definition of employee welfare benefit plan under section 3(1) of ERISA 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 proposed clarification described later in this preamble are met.

<sup>50</sup> Under section 106(g) of the Code, payments or reimbursements from a QSEHRA are not treated as paid or reimbursed under employer-provided coverage for medical expenses under an accident or health plan for purposes of sections 106 and 105 of the Code if, for the month in which the medical care is provided, the individual does not have minimum essential coverage within the meaning of section 5000A(f) of the Code. See IRS Notice 2017–67 for additional discussion of this minimum essential coverage requirement.

<sup>51</sup> Section 9831(d)(2)(D)(ii) of the Code provides that both statutory dollar limits are adjusted for inflation beginning after 2016. The adjusted limits for 2018 are \$5,050 for self-only coverage and \$10,250 for family coverage.

<sup>52</sup> Section 9831(d)(2)(C) of the Code provides that an arrangement shall not fail to be treated as

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 section 4980H(c)(2) of the Code and that does not offer a group health plan to any of its employees. The statute also requires that an employer providing a QSEHRA provide a written notice to each eligible employee (as defined in section 9831(d)(3)(A) of the Code) not later than 90 days before the beginning of the plan year (or, in the case of an employee who is not eligible to participate in the arrangement as of the beginning of the plan year, the date on which the employee is first eligible). Section 9831(d)(4) of the Code requires that the notice contain certain content, including information about the maximum dollar amount of payments and reimbursements that may be made under the terms of the QSEHRA for the year to the employee (the permitted benefit), and 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 PTC.

On October 31, 2017, the Treasury Department and the IRS issued Notice 2017–67<sup>53</sup> to provide guidance on the requirements for providing a QSEHRA to eligible employees, the tax consequences of the arrangement, and the requirements for providing written notice of the arrangement to eligible employees.

If an eligible employer complies with the guidance provided in section 9831(d) of the Code and Notice 2017–67, it may provide a QSEHRA to its eligible employees and the QSEHRA does not have 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 section 36B of the Code relating to how a QSEHRA affects a taxpayer’s eligibility for the PTC and how a QSEHRA affects a taxpayer’s computation of the PTC. Under section

provided on the same terms merely because the employee’s permitted benefit varies in accordance with the variation in price of an insurance policy in the relevant individual health insurance market based on the employee’s age or the number of family members whose expenses may be reimbursed under the arrangement. See section 9831(d)(2)(C) of the Code and IRS Notice 2017–67 for additional detail.

<sup>53</sup> See IRS Notice 2017–67, 2017–47 IRB 517. See also IRS Notice 2017–20, 2017–11 IRB 1010, which extended the period for an employer to furnish an initial written notice to its eligible employees regarding a QSEHRA.

36B(c)(4)(A) of the Code, 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. Section 36B(c)(4)(C) of the Code 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  $\frac{1}{12}$  of the employee’s permitted benefit, as defined in section 9831(d)(3)(C) of the Code, does not exceed  $\frac{1}{12}$  of a percentage of the employee’s household income. The percentage, which is adjusted annually, is 9.56 for 2018.<sup>54</sup>

Section 36B(c)(4)(B) of the Code 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  $\frac{1}{12}$  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 before the beginning of the calendar year only during the annual open enrollment period described in 45 CFR 155.410. An individual may qualify for a special enrollment period to enroll in or change to a different Exchange plan outside of the annual open enrollment period under a variety of circumstances prescribed by section 1311(c)(6)(C) and (D) of PPACA and as described in 45 CFR 155.420. These special enrollment periods are under the jurisdiction of HHS, and apply to persons seeking individual health insurance coverage through a State or Federal Exchange and, in some cases, to individuals seeking individual health insurance coverage outside an Exchange.<sup>55</sup>

<sup>54</sup> IRS Notice 2017–67 provides that for purposes of determining whether a QSEHRA constitutes affordable coverage under section 36B(c)(4) of the Code the permitted benefit for self-only coverage is used, regardless of whether the permitted benefit provided to a particular eligible employee is for self-only or family coverage. Further, if the amount of permitted benefit varies based on the age of the employee, the age-applicable self-only coverage amount is used.

<sup>55</sup> Group health plans must provide special enrollment periods under certain circumstances and the Departments have jurisdiction over those provisions. See section 9801(f) of the Code, section 701(f) of ERISA, and section 2704(f) of the PHS Act; see also 26 CFR 54.9801–6, 29 CFR 2590.701–6, 45 CFR 146.117, and 45 CFR 147.104(b)(3)–(5). The proposed rules do not affect the group health plan special enrollment periods, which continue to apply to group health plans, including HRAs.

Paragraph (d) of 45 CFR 155.420 describes the special enrollment periods available on the Exchanges to qualified individuals, enrollees, and their dependents. Paragraph (b) of 45 CFR 155.420 describes the coverage effective dates available in connection with each special enrollment period, and paragraph (a)(4) describes the plan changes a qualified individual, enrollee, or dependent may make upon qualifying for a special enrollment period.

With regard to individual health insurance coverage sold outside of the Exchange, 45 CFR 147.104(b)(2) provides that health insurance issuers must provide special 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).

## II. Overview of the Proposed Rules on HRA Integration and Excepted Benefits—the Departments of the Treasury, Labor, and Health and Human Services

In developing the proposed rules, the Departments carefully considered how to meet the objectives of Executive Order 13813 in a way that is permitted by law and supported by sound policy. The proposed rules are intended to increase the usability of HRAs to provide more Americans, including employees who work at small businesses, with additional healthcare options. Such changes will facilitate the development and operation of a more efficient healthcare system that provides high-quality care at affordable prices by increasing consumer choice for employees and promoting competition in healthcare markets by adding additional options for employers. In addition, the proposed rules include certain conditions designed to prevent negative consequences that would be inconsistent with certain provisions of HIPAA and PPACA.

The proposed rules would expand the use of HRAs in several ways. First, the proposed rules would remove the current prohibition against integrating an HRA with individual health insurance coverage<sup>56</sup> under the PHS Act

<sup>56</sup> For purposes of this preamble and the proposed regulations, “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), 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), 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103. “Group health

section 2711 regulations.<sup>57</sup> The proposed rules would instead 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 are met (hereinafter, “the proposed integration rules”).

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

As discussed later in this preamble, the Treasury Department and the IRS are also proposing regulations under section 36B of the Code that would provide the PTC eligibility rules for individuals who are offered an HRA integrated<sup>58</sup> with individual health insurance coverage.<sup>59</sup> DOL is also proposing 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 met. Finally, HHS is proposing changes

insurance coverage” means health insurance coverage offered in connection with a group health plan. See ERISA section 733(b)(4), PHS Act section 2791(b)(4), 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103.

<sup>57</sup> These proposed rules would make several non-substantive modifications to language throughout the regulations implementing PHS Act section 2711 to account for this change. See later in this preamble for a summary of these changes. The proposed regulations do not substantively change the current rules for integration of an HRA with non-HRA group coverage, Medicare or TRICARE. Unless the proposed regulations explicitly conflict with the subregulatory guidance that has been issued under PHS Act section 2711, that guidance remains in effect.

<sup>58</sup> References in the preamble to “an offer of an HRA integrated with individual health insurance coverage” or to similar phrases mean an offer of an HRA designed to be integrated with individual health insurance coverage under the proposed integration rules and that will be considered integrated with such individual health insurance coverage for an individual who enrolls in such coverage.

<sup>59</sup> The Treasury Department and the IRS are not proposing regulations under section 36B of the Code related to the excepted benefit HRA because the application of the PTC eligibility rules to excepted benefits is clear under current law. Also, the Treasury Department and the IRS are not proposing regulations under section 4980H of the Code, but see the discussion later in this preamble regarding how an offer of an HRA that is integrated with individual health insurance coverage is treated under section 4980H of the Code.

to regulations regarding special enrollment periods in the individual market that would provide special enrollment periods for individuals who gain access to HRAs integrated with individual health insurance coverage or who are provided QSEHRAs.

The Departments request comments on all aspects of the proposed rules. The following explanation of the proposed rules also solicits comments on specific topics of particular interest to the Departments.

### A. Integration Rules

Pursuant to the President’s Executive Order to consider proposing regulations to expand and facilitate access to HRAs, the proposed rules would remove the prohibition on integration of an HRA with individual health insurance coverage, if certain conditions are met, and propose requirements that an HRA must meet in order to be integrated with individual health insurance coverage. In order to ensure compliance with PHS Act sections 2711 and 2713, the proposed integration rules provide that to be integrated with individual health insurance coverage, the HRA must require participants<sup>60</sup> and any dependents<sup>61</sup> covered by the HRA to be enrolled in individual health insurance coverage (other than coverage that consists solely of excepted benefits) and to substantiate compliance with this requirement.

Further, in crafting the proposed integration rules, the Departments have considered the possibility that expanding access to HRAs could lead to employers offering coverage options to their employees in a manner that discriminates based on health status and that negatively impacts the individual market for health insurance coverage. 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

<sup>60</sup> For this purpose, the definition of participant under 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103 applies, which is defined as a participant within the meaning of section 3(7) of ERISA. Under section 3(7) of ERISA, “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>61</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.”



participants and beneficiaries in eligibility, benefits, or premiums based on a health factor. Later, in 2010, Congress enacted PPACA (which included PHS Act sections 2711 and 2713), in part, because individual health insurance coverage was not a viable option for many individuals since issuers in many States could deny coverage or charge higher premiums 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 described in more detail later in this section of the preamble. In developing these proposed regulations, the Departments have carefully considered how to exercise their rulemaking authority in a manner that is consistent with Congress's overall intent in enacting HIPAA and PPACA. As part of that process, the Departments have considered how to avoid permitting discrimination based on health status or similar employer practices with respect to offering HRAs to employees that might have destabilizing effects on the individual market or lead to higher premiums in that market.

The Departments are of the view that allowing HRAs to be integrated with individual health insurance coverage could result in opportunities for employers to encourage higher risk employees (that is, those 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.<sup>62</sup> This could happen in a number of ways. For example, if employees are permitted to choose between participating in an employer's traditional group health plan or participating in an HRA integrated with individual health insurance coverage, some higher risk employees may have an incentive to select the HRA and enroll in individual health insurance coverage. This is because most individual health insurance coverage must cover all EHBs and large group market and self-insured group health plans are not required to cover all categories of EHBs. 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 HRAs integrated with individual health insurance coverage are used disproportionately by higher risk employees, such arrangements could worsen adverse selection and raise premiums in the individual market.

The Departments also considered the possibility that the market would develop the opposite way. Lower risk employees might choose HRAs integrated with individual health insurance coverage, while higher risk employees might remain with the relative certainty of their employer's traditional group health plan. Such an outcome could result for a host of reasons, including because higher risk employees tend to be more risk averse with respect to changing health benefits and because individual health insurance coverage might have much more restrictive provider networks than traditional group health plans and higher risk employees tend to be more sensitive to the make-up of the provider network than lower risk employees. Also, lower risk employees may prefer an HRA integrated with individual health insurance coverage, as compared to a more generous traditional group health plan, because it could allow them to spend less on premiums and have more funds available to cover cost sharing. Further, employers would have incentives to avoid legal concerns that could be raised by an attempt to steer higher risk employees toward an HRA integrated with individual health insurance coverage.

However, employers will face countervailing incentives to maintain (or improve) the average health risk that they insure. Therefore, the Departments have determined that the risk of market segmentation and health factor discrimination is sufficiently significant to justify including conditions in the proposed regulations intended to address those risks. Accordingly, the proposed regulations would add new regulations at 26 CFR 54.9802-4, 29 CFR 2590.702-2, and 45 CFR 146.123 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. In particular, the proposed integration rules prohibit a plan sponsor from offering the same class of employees both a traditional group health plan and an HRA integrated with individual health insurance coverage. In addition, to the extent a plan sponsor offers an

HRA that is integrated with individual health insurance coverage to a class of employees, the proposed integration rules require that the HRA be offered on the same terms to all employees within the class, subject to certain exceptions described later in this preamble.

In the Departments' view, these proposed integration requirements are necessary and appropriate to avoid the risk of market segmentation and to ensure there are protections against discrimination based on health status when HRAs are permitted to integrate with individual health insurance coverage for purposes of compliance with PHS Act sections 2711 and 2713. The Departments also are of the view these requirements are consistent with Congress's intent in enacting both HIPAA and PPACA as well as in granting the Departments the authority to promulgate such 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 those Acts.<sup>63</sup> More specifically, these proposed integration requirements are intended to mitigate circumstances in which higher risk employees are incentivized (based on the design of the traditional group health plan versus the offer of the HRA) to obtain coverage in the individual market.

These proposed integration conditions avoid creating a high risk of market segmentation. As noted earlier in this preamble, PPACA includes several provisions designed to create a competitive individual market that makes affordable coverage available to individuals who do not have access to other health coverage. *See* PPACA section 1311 (establishing the Exchanges), section 1312(c) (instructing health insurance issuers to consider all enrollees in all health plans in a market—either individual or small group—as members of a single risk pool), section 1401 (establishing the PTC to help qualifying individuals and families pay for individual health insurance coverage), section 1402 (reducing cost-sharing for qualifying individuals enrolled in qualified health plans), and section 1501 (requiring non-exempt applicable individuals to maintain MEC or be subject to the individual shared responsibility payment).<sup>64</sup> These provisions are

<sup>63</sup> *See* section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act.

<sup>64</sup> Section 5000A of the Code, added by PPACA, provides that all non-exempt applicable individuals must maintain MEC or pay an individual shared responsibility payment. On December 22, 2017, the President signed tax reform legislation (Pub. L. 115-97, 131 Stat. 2054) under which the individual

<sup>62</sup> Amy Monahan and Daniel Schwarcz, "Will Employers Undermine Health Care Reform by Dumping Sick Employees?" *Virginia Law Review*, Vol. 97 (2011).

intended, in part, to draw more individuals of all risk profiles into the individual market and make premiums for individual market coverage more affordable. In addition, PPACA requires that non-grandfathered individual health insurance coverage cover generally the same categories of EHBs, in part, to prevent health insurance coverage with better benefits from becoming prohibitively expensive as lower-risk individuals gravitate to less expensive individual health insurance coverage with limited benefits while higher risk individuals select more expensive individual health insurance coverage with more generous benefits. PPACA also includes risk adjustment, reinsurance, and risk corridor programs to provide consumers with affordable health insurance coverage, to reduce incentives for issuers to avoid enrolling higher risk individuals, and to stabilize premiums in the individual and small group markets inside and outside of the Exchanges. Taken altogether, these PPACA provisions intend to create a robust and competitive individual market, in part by ensuring that risk pools included both higher risk and lower risk individuals.

If integration of HRAs led to market segmentation, it would result in significant destabilization in the individual market, undermining those provisions of PPACA that are intended to create a robust and competitive individual market. The text of PHS Act sections 2711 and 2713 is ambiguous with regard to whether and how separate plans can integrate to comply with its provisions, and the structural and practical policy concerns discussed earlier in this preamble could, if realized, prompt the Departments to adopt an interpretation of PHS Act sections 2711 and 2713 that prohibits integration of HRAs with individual health insurance coverage. By requiring employers who wish to take advantage of HRA integration with individual health insurance coverage to adhere to the protections described in more detail later in this preamble, in particular the prohibition on offering an HRA integrated with individual health insurance coverage and a traditional group health plan to the same employees, the Departments intend to prevent large-scale destabilization of the individual market, thus allowing the Departments to interpret PHS Act sections 2711 and 2713 to permit integration with individual health insurance coverage. Accordingly, the proposed regulations provide

integration rules that are intended to avoid creating a high risk of market segmentation.

Lastly, because eligibility for coverage under an HRA may affect an individual's eligibility for the PTC and enrollment in an HRA affects an individual's eligibility for the PTC, the proposed integration rules allow employees of employers who offer an HRA to opt out of and waive future reimbursements under the HRA. The Departments also propose that HRAs be required to provide a notice to participants eligible for coverage under an HRA integrated with individual health insurance coverage with information regarding how the offer of the HRA or enrollment in the HRA affects their ability to claim the PTC.

The conditions in the proposed integration rules are discussed in detail below.

#### 1. Requirement That All Individuals Covered by the HRA Are Enrolled in Individual Health Insurance Coverage

As discussed earlier in this preamble, an HRA is a group health plan that does not comply with PHS Act sections 2711 and 2713 on its own. However, the Departments previously have determined that an HRA can be considered to be in compliance with PHS Act sections 2711 and 2713 if it is integrated with non-HRA group coverage that is subject to and complies with these sections of the PHS Act. In the past, the Departments have made the determination that it is appropriate to treat an HRA as complying with PHS Act sections 2711 and 2713 when integrated with other group health plan coverage because, generally, an individual covered by the combined arrangement has coverage that complies with PHS Act sections 2711 and 2713. (Similarly, as discussed elsewhere in this preamble, other combined arrangements involving Medicare and TRICARE, are also considered to comply with PHS Act sections 2711 and 2713.)

The proposed integration rules similarly provide that an HRA may be integrated with individual health insurance coverage, and will 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) for each month the individual(s) are covered by the HRA. If the individual covered by the HRA merely has the ability to obtain individual health insurance coverage, but does not actually have that coverage, the HRA would fail to comply with PHS

Act sections 2711 and 2713. This proposed requirement would apply with respect to all individuals whose medical care expenses may be reimbursed under the HRA, not just the participant.

For purposes of integrating an HRA with individual health insurance coverage, the Departments are proposing to treat all individual health insurance coverage as subject to and compliant with PHS Act sections 2711 and 2713, except for coverage that consists solely of excepted benefits. While this would allow for integration with grandfathered individual health insurance coverage, which is not subject to and may not be compliant with PHS Act sections 2711 and 2713, only a small number of individuals are currently enrolled in grandfathered individual health insurance coverage and grandfathered coverage may not be sold in the individual market to new enrollees and may only be renewed by current enrollees so long as the coverage meets strict conditions. Additionally, 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 will continue to decline each year. Because it is the Departments' understanding that there are few individuals covered by grandfathered individual health insurance coverage, the Departments are of the view that there will be few instances where such individuals will be offered and accept an HRA that would be integrated with their grandfathered individual health insurance coverage. Moreover, new enrollees cannot enroll in grandfathered individual health insurance coverage, so employers offering traditional group health plans would not be able to shift workers into this coverage. Furthermore, even for non-grandfathered individual health insurance coverage, requiring participants or plan sponsors to substantiate compliance with PHS Act sections 2711 and 2713 for each individual health insurance policy separately is impracticable given that most participants and HRAs are unlikely to be able to reasonably determine the compliance of the individual health insurance policy. An independent assessment of compliance could require the participant or HRA to identify which benefits under each individual health insurance coverage enrolled in by a participant or dependent are considered EHBs for purposes of PHS Act section 2711, and whether all preventive services are covered without cost-sharing under

each individual health insurance coverage enrolled in by a participant or dependent. The Departments are of the view that this would be an unwieldy and burdensome task.

The Departments' final rules for grandfathered plans provide that "a plan or health insurance coverage must include a statement that the plan or coverage believes it is a grandfathered health plan . . . in any summary of benefits provided under the plan."<sup>65</sup> The Departments remain concerned, however, that the frequency of this disclosure to participants may be insufficient to substantiate compliance for purposes of these rules. For comparison's sake, ERISA plans must provide a new SPD only every 5 years, and the required disclosure for individual market coverage will differ from state to state. Additionally, other plan materials that provide a summary of benefits that may trigger the grandfathered plan disclosure requirement may not be subject to any specific timing requirements. Furthermore, the Departments have concerns as to whether participants will be able to locate or receive the disclosure materials in the time necessary to allow for a determination of whether the plan with which the HRA will be integrated is grandfathered (and therefore unlikely to comply with sections 2711 and 2713 of the PHS Act) or non-grandfathered (and therefore generally compliant). For example, for ERISA plans, a plan sponsor has 30 days to fulfill a disclosure request. Additionally, despite the fact that individual health insurance coverage may include a disclosure that the policy is grandfathered, there may be instances in which such disclosure is not accurate, or other instances where non-grandfathered individual health insurance coverage does not comply with PHS Act sections 2711 or 2713. For these reasons, the Departments have preliminarily determined that adopting this proxy approach of relying on the sale of the policy in the individual market to deem the policy compliant for purposes of the proposed integration rules strikes an appropriate balance. (See later in this preamble for a discussion of the substantiation requirements that would apply under the proposed integration rules).

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

Under the proposed integration rules, the requirement that each individual whose medical care expenses may be reimbursed under the HRA must be enrolled in individual health insurance coverage (other than coverage that consists solely of excepted benefits) would apply for each month that the individual is covered by the HRA. If an individual whose medical care expenses may be reimbursed under an HRA fails to have such 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 provide that an HRA may not be integrated with individual health insurance coverage unless the HRA provides that medical care expenses for any individual covered by the HRA will not be reimbursed if the individual ceases to be covered by individual health insurance coverage and, if the individuals covered by the HRA cease to be covered by such individual health insurance coverage, the participant must forfeit the HRA, in accordance with applicable laws (including COBRA and other continuation of coverage requirements).<sup>66</sup>

## 2. Prohibition Against Offering Both an HRA Integrated With Individual Health Insurance Coverage 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, under the proposed integration rules, a plan sponsor may offer an HRA integrated with individual health insurance coverage to a class of employees only if the plan sponsor does not also offer a traditional group health

plan to the same class of employees.<sup>67</sup> Therefore, a plan sponsor would not be permitted to allow any employee within a class of employees a choice between a traditional group health plan or an HRA integrated with individual health insurance coverage. For this purpose, the term "traditional group health plan" means any group health plan other than either an account-based group health plan or a group health plan that consists solely of excepted benefits. The Departments solicit comments on whether employers should be able to offer employees a choice between a traditional group health plan or an HRA integrated with individual health insurance coverage, and on the definition of "traditional group health plan," including whether an alternate definition or term might be appropriate and whether a definition should be codified as part of these proposed regulations.

### b. Classes of Employees

In addition, as described in more detail later in the preamble, the proposed integration rules require a plan sponsor that offers an HRA integrated with individual health insurance coverage to a class of employees to offer the HRA on the same terms to each participant within the class of employees, subject to certain exceptions. The proposed integration rules provide that a plan sponsor may only offer the HRA on different terms to different groups of employees, and may only offer either an HRA integrated with individual health insurance coverage or a traditional group health plan by groups of employees, if those groups are specific classes of employees identified by the proposed rules. The classes are: (1) Full-time employees (using either the definition that applies for purposes of section 105(h) or 4980H of the Code, as determined by the plan sponsor); (2) part-time employees (using either the definition that applies for purposes of section 105(h) or 4980H of the Code, as determined by the plan sponsor); (3) seasonal employees (using either the definition that applies for purposes of section 105(h) or 4980H of the Code, 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)); (5) employees who have not satisfied a waiting period for

<sup>65</sup> 26 CFR 54.9815-1251(a)(2); 29 CFR 2590.715-1251(a)(2); 45 CFR 147.140(a)(2).

<sup>66</sup> For an explanation of the application of COBRA to HRAs, see section VII of IRS Notice 2002-45.

<sup>67</sup> The Departments note that an employer may not provide a QSEHRA to any employee if it offers any employee a group health plan, including a traditional group health plan or an HRA. See section 9831(d)(3)(B)(ii) of the Code.

coverage (if the waiting period complies with the waiting period rules in PHS Act section 2708 and its implementing regulations);<sup>68</sup> (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)); (7) 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); and (8) employees whose primary site of employment is in the same rating area, as defined in 45 CFR 147.102(b). In addition, the proposed integration rules allow as additional classes, groups of employees described as a combination of two or more of the enumerated classes. For example, part-time employees included in a unit of employees covered by a CBA might be one class of employees, and full-time employees included in the same unit of employees covered by a CBA might be another class of employees. In that case, for example, the employer could offer an HRA to the part-time employees and not offer (or offer on different terms) an HRA to the full-time employees, but could not differentiate between the part-time employees covered under the CBA except based on any of them being in another class or, if within the same class, except as otherwise allowed under the same-terms requirement as explained later in this preamble. If an HRA is offered to former employees (such as retirees), former employees are considered to be in the same class they were in immediately before separation from service.

The Departments have concluded that it is appropriate to permit plan sponsors to offer different benefits to these classes of employees under the proposed integration rules. First, many employers historically have offered varying benefit packages to members of these different classes of employees clearly for purposes other than inducing higher risk employees to leave the plan sponsor's traditional group health plan. Second, the Departments have determined that 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, thereby reducing the risk that a plan sponsor will offer an HRA integrated with individual health insurance coverage only to its higher risk employees. Accordingly, the classes of employees identified in these proposed rules would balance

employers' reasonable need to make distinctions among employees with respect to offering health benefits with the public interest in protecting the stability of the individual market risk pools.

Historically, employers have often provided different benefit packages to employees included in a unit of employees covered by a CBA, full-time employees, part-time employees, seasonal employees, employees who work abroad, employees of different ages, employees based on whether they have completed a waiting period, and employees in different locations. This is particularly true in the case of health benefits. For example, unions typically bargain with employers over health benefits provided to employees who are members of that union, and the health benefits that an employer provides pursuant to a CBA are often different than those that it provides to its employees who are not covered by the CBA. Similarly, health benefit packages offered to employees often vary by location, in part because certain healthcare providers or health insurance issuers operate only in some areas and not in others. A rule that prohibited employers from differentiating between these classes of employees for purposes of offering HRAs integrated with individual health insurance coverage would pose significant costs that might undermine the willingness of employers to offer HRAs in the first place.

The Departments are of the view that these classes of employees are not ones that could be easily manipulated in order to transfer the risks (and perceived higher costs) from the employer's traditional group health plan to the individual market. For example, labor laws generally prevent an employer from classifying an employee as subject to a CBA when the employee traditionally has not been subject to a CBA. Similarly, economic and labor forces generally make it difficult for employers to increase or reduce significantly the number of hours worked by employees in particular positions. In certain situations, ERISA may also prevent an employer from changing employee's hours in order to interfere with an employee's ability to participate in a health plan.<sup>69</sup> The Departments have not proposed permitting plan sponsors to treat salaried and hourly employees as different classes of employees for purposes of these rules, however, as many 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.

To minimize burden and complexity, the Departments do not propose a minimum employer size or employee class size for purposes of applying the proposed integration rules. The Departments recognize that very small employers could manipulate these classes (for example, a very small employer could put someone who is a higher-risk employee in a separate class on his or her own), but note that other economic incentives related to attracting and retaining talent would discourage employers from doing so. The Departments invite comments on whether employer size or employee class size should be considered in determining permissible classes of employees.

In defining certain classes of employees to which different benefits may be offered in the proposed rules, the Departments propose to adopt definitions that are the same as those that apply under sections 105(h) and 4980H of the Code.

Specifically, for purposes of identifying classes of employees for purpose of the proposed integration regulations, an HRA plan sponsor may define "full-time employee," "part-time employee," and "seasonal employee" in accordance with either of those definitions under sections 105(h) and 4980H of the Code, but it must be consistent across these three classes of employees, to the extent it differentiates based on these classes, in using either sections 105(h) or 4980H of the Code to avoid overlapping classes of employees, and the HRA plan document must set forth the applicable definitions prior to the beginning of the plan year in which the definitions will apply. Thus, an HRA plan document may provide that, for the plan year, the term "full-time employee" means a full-time employee under section 4980H of the Code and the regulations thereunder and "part-time employee" means an employee who is not a full-time employee under section 4980H of the Code and the regulations thereunder, for the applicable plan year. But an HRA plan document may not provide that, for the plan year, the term "full-time employee" has the meaning set forth in section 4980H of the Code and the regulations thereunder, and the term "part-time employee" has the meaning set forth in 26 CFR 1.105–11(c)(2)(iii)(C), for the applicable plan year. Nothing would prevent an employer from changing the definitions

<sup>68</sup> 26 CFR 54.9815–2708; 29 CFR 2590.715–2708; 45 CFR 147.116.

<sup>69</sup> See e.g., *Marin v. Dave & Buster's, Inc.*, 159 F. Supp. 3d 460 (SDNY 2016).

for a subsequent plan year so long as each class is defined in accordance with the same provision for the applicable plan year and the HRA plan document is updated to reflect the applicable definitions prior to the beginning of the plan year in which the definitions would apply.

For the other classes of employees, the relevant definition under section 105(h) of the Code applies, except for the class of employees based on worksite rating area. The Departments propose to adopt the Code section 105(h) definitions, in part, because they reflect a relatively common understanding of the terms “full-time,” “part-time” and “seasonal” employees and because HRAs generally are subject to the nondiscrimination rules of section 105(h) of the Code. The Departments understand that plan sponsors may want to design their employee health plans, which may include offering a traditional group health plan and HRAs (or HRAs in different amounts or under different terms and conditions) to different classes of employees in a manner that complies with the requirements of Code section 105(h) to avoid the inclusion of amounts in income under that section.<sup>70</sup> The Departments have concluded that defining the classes of employees to which different offers of coverage may be made by using the Code section 105(h) definitions may be helpful in accomplishing that result.

As noted earlier, the Departments propose to allow employers to adopt the Code section 4980H definitions as an alternative set of definitions for identifying full-time, part-time, and seasonal employees. The Departments acknowledge that certain employers have already determined how those definitions apply to their workforce and using those same definitions for purposes of applying the proposed integration rules may reduce burden for those employers. Section 4980H of the Code applies to ALEs, which generally includes employers that employed at least 50 full-time employees (including full-time equivalent employees) in the prior calendar year.<sup>71</sup> An employer

<sup>70</sup> HRAs generally are subject to the rules under section 105(h) of the Code and its related regulations as self-insured medical reimbursement plans. In general, section 105(h) of the Code provides that certain amounts paid to highly compensated individuals under self-insured medical reimbursement plans are includible in the income of the highly compensated individual. In the near term, the Treasury Department and the IRS intend to issue guidance that addresses the interaction of section 105(h) of the Code and HRAs integrated with individual health insurance coverage.

<sup>71</sup> Discussion of how section 4980H of the Code would affect an ALE that offers an HRA integrated

must classify its employees as either full-time or part-time employees, and in some cases as seasonal employees, in accordance with section 4980H of the Code and the regulations thereunder, in order to determine whether it is an ALE and, if so, to determine which employees it must offer coverage to in order to avoid liabilities under section 4980H of the Code and to complete the associated reporting requirements. Accordingly, ALEs that want to offer HRAs to a particular class of employees, or offer HRAs of differing amounts or under different terms and conditions based on particular classes of employees, may prefer to use the Code section 4980H definitions with which they are familiar and which they have historically communicated to employees through the reporting requirements. The Departments understand, however, that some ALEs may still wish to use the Code section 105(h) definitions, and some non-ALEs may wish to use the Code section 4980H definitions. Therefore, the proposed rules would offer each employer the flexibility to determine which set of definitions are 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 each of these classifications.

The proposed employee classes are intended to provide the flexibility needed to achieve increased HRA usability while establishing parameters sufficient to address the health status discrimination and adverse selection concerns described earlier in this preamble. The Departments considered whether employers should be allowed to offer or vary HRAs integrated with individual health insurance coverage for classes of employees based on a very general standard (like the one that generally applies under the HIPAA nondiscrimination rules, with a broad employment-based classification standard) or a more finite list of classes of employees that have been used in other rules for various employee benefits purposes (for example, under section 105(h) and/or 4980H of the Code). The Departments' view is that a broad and open-ended standard would not be sufficient to mitigate health factor discrimination that could increase adverse selection in the individual market. The classes the Departments propose to permit are ones which, based on the Departments' experience, employers use for other employee benefits and other purposes, with the

with individual health insurance coverage is included later in this preamble.

result that an employer would be unlikely to shift employees between the classes simply for purposes of offering an HRA.

The Departments request comments on the proposed classes of employees, the definitions used, and whether additional classes of employees should be provided (for example, classifications based on form of compensation (hourly versus salaried), employee role or title, occupation, or whether the individual is a former employee). The Departments also seek comment on whether any additional classifications within the proposed classes of employees should be allowed, for example, allowing classifications based on more specific geographic locations, multiple gradations of part-time employees, or gradations based on employee tenure. In addition, the Departments request comments on whether the proposed classes of employees, including the class of employees based on employees having a primary worksite in a particular rating area and the rule allowing combinations of classes of employees, and any potential additional classes, are sufficient to mitigate adverse selection and health status discrimination concerns.

#### c. Salary Reduction Arrangements

The Departments have been made aware that some employers may wish to allow employees to pay the portion of the premium for individual health insurance coverage that is not covered by an HRA integrated with individual health insurance coverage, if any, by using a salary reduction arrangement under a cafeteria plan. Pursuant to section 125(f)(3) of the Code, an employer may not provide a qualified health plan (as defined in section 1301(a) of PPACA) offered through the Exchange as a benefit under its cafeteria plan.<sup>72</sup> Therefore, an employer may not permit employees to make salary reduction contributions to a cafeteria plan to purchase a qualified health plan (including individual health insurance coverage) offered through an Exchange.

However, section 125(f)(3) of the Code does not apply to individual health insurance coverage that is not purchased on an Exchange. Therefore, for an employee who purchases individual health insurance coverage outside the Exchange, the employer could permit the employee to pay the balance of the premium for the coverage through its cafeteria plan, subject to all

<sup>72</sup> Note that section 125(f)(3)(B) of the Code provides an exception to this prohibition for certain small employers offering employees the opportunity to enroll in the group market through an Exchange.

applicable guidance.<sup>73</sup> To the extent the arrangement to pay the balance of the premium is a group health plan, such an arrangement would not be considered to be a traditional group health plan for purposes of the proposed integration rules. For a discussion of the application of the same-terms requirement to such an arrangement, see the next section of this preamble. For a general comment solicitation on cafeteria plan premiums arrangements, see later in this preamble.

### 3. Same-Terms Requirement

To address the Departments' concerns about health status discrimination leading to additional adverse selection in the individual market, the proposed integration rules generally require that a plan sponsor that offers an HRA integrated with individual health insurance coverage 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. For this purpose, a class of employees has the meaning described earlier in this preamble, but see later in this section of the preamble for a discussion of the application of this requirement to former employees. As part of this proposed requirement, the Departments make clear that offering a more generous HRA to individuals based on an adverse health factor violates the integration rules.

The Departments recognize, however, that premiums for individual health insurance coverage obtained by HRA participants and their dependents may vary and thus some variation in amounts made available under an HRA, even within a class of employees, may be appropriate. Therefore, under the proposed integration rules, the maximum dollar amount made available under the HRA for participants within a class of employees may increase as the age of the participant increases, so long as the same maximum dollar amount attributable to that increase in age is made available to all participants of the same age within the same class of employees. In addition, under the proposed integration rules, the maximum dollar amount made available under an HRA within a class of employees may increase 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 that 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. Under this exception, a plan sponsor may increase the HRA amount for a class of employees for both age and family size, which would mean, for example, that a plan sponsor could offer two employees in a class of employees of the same age different HRA amounts if the different HRA amounts are attributable to differences in family size. By permitting such variation, the Departments seek to balance the disparate costs of health insurance in the individual market with the need to prevent health status discrimination against HRA participants and their dependents.

Further, although the proposed integration regulations would generally apply to a former employee in the same way that they apply to a current employee (and former employees are considered to be in the same class that they were in immediately before separation from service), the Departments recognize that eligibility for post-employment health 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 integration rules provide that an HRA may be treated as provided on the same terms even if the plan sponsor offers the HRA to some former employees (for example, to all former employees with a minimum tenure of employment) but fails to offer the HRA to the other former employees within a class of employees. But if a plan sponsor does offer the 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.<sup>74</sup> For example, if a plan sponsor offers an HRA to all of its current full-time employees and also to its former employees who were full-time employees immediately prior to separation from service who had at least five years of service, the plan sponsor must provide the HRA on the same terms to the eligible former employees and to the current full-time employees, subject to the generally applicable exceptions to the same terms

<sup>74</sup> 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. See section 9831(a)(2) of the Code and section 732(a) of ERISA. 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 34539 (June 17, 2010). Therefore, a retiree-only HRA need not meet the requirements of any integration test.

requirement described elsewhere in this section of the preamble.

The proposed integration rules further provide that if a participant or dependent in an HRA integrated with individual health insurance coverage does not use all of the amounts made available in the HRA to reimburse medical care expenses for a plan year, and the HRA allows for these amounts to be made available to participants and their dependents in later plan years, these carryover amounts would be disregarded for purposes of determining whether the HRA is offered on the same terms, so long as 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 that they may access in future years, is the same for all participants in a class of employees. In addition, the proposed rules provide that 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 a cafeteria plan<sup>75</sup> is considered to be a term of the HRA for purposes of the proposed integration rules; therefore an HRA shall fail to be treated as provided on the same terms unless such a 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) in a class of employees.

Further, the Treasury Department and the IRS are aware that an HRA under which the maximum dollar amount varies based on age may face issues regarding the application of section 105(h) of the Code and the regulations thereunder. Accordingly, the Treasury Department and the IRS intend to issue guidance in the near term that describes an anticipated safe harbor that would allow increases in the maximum dollar amount made available under an HRA integrated with individual health insurance coverage, if certain conditions are met, without a consequence under section 105(h) of the Code.<sup>76</sup>

<sup>75</sup> As previously noted, pursuant to section 125(f)(3) of the Code, a cafeteria plan may not permit employees to use salary reduction contributions made to a cafeteria plan to purchase individual health insurance coverage offered through an Exchange.

<sup>76</sup> HRAs generally are subject to the rules under Code section 105(h) and its related regulations as self-insured medical reimbursement plans. In general, Code section 105(h) provides that certain amounts paid to highly compensated individuals under self-insured medical reimbursement plans are includible in the income of the highly compensated individual. The regulations under

<sup>73</sup> See Prop. Reg. 26 CFR 1.125-1(m); see also Rev. Rul. 61-146, 1961-2 CB 25.

#### 4. Opt-Out Provision

As described elsewhere in this preamble, if an individual is covered by an HRA integrated with individual health insurance coverage 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 be better off claiming the PTC than receiving reimbursements under an HRA, the Departments' existing rules regarding integration with non-HRA group coverage and with Medicare require plan sponsors that offer HRAs to allow participants to opt out of and waive future reimbursements from the HRA at least annually.<sup>77</sup> These proposed rules include the same requirement. Thus, current employees may 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>78</sup>

Furthermore, as with the current integration rules, the proposed integration rules require 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 to ensure that the HRA participant

Code section 105(h) provide that, for purposes of the nondiscriminatory benefits rule under Code section 105(h)(4), "a plan may establish a maximum limit for the amount of reimbursement which may be paid a participant for any single benefit or a combination of benefits. However, any maximum limit attributable to employer contributions must be uniform for all participants and for all dependents of employees who are participants and may not be modified by reason of a participant's age or years of service." See 26 CFR 1.105-11(c)(3)(i). The guidance that the Treasury Department and the IRS intend to issue is also anticipated to address the application of the Code section 105(h) uniformity requirement to an HRA integrated with individual health insurance coverage more generally.

<sup>77</sup> See 26 CFR 54.9815-2711(d)(2)(i)(E), (d)(2)(ii)(D), (d)(5)(iv), 29 CFR 2590.715-2711(d)(2)(i)(E), (d)(2)(ii)(D), (d)(5)(iv), and 45 CFR 147.126(d)(2)(i)(E), (d)(2)(ii)(D) and (d)(5)(iv). Note that the rule for integration of an HRA with non-HRA group coverage allows certain HRA amounts that are forfeited to be reinstated in the future, but the proposed rules do not contain a similar provision for HRAs integrated with individual health insurance coverage due to concerns by the Departments about complexity and burden on employers. See 26 CFR 54.9815-2711(d)(3), 29 CFR 2590.715-2711(d)(3), and 45 CFR 147.126(d)(3).

<sup>78</sup> See elsewhere in this preamble for a discussion of rules being proposed by the Treasury Department and the IRS regarding the circumstances in which an offer of an HRA integrated with individual health insurance coverage is affordable and provides MV. Also 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.

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.

#### 5. Substantiation and Verification of Individual Health Insurance Coverage

As discussed earlier in this preamble, the proposed integration rules would require that the individuals whose medical care expenses may be reimbursed under the HRA must be enrolled in individual health insurance coverage. To facilitate the administration of this requirement, under the proposed integration rules, an HRA must implement, and comply with, reasonable procedures to verify that individuals whose medical care expenses are reimbursable by the HRA are, or will be, enrolled in individual health insurance coverage (other than coverage that consists solely of excepted benefits) during the plan year. The reasonable procedures may include a requirement that a participant substantiate enrollment in individual health insurance coverage by providing either: (1) A document from a third party (for example, the issuer) showing that the participant and any dependent(s) covered by the 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 relevant time period); 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.<sup>79</sup> For this purpose, an HRA may rely on the documentation or attestation provided by the participant unless the HRA has actual knowledge that any individual covered by the HRA is not, or will not be, enrolled in individual health insurance coverage (other than coverage that consists solely of excepted benefits) for the plan year.

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 proposed integration rules provide that the HRA may not reimburse a participant for any medical care expenses unless, prior to each reimbursement, the participant provides substantiation (which may be

<sup>79</sup> For purposes of the Code provisions affected by the proposed regulations, the otherwise generally applicable substantiation and recordkeeping requirements under section 6001 of the Code apply, including the requirements specified in Rev. Proc. 98-25 (1998-1 CB 689) for records maintained within an Automated Data Processing system.

in the form of a written attestation) that the participant and, if applicable, any dependent(s) whose medical care expenses are requested to be reimbursed continue to be enrolled in individual health insurance coverage (other than coverage that consists solely of excepted benefits) for the month during which the medical care expenses were incurred. The attestation may be part of the form used for requesting reimbursement. As with the substantiation of enrollment for the plan year, for this purpose, an HRA may rely on the documentation or attestation provided by the participant unless the HRA has actual knowledge that the participant and any individual seeking reimbursement for the month were not enrolled in individual health insurance coverage (other than coverage that consists solely of excepted benefits) for the month.

#### 6. Notice Requirement

Because HRAs are different from traditional employer-provided health coverage in many respects, the Departments are concerned that individuals eligible for HRAs integrated with individual health insurance coverage may not recognize that the offer and/or acceptance of an HRA will have consequences for PTC eligibility, as described elsewhere in this preamble. Therefore, in order to ensure that participants who are eligible to participate in an HRA integrated with individual health insurance coverage understand the potential effect that the offer of and enrollment in the HRA might have on their ability to claim the PTC, these proposed rules include a requirement that an HRA provide written notice to eligible participants. The HRA would 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 would be required to provide the notice no later than the date on which the participant is first eligible to participate in the HRA.

The proposed written notice would be required to include certain relevant information, including a description of the terms of the HRA, including the maximum dollar amount made available, as used in the affordability determination under the Code section 36B proposed rules;<sup>80</sup> a statement of the

<sup>80</sup> The Departments note that in order to comply with the notice requirement, the HRA must determine the amounts that will be newly made

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 regulations; 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 advance payments of the PTC of the availability of the HRA, the amount of the HRA, the number of months the HRA is available to participants during the plan year, whether the HRA is available to their dependents and whether they are a current or former employee; 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 met; and a statement that it is the responsibility of the participant to inform the HRA if the participant or any dependent whose medical care expenses are reimbursable by the HRA is no longer enrolled in individual health insurance coverage.

This notice would provide some of the information the participant needs in order for the participant to ascertain the consequences of the HRA for PTC eligibility, and would inform them of their responsibilities for the HRA. If the requirements of the Department of Labor's proposed rules at 29 CFR 2510.3-1(l) are met, the notice would be required to also include a statement to advise participants that individual health insurance coverage integrated with the HRA is not subject to ERISA (see section IV of this preamble and the Department of Labor's proposed rules at 29 CFR 2510.3-1(l) for additional explanation regarding this requirement).

The written notice would be required to include the information required by the proposed integration rules, and would be permitted to include other information, as long as the additional information does not conflict with the required information.

The written notice would not need to include information specific to a participant. More specifically, although the notice must contain a description of the potential availability of the PTC for a participant who opts out of and waives an unaffordable HRA and must include the HRA amount that is relevant

available for the plan year prior to the plan year. A similar requirement applies under the proposed premium tax credit regulations. See proposed 26 CFR 1.36B-2(c)(5)(v).

for determining affordability under the proposed rules at 26 CFR 1.36B-2(c)(5), the proposed rules would not require the HRA to include in the notice a determination of whether the HRA is considered affordable for the participant. The participant would need additional information (that is, their household income and the premium for the lowest cost silver plan in the Exchange for the rating area where they reside) to determine whether the HRA is affordable under the proposed PTC rules, as described in detail in section III of this preamble.

#### 7. Student Health Insurance Coverage

Federal regulations under PPACA define student health insurance coverage as a type of individual health insurance coverage.<sup>81</sup> Although those regulations exempt student health insurance coverage from certain provisions of PPACA and HIPAA,<sup>82</sup> they do not exempt such coverage from sections 2711 and 2713 of the PHS Act. Therefore, given that student health insurance coverage is a type of individual health insurance coverage, and is required to comply with sections 2711 and 2713 of the PHS Act, the Departments clarify that under the proposed integration rules an HRA may be integrated with student health insurance coverage that satisfies the requirements in 45 CFR 147.145.<sup>83</sup>

The Departments also wish to confirm that prior guidance,<sup>84</sup> which provided

<sup>81</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 meets any additional requirements that may be imposed under State law. See 45 CFR 147.145(a).

<sup>82</sup> See 45 CFR 147.145(b).

<sup>83</sup> Self-insured student health plans are not a form of individual health insurance coverage. Therefore, these proposed integration regulations do not provide for HRA integration with self-insured student health plans.

<sup>84</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, 2016-9 IRB 358; DOL Technical Release 2016-1, available at <http://www.dol.gov/ebsa/newsroom/tr16-01.html>; and Insurance Standards Bulletin, Application of the Market Reforms and Other Provisions of the Affordable Care Act to Student Health Coverage, February 5, 2016, available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/student-health-bulletin.pdf>.

enforcement relief to institutions of higher education for certain healthcare premium reduction arrangements offered in connection with student health coverage (insured or self-insured), remains in effect, pending further guidance.

#### 8. Comment Solicitation Regarding Various Integration-Related Issues

In developing the proposed integration rules, the Departments considered whether to allow HRAs intended to satisfy the individual health insurance coverage integration test also 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, because like individual health insurance coverage, group health plan coverage is generally subject to and compliant with PHS Act sections 2711 and 2713. The Departments are not proposing such a rule because allowing such integration would add significant complexity to the individual health insurance coverage integration test.<sup>85</sup> The Departments request comments regarding whether the Departments should allow for such integration and if so, with respect to PHS Act section 2711 compliance, how such an integration test should be designed to take into account that, while most individual health insurance coverage is required to cover all EHBs, large group market and self-insured group health plans are not required to cover all EHBs. The Departments request comments on the demand for

<sup>85</sup> PHS Act section 2711 applies with respect to the provision of EHBs. Because large group market and self-insured group health plan coverage are not required to provide EHBs, unlike individual health insurance coverage which is generally required to provide 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 regulations under PHS Act section 2711, and in subregulatory guidance that preceded the Departments final 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 regulations 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 EHBs. For additional discussion of the final regulations under PHS Act section 2711 see the discussion earlier in this preamble.



such a rule, and any problems such a rule may raise.

The Departments also considered whether to propose a rule to permit HRAs to be integrated with other types of non-group coverage other than individual health insurance coverage, such as STLDI.<sup>86</sup> However, while all individual health insurance coverage that is currently written is non-grandfathered coverage, and therefore is subject to and, presumably, compliant with PHS Act sections 2711 and 2713 (and most individual market coverage that is renewed is also non-grandfathered), other types of non-group coverage, such as STLDI, may not be subject to PHS Act sections 2711 and 2713, in which case, integration would not be sufficient to ensure that the combined benefit package satisfies these requirements. The Departments request comments on whether integration with STLDI (which is not required to, but which may, satisfy PHS Act sections 2711 and 2713) should be permitted, including whether integration should be permitted with any other type of coverage that satisfies PHS Act sections 2711 and 2713, how such integration rules should be structured, as well as comments on what, if any, potential benefits and problems might arise from allowing these types of HRA integration. The Departments also seek comment on whether allowing such integration would raise any concerns about health status discrimination leading to additional adverse selection in the individual market.

The Departments also seek comment on whether the ability to integrate an HRA with individual health insurance coverage has the potential to increase participation in and strengthen the viability of States' individual market risk pools. Further, the Departments invite comment on whether the proposed integration safeguards are appropriate and narrowly tailored to mitigate adverse selection and the potential for discrimination based on health status, or whether less restrictive safeguards would suffice.

Further, as noted earlier in this preamble, the proposed integration rules do not address cafeteria plan premium arrangements, other than to provide that plan sponsors may offer such an arrangement in addition to an HRA integrated with individual health insurance coverage in certain circumstances. The Departments invite comments on whether employers may seek to provide cafeteria plan premium

arrangements, including as a standalone arrangement, and, if so, what additional guidance is needed in order to facilitate the offering of such arrangements. In particular, the Departments solicit comments on whether the definition of the term "account-based group health plan" should include cafeteria plan premium arrangements in order to permit these arrangements to integrate with individual health insurance coverage subject to the requirements of the rule, including how that treatment would be coordinated with other requirements applicable to employee benefit plans.

#### 9. Revisions to PHS Act Section 2711 Regulations Regarding Integration With Other Group Health Plan Coverage and Medicare

The 2015 regulations under PHS Act section 2711 provide methods for integrating HRAs with coverage under another group health plan, and, in certain circumstances, with Medicare parts B and D. These proposed rules do not substantively change the current group health plan or Medicare integration tests under the existing PHS Act section 2711 regulations. However, these proposed rules include minor proposed revisions to those regulations, including changing the term "account-based plan" to "account-based group health plan" and moving defined terms to a definitions section.

More substantively, these proposed rules would amend the regulations 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. Paragraph (d)(4) of 26 CFR 54.9815-2711, 29 CFR 2590.715-2711 and 45 CFR 147.126 is revised accordingly. In addition, for the sake of clarity, the proposed rules add to paragraph (d)(2) in each of the aforementioned PHS Act section 2711 regulations that an HRA integrated with non-HRA group coverage may not be used to purchase individual health insurance coverage (other than coverage that consists solely of excepted benefits), as the Departments previously clarified in Notice 2015-87, Q&A 2.

In addition, the proposed rules update the definition of EHBs set forth in paragraph (c) of the regulations 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 reflects 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>87</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>88</sup>

#### B. Excepted Benefit HRAs

There may be scenarios in which an employer wishes to offer an HRA that may not be integrated with non-HRA group coverage, Medicare, TRICARE, or individual health insurance coverage. For example, some employers may wish to offer an HRA without regard to whether its employees have other coverage at all or without regard to whether its employees have coverage that is subject to and satisfies the market requirements. Therefore, these proposed rules would utilize the Departments' discretion under section 9832(c)(2)(C) of the Code, section 733(c)(2)(C) of ERISA, and section 2791(c)(2)(C) of the PHS Act, to recognize HRAs as limited excepted benefits, if certain conditions are met.<sup>89</sup>

As explained earlier in this preamble, the Departments have the authority and discretion to specify in regulations additional limited excepted benefits, that are similar to the limited benefits specified in the statute and that either are insured under a separate policy, certificate, or contract, or are otherwise not an integral part of a plan. The Departments are proposing an excepted benefit HRA that is both consistent with this statutory framework and consistent with the Departments' objective of expanding the availability and usability of HRAs.

The proposed rules provide the following four requirements for an HRA to qualify as an excepted benefit HRA: (1) The HRA must not be an integral part of the plan, (2) the HRA must

<sup>87</sup> See 83 FR 16930 (April 17, 2018). The definition of EHB that applies under the PHS Act section 2711 regulations for plan years beginning before January 1, 2020 would not be substantively changed by the proposed rules.

<sup>88</sup> For more information on the revised EHB standard, refer to the preamble to the 2019 Payment Notice, beginning at page 17007.

<sup>89</sup> The proposed rules that recognize certain HRAs as limited excepted benefits do not apply to health FSAs. For a health FSA to qualify as an excepted benefit, the current regulations continue to apply.

<sup>86</sup> See the definition of short-term, limited-duration insurance (STLDI) under 26 CFR 54.9801-2, 29 CFR 2590.701-2, 45 CFR 144.103.

provide benefits that are limited in amount, (3) the HRA cannot provide reimbursement for premiums for certain health insurance coverage, and (4) the HRA must be made available under the same terms to all similarly situated individuals.

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

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, HRAs must meet the statutory requirement to not be “an integral part of the plan.” To satisfy this condition, the proposed rules specify that for an HRA to be an excepted benefit, 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 HRA. Only individuals who are eligible for participation in the other group health plan would be eligible for participation in the excepted benefit HRA. However, while the plan sponsor would be required to make an offer of other group health plan coverage in order to meet this requirement, HRA participants (and their dependents) would not be required to enroll in the other group health plan in order to be eligible for the excepted benefit HRA.

This provision of the proposed excepted benefit HRA is similar to the requirement that applies under the limited excepted benefits regulations 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).

#### 2. Limited in Amount

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. Under the statute, limited benefits may include limited scope vision or dental benefits, benefits for long-term care, nursing home care, home health care, or community-based care, or any combination thereof and may include “such other similar, limited benefits as are specified in regulations” by the Departments.

The Departments consistently have applied limiting principles in prior rulemakings under which discretion was exercised to establish additional types of limited excepted benefits. For example, health FSAs constitute excepted benefits only if the arrangement is structured so that the maximum benefit payable to any

participant in the class for a year may not exceed two times the participant’s salary reduction election under the arrangement for the year (or, if greater, may not exceed \$500 plus the amount of the participant’s salary reduction election).<sup>90</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,<sup>91</sup> or 15 percent of the cost of coverage under the primary plan.<sup>92</sup>

In the proposed rules, the Departments propose that the 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 is defined in these proposed rules by reference to the Chained Consumer Price Index for All Urban Consumers, unadjusted (C–CPI–U), published by the Department of Labor. The adjusted limit for plan years beginning in a particular calendar year will be made available early in the fall of the prior calendar year.

In proposing this limit, the Departments considered several factors, including the limits on employer contributions to excepted benefit health FSAs (set at \$500 in 1997 if there are no employee contributions to the FSA, although it might be much higher if there are employee contributions).<sup>93</sup> The Departments also considered indexing \$500 for medical inflation using the medical care component of the Consumer Price Index for all Urban Consumers (CPI–U). The Departments considered the relationship between \$500 and the average cost of insurance in 1997. The Departments also considered a limit of 15 percent-of-the-cost-of-coverage-under-the-primary-plan test, which is the limit used for both supplemental excepted benefits in the group market and limited wraparound coverage, as a benchmark to ensure that the benefits are limited in amount.<sup>94</sup> In

<sup>90</sup> 26 CFR 54.9831–1(c)(3)(v); 29 CFR 2590.732(c)(3)(v); 45 CFR 146.145(b)(3)(v).

<sup>91</sup> See section 125(i) of the Code.

<sup>92</sup> 26 CFR 54.9831–1(c)(3)(vii); 29 CFR 2590.732(c)(3)(vii); 45 CFR 146.145(b)(3)(vii).

<sup>93</sup> See 26 CFR 54.9831–1(c)(3)(v)(B); 29 CFR 2590.732(c)(3)(v)(B); 45 CFR 146.145(b)(3)(v)(B).

<sup>94</sup> See 26 CFR 54.9831–1(c)(3)(vii)(B)(2); 29 CFR 2590.732(c)(3)(vii)(B)(2); 45 CFR 146.145(b)(3)(vii)(B)(2). See also EBSA Field Assistance Bulletin No. 2007–04 (available at [https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2007-](https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2007-04)

considering how such a limit could be an appropriate limit for excepted benefit HRAs, the Departments considered 15 percent of the cost of group coverage for both employee-only and family coverage. However, the Departments also considered how to determine the primary plan in circumstances in which the participant does not enroll in a traditional group health plan, and concluded that such a determination would likely be difficult for employers. The Departments also considered using the cost of coverage for the second-lowest cost silver plan in various markets. These methodologies produced a wide range of possible excepted benefit HRA limits from \$1,100 to \$2,850. Consistent with the principle of promoting HRA use and availability, rather than proposing a complex test for the limit on amounts newly made available in the excepted benefit HRA, the Departments are proposing a maximum of \$1,800 (indexed for inflation) on amounts newly made available for a plan year. This approximates the midpoint amount yielded by the various methodologies considered.

In proposing to index the amount by C–CPI–U, the Departments considered several factors, including the difficulties of administering an HRA with a changing amount, and the cost, including the cost to the Departments to publish the amount and provide notice every year, as balanced with the decreasing real value of a set HRA limit and the ability of an employer to maintain the HRA benefit at \$1,800, should it choose to do so.

The Departments invite comment on the amount of the proposed maximum dollar limit and whether an alternate amount or formula for determining the maximum dollar limit for an excepted benefit HRA would be more appropriate and, if so, what that alternative would be and why. The Departments specifically request comments on whether the proposed HRA maximum amount of \$1,800 should be higher if the HRA covers dependents (or alternatively, whether the \$1,800 maximum amount should be lower if the HRA only covers the employee). The Departments also invite comments on the measure of inflation used, including whether the amount should be indexed to inflation (and if there are any administrability concerns associated with indexing), if C–CPI–U is the correct measure of inflation, or whether an

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 (2008–07 IRB 433).

alternate measure, such as the overall *medical* care component for CPI-U, or the method specified under section 9831(d)(2)(D) of the Code for QSEHRAs, should be used. The Departments also invite comment on whether the publication of the adjusted limit for plan years beginning in a particular calendar year by early fall of the preceding calendar year will provide employers with sufficient time to adjust the excepted benefit HRA for the upcoming year.

If a participant or dependent in an excepted benefit HRA does not use all of the amounts made available in the excepted benefit HRA to reimburse medical care expenses for a plan year, and the excepted benefit HRA allows for these amounts to be made available to the participant and dependents in later plan years, the Departments propose that these carryover amounts would be disregarded for purposes of determining whether the benefits in the excepted benefit HRA are limited in amount.

Further, the proposed rules provide that if the plan sponsor provides more than one excepted benefit HRA to the participant for the same time period, the amounts made available under such plans are aggregated to determine whether the benefits are limited in amount.

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

As the third requirement for an HRA to be recognized as a limited excepted benefit, the Departments propose that the HRA would not be permitted to reimburse premiums for individual health insurance coverage, coverage under a group health plan (other than COBRA or other group continuation coverage), or Medicare parts B or D. However, the proposed rules would allow an excepted benefit HRA to reimburse premiums for individual health insurance coverage that consists solely of excepted benefits or coverage under a group health plan that consists solely of excepted benefits, as well as for STLDI premiums, and for COBRA premiums.

The Departments have concluded that this limit is appropriate in light of the requirement that excepted benefits under this statutory provision provide only limited benefits. In addition, the Departments have concluded that this condition is appropriate because under our concurrent proposal to permit HRAs to be integrated with individual health insurance coverage and the current regulations that allow HRAs to be integrated with group health plan coverage and to reimburse premiums for Medicare parts B and D in certain

circumstances, an employer that wishes to provide an HRA that reimburses premiums for individual health insurance coverage, coverage under a group health plan, or Medicare parts B or D may do so under the applicable integration rules. Such an approach ensures that excepted benefit HRAs provide limited benefits different from what a traditional group health plan would provide, similar to limited scope dental or vision plans and benefits for long-term care, nursing home care, home health care, and community-based care.

This proposed condition would not limit the ability of an excepted benefit HRA to reimburse premiums for COBRA or other group continuation coverage (premiums for which are generally paid with after-tax funds) or STLDI. Further, the excepted benefit HRA may reimburse premiums other than those listed as specifically excluded. The Departments request comments on this condition, including whether additional clarity is needed regarding whether premiums for certain types of coverage may be reimbursed under the proposed excepted benefit HRA.

### 4. Uniform Availability

To prevent a plan sponsor from intentionally or unintentionally, directly or indirectly, steering any participants or dependents with adverse health factors away from the sponsor's traditional group health plan, the fourth and final requirement for an HRA to be recognized as a limited excepted benefit relates to uniform availability.

Specifically, an excepted benefit HRA would be required to be made available under the same terms to all similarly situated individuals (as defined in the HIPAA nondiscrimination regulations) regardless of any health factor. In the Departments' view, this condition is necessary 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. Therefore, the Departments are proposing a uniform-availability requirement and wish to make it clear that benefits must be provided uniformly, without regard to any health factor. Accordingly, for example, the HRA could not be offered only to employees who have cancer or fail a physical examination, just as the HRA could not be offered only to employees who are cancer-free or who pass a physical examination. Similarly, an employer could not make greater

amounts available to an HRA for employees who have cancer or who fail a physical examination, just as an employer could not make greater amounts available to an HRA for employees who are cancer-free or who pass a physical examination. The Departments request comment on whether additional standards are necessary to prevent abuse and discrimination based on a health factor.

### C. Interaction Between HRAs Integrated With Individual Health Insurance Coverage and Excepted Benefits HRAs

Under the proposed rules, an employer would be permitted to offer an HRA integrated with individual health insurance coverage 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 additional conditions discussed elsewhere in this preamble. However, an employer could 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, an employer would not be permitted to offer both an HRA integrated with individual health insurance coverage and an excepted benefit HRA to any employee.<sup>95</sup>

## III. Overview of the Proposed Rules Regarding the Premium Tax Credit—Department of the Treasury and IRS

### A. Premium Tax Credit Under Section 36B of the Code

Consistent with the objectives in Executive Order 13813 to expand the use of HRAs, the proposed rules would amend the regulations under section 36B of the Code to provide guidance for individuals who are offered or covered by an HRA integrated with individual health insurance coverage as described in the proposed integration rules and who otherwise may be eligible for the PTC.

An individual who is covered by an HRA integrated with individual health insurance coverage is ineligible for the PTC. However, see the discussion earlier in this preamble of the related requirement under the proposed integration rules that plan sponsors provide participants with the periodic opportunity to opt-out of and waive future reimbursements under an HRA.

<sup>95</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 HRA that may be integrated with individual health insurance coverage or an excepted benefit HRA. See section 9831(d)(3)(B)(ii) of the Code.

The proposed rules under section 36B of the Code describe the PTC eligibility of an individual who is offered, but opts out of, an HRA that is integrated with individual health insurance coverage. Consistent with section 36B of the Code and the existing regulations thereunder, the proposed rules provide that an employee who is offered, but opts out of, an HRA integrated with individual health insurance coverage, and an individual who is offered such an HRA because of a relationship to the employee (a related HRA individual), are eligible for MEC under an eligible employer-sponsored plan for any month the HRA is affordable and provides MV. Thus, these individuals are ineligible for the PTC for their Exchange coverage for months the HRA is affordable and provides MV.

Under the proposed rules, an HRA integrated with individual health insurance coverage is affordable for an employee (and a related HRA individual) for a month if the employee's required HRA contribution does not exceed 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)). For this purpose, an employee's required HRA contribution would be 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, or, 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. Under the proposed rules, the monthly self-only HRA amount would be the self-only HRA amount newly made available to the employee from the employee's employer under the HRA for the plan year, divided by the number of months in the plan year the HRA is available to the employee. The monthly maximum amount available to the employee under the HRA, which is relevant if the HRA provides one amount regardless of the number of individuals covered, would be the maximum amount newly made available to the employee under the HRA, divided by the number of months in the plan year the HRA is available to the employee.

The affordability rule in the proposed rules uses 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, without regard to the type of plan in which the employee actually enrolls. 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 section 36B(c)(2)(C)(ii) of the Code for a plan to provide MV. Specifically, section 36B(c)(2)(C)(ii) of the Code and 26 CFR 1.36B-6 provide that an eligible employer-sponsored plan provides MV only if the plan's share of the total allowed costs of benefits provided to an employee under the plan is at least 60 percent.<sup>96</sup> 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 seek to most closely approximate the PTC eligibility rules that apply to offers of eligible-employer sponsored coverage that is not an HRA.<sup>97</sup> That is, the PTC eligibility rules under the proposed regulations for an HRA offer, as well as under section 36B of the Code for an offer of traditional employer coverage, are both based on the affordability of a plan available to the employee for which the plan's share of the total allowed costs of benefits provided under the plan must be at least 60 percent of such costs. (See the discussion later in this section of when an HRA integrated with individual health insurance coverage is considered to provide MV.) The Treasury Department and the IRS seek comment on whether the silver level plan used for this purpose should be the second lowest cost silver plan,<sup>98</sup> instead of the lowest cost silver plan, for self-only coverage offered in the Exchange for the rating area in which the employee resides or whether another plan should be used, and any operational or other issues that the use of the plan proposed

<sup>96</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 section 36B(c)(2)(C)(ii) of the Code for a plan to provide MV. See 45 CFR 156.140.

<sup>97</sup> With regard to an offer of eligible employer-sponsored coverage that is not an HRA, an individual is eligible for the PTC 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 section 36B(c)(2)(C) of the Code.

<sup>98</sup> Note that the monthly premium for self-only coverage for the second lowest cost silver plan in the employee's individual health insurance market is used to determine the affordability of a QSEHRA. See section 36B(c)(4)(C) of the Code.

or any alternative plan would entail. The proposed rules further provide that only amounts that are newly made available for the plan year of the HRA would be taken into account for determining affordability, provided that the amounts are determinable within a reasonable time before the beginning of the plan year of the HRA. Additionally, consistent with the rules for traditional employer coverage,<sup>99</sup> the proposed rules require affordability to be determined separately for each employment period that is less than a full calendar year or for the portions of the plan year of the HRA that fall within different taxable years of the employee. In addition, the proposed rules include examples of affordability calculations.

The proposed rules also address the circumstances in which an HRA is considered to provide MV. As noted earlier in this section of the preamble, section 36B of the Code generally provides that an offer of employer coverage prevents an employee from being allowed the PTC for his or her Exchange coverage only if the employer coverage is both affordable and provides MV. With respect to an offer of an HRA integrated with individual health insurance coverage, the individual health insurance coverage that is proposed to be used for purposes of the affordability test is the lowest cost silver level Exchange coverage for the rating area in which the employee resides, which, as previously noted, will always provide MV. A determination that the integrated arrangement is affordable under the proposed regulations is therefore sufficient to ensure that an employee who is offered an HRA integrated with individual health insurance coverage, and that is determined to be affordable, has the ability to purchase affordable coverage that provides MV. Consequently, the proposed rules provide that an HRA integrated with individual health insurance coverage that is affordable is treated as providing MV.

Determining PTC eligibility in the manner provided under the proposed rules is consistent with current rules for traditional employer coverage. That is, the proposed rules result in consistent treatment for purposes of section 36B of the Code for employees offered an HRA integrated with individual health insurance coverage and employees offered traditional employer coverage. 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

<sup>99</sup> See 26 CFR 1.36B-2(c)(3)(v)(B).

contribution is based on the amount the employee must pay for self-only coverage that provides MV because under the proposed rules affordability would be 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.

The proposed rules also clarify the ways in which the generally applicable employer-sponsored coverage PTC eligibility rules apply to HRAs integrated with individual health insurance coverage.<sup>100</sup> For example, as with traditional coverage under eligible employer-sponsored plans, the proposed rules provide that an HRA integrated with individual health insurance coverage is not affordable for a month for an employee or related HRA individual if, at the time of enrollment in a qualified health plan, an Exchange determines that the HRA is not affordable. This employee safe harbor locks in an Exchange's determination of unaffordability, which is based on estimated household income, even if the HRA ultimately proves to be affordable based on actual household income for the tax year. Consistent with the existing regulations under section 36B of the Code, the employee safe harbor does not apply (1) 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 on affordability; or (2) for an individual who, with intentional or reckless disregard for the facts, provides incorrect information to an Exchange concerning the relevant HRA amount.

#### *B. Employer Shared Responsibility Provisions Under Section 4980H of the Code*

As part of implementing the objectives of Executive Order 13813, the Treasury Department and the IRS have considered how section 4980H of the Code would apply to an employer

<sup>100</sup> The Treasury Department and the IRS have provided guidance regarding 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. This document does not make substantive revisions to those rules but does make clarifying updates to 26 CFR 1.36B-2(c)(3)(v)(A)(5), mainly to incorporate a reference to more recent guidance.

offering an HRA integrated with individual health insurance coverage, as set forth in the proposed integration rules and taking into account the proposed rules described previously in this preamble under section 36B of the Code.

Only ALEs are subject to section 4980H of the Code.<sup>101</sup> The Departments anticipate that many employers that would be interested in offering an HRA integrated with individual health insurance coverage, as set forth in the proposed integration rules, may be smaller employers and, therefore, may not need to consider section 4980H of the Code when designing their HRA program.

For an employer that is an ALE, the employer may owe a payment for a month under section 4980H(a) or section 4980H(b) of the Code or neither. In general, an employer will owe a payment under section 4980H(a) of the Code 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>102</sup> An HRA is an eligible employer-sponsored plan; therefore, if an ALE offers an eligible employer-sponsored plan (including an HRA) to at least 95 percent of its full-time employees and their dependents, the ALE would not be liable for a payment under section 4980H(a) of the Code for the month.

An employer that is an ALE and which 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 section 4980H(a) of the Code) may be liable for a payment under section 4980H(b) of the Code if at least one full-time employee is allowed the PTC, which may occur if the eligible employer-sponsored plan offered was not affordable or did not provide MV, or if the employee was not offered coverage. The extent to which a full-time employee who was offered an HRA will be eligible for the PTC depends on the rules proposed under section 36B of the Code. However, in the near term, the Treasury Department and the IRS intend

<sup>101</sup> The explanation of section 4980H of the Code 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.*, published in the **Federal Register** at 79 FR 8544 (Feb. 12, 2014).

<sup>102</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 section 4980H(a) of the Code. See 26 CFR 54.4980H-4(a).

to issue guidance that describes an anticipated safe harbor for purposes of determining whether an employer that has offered an HRA integrated with individual health insurance coverage would be treated as having made an offer of affordable coverage that provides MV for purposes of section 4980H of the Code, regardless of whether the employee who received that offer declines the HRA and claims the PTC.<sup>103</sup>

#### **IV. Individual Health Insurance Coverage and ERISA Plan Status**

This document includes a DOL-only proposed regulation that would clarify that the ERISA terms "employee welfare benefit plan," "welfare plan," and, as a direct result, "group health plan" would not include individual health insurance coverage the premiums of which are reimbursed by an HRA and certain other arrangements, provided that the employer, employee organization, or other plan sponsor is not involved in the selection of the individual health insurance coverage, among other criteria. Later, this section of the preamble also describes a related clarification made to regulations of all three Departments. DOL's objective in proposing this regulatory clarification is to provide employees; employers, employee organizations, and other plan sponsors; health insurance issuers; state insurance regulators; and other stakeholders with assurance that insurance policies sold as individual health insurance coverage, and subject to comprehensive Federal (and state) individual market rules for minimum and uniform coverage, standardized pricing, guaranteed availability, and guaranteed renewability, are not part of an HRA or certain other arrangements for purposes of ERISA.<sup>104</sup> Specifically, DOL is proposing an amendment to 29 CFR 2510.3-1 on the definition of "employee welfare benefit plan" in section 3(1) of ERISA.<sup>105</sup> This proposed

<sup>103</sup> In addition to setting forth a potential affordability safe harbor, the Treasury Department and the IRS intend to clarify in the upcoming guidance that the affordability safe harbors set forth under 26 CFR 54.4980H-5(e)(2) are available to employers offering an HRA integrated with individual health insurance coverage, subject to the relevant conditions set forth in those regulations.

<sup>104</sup> 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 2004-01 and 2006-02.

<sup>105</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 provided medical care . . . directly or through insurance, reimbursement, or otherwise[.]" DOL has concluded that a separate

amendment would also apply to certain existing 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 individual health insurance coverage that is not covered by the HRA with which the coverage is integrated or that is not covered by a QSEHRA by using a salary reduction arrangement under a cafeteria plan (supplemental salary reduction arrangement).

Section 3(1) of ERISA specifically defines ERISA-covered welfare plans to include “any plan, fund, or program” “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, provisions in the PHS Act generally treat individual health insurance and group health insurance as mutually exclusive categories.<sup>106</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 would likely violate some of the market requirements (for example, the single risk pool requirement). Treatment of such individual health insurance coverage as subject to both individual market and group market requirements thus could 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.

In light of the PHS Act’s treatment of group and individual health insurance coverage policies as mutually exclusive

regulation relating to the definition of group health plan is not needed.

<sup>106</sup> As described earlier, 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), 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103. 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), 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103. Group health insurance coverage means health insurance coverage offered in connection with a group health plan. See ERISA section 733(b)(4), PHS Act section 2791(b)(4), 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103.

categories and the other provisions in this rulemaking addressing the permissible integration of individual health insurance coverage with HRAs, DOL concluded that the ERISA status of such individual health insurance coverage should be clarified in the context of the proposed rules.<sup>107</sup>

Under the proposed regulatory clarification, the status under ERISA of an HRA, QSEHRA, or supplemental salary reduction arrangement would remain unaffected. However, under the proposal, individual health insurance coverage selected by the employee in the individual market and reimbursed by such a plan would not be treated as part of a group health plan, or as health insurance coverage offered in connection with a group health plan, or as a part of any employee welfare benefit plan for purposes of title I of ERISA, provided all the following conditions are satisfied:

- The purchase of any individual health insurance coverage is completely voluntary for employees.<sup>108</sup>
- The employer, employee organization, or other plan sponsor does not select or endorse any particular issuer or insurance coverage. 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.
- Reimbursement for nongroup health insurance premiums is limited solely to individual health insurance coverage.
- The employer, employee organization, or other plan sponsor

<sup>107</sup> It is the intention of DOL that integration of an HRA with individual health insurance coverage obtained in the individual market, as described in the proposed rules, generally will not result in the individual health insurance coverage being treated as an “employee welfare benefit plan” or a “group health plan” within the meaning of title I of ERISA. However, depending on the particular facts and circumstances surrounding the involvement of an employer, the issue may not be free from doubt. Consequently, DOL proposes the clarification herein.

<sup>108</sup> 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. 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.

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.

- Each plan participant is notified annually that the individual health insurance coverage is not subject to ERISA. For an HRA integrated with individual health insurance coverage, the notice must meet the requirements set forth in the proposed integration rules at 29 CFR 2590.702–2(c)(6). For a QSEHRA or an HRA that is not subject to 29 CFR 2590.702–2(c)(6), model language is provided in the DOL proposed amendment, which can be used to satisfy the condition.<sup>109</sup> A supplemental salary reduction arrangement need not provide the required notice; the notice will be provided by the HRA or QSEHRA that the salary reduction arrangement supplements.

DOL invites comments on all aspects of the proposed regulatory clarification. Some of the conditions parallel or are similar to conditions in other existing DOL regulations and related guidance for other types of arrangements, and DOL specifically invites comments on whether all of these conditions are necessary or whether other conditions should be used in place of, or in addition to, those being proposed in this document. DOL has issued guidance describing certain types of employee communications that would not constitute “endorsement” as that condition applies under its regulations on payroll-deduction IRAs, see 29 CFR 2509.99–1, and specifically invites comments on whether similar regulatory or interpretive guidance would be helpful in the context of this proposed regulation. DOL also specifically invites comments on which forms of payment are appropriately treated as “reimbursement” to participants for purposes of this regulatory clarification, consistent with the terms and purposes of ERISA section 3(1). For example, should “reimbursement” be interpreted to include direct payments, individual or aggregate, by the employer, employee organization, or other plan sponsor to the insurance company? DOL also specifically invites comments on whether a better approach would involve providing relief from specified

<sup>109</sup> In DOL’s view, the summary plan description (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 and 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 Title I of ERISA.

otherwise-applicable obligations under ERISA Title I, rather than carving the policy out as if it were outside of ERISA Title I.

Additionally, existing regulations of all three Departments define “group health insurance coverage” as health insurance coverage offered in connection with a group health plan.<sup>110</sup> The Departments propose to amend that definition by clarifying that individual health insurance coverage the premiums of which are reimbursed by an HRA or a supplemental salary reduction arrangement is not offered in connection with a group health plan, and is not group health insurance coverage, provided all the conditions in proposed 29 CFR 2510.3–1(l) (described earlier in this preamble) are satisfied.<sup>111</sup>

In light of the fact that HRAs are subject to many statutory rules and regulations not specifically addressed in this proposed rulemaking, including various reporting, disclosure, fiduciary, and enforcement provisions under title I of ERISA, DOL also specifically invites comment on whether it would be helpful for DOL to issue additional regulations 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). Similarly, the limitation in the proposal 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 which plans, including HRAs, may reimburse employers, employee organizations and other plan sponsors for certain expenses associated with administration of the plan. DOL specifically invites comments on whether there are particular issues in that area related to HRAs, QSEHRAs, or supplemental salary reduction arrangements that would benefit from additional regulatory or interpretive guidance.

<sup>110</sup> 26 CFR 54.9801–2; 29 CFR 2590.701–2, 45 CFR 144.103.

<sup>111</sup> Note that the clarification with respect to the meaning of group health insurance coverage is not relevant for QSEHRAs because QSEHRAs are not group health plans.

## V. Overview of the Proposed Rules Regarding Individual Market Special Enrollment Periods—Department of Health and Human Services

As set forth earlier in this preamble, the Departments are proposing regulations to expand the usability of HRAs and to provide flexibility to employers. The proposed rules allowing integration of an HRA with individual health insurance coverage require that the individuals whose medical care expenses may be reimbursed under the HRA must be enrolled in individual health insurance coverage (other than coverage that consists solely of excepted benefits). With the ability to integrate HRAs with individual health insurance coverage, many employees may need access to individual health insurance coverage, on or off Exchange, or may wish to change to another individual health insurance plan in order to take advantage of this employee benefit. Therefore, HHS is proposing a regulation to allow employees and their dependents to enroll in individual health insurance coverage or to change from one individual health insurance coverage plan to another outside of the individual market annual open enrollment period if they gain access to an HRA integrated with individual health insurance coverage.

In addition, because employees and dependents with a QSEHRA generally must be enrolled in MEC,<sup>112</sup> and a significant category of MEC is individual health insurance coverage, HHS has determined that it is also appropriate to apply the new special enrollment period to individuals who are provided QSEHRAs.<sup>113</sup>

More specifically, HHS proposes to add new paragraph 45 CFR 155.420(d)(14) to establish a special enrollment period for when a qualified individual, enrollee, or his or her dependent gains access to and enrolls in an HRA integrated with individual health insurance coverage or is provided a QSEHRA, so that the individual and his or her dependents may enroll in or

<sup>112</sup> Generally, payments from a QSEHRA to reimburse an eligible employee’s medical care expenses are not includible in the employee’s gross income if the employee has coverage that provides MEC as defined in section 5000A(f) of the Code, which includes individual health insurance coverage.

<sup>113</sup> The Departments note that the new special enrollment period provided in the proposed rules applies only for individuals who gain access to HRAs integrated with individual health insurance coverage or for individuals who are provided QSEHRAs. Therefore, the new special enrollment period provided in the proposed rules would not apply for individuals who gain access to the proposed excepted benefit HRA.

change his or her enrollment in individual health insurance coverage.

45 CFR 155.420(d)(14) would provide access to coverage in the circumstance in which an employer after the start of the calendar year newly begins offering an HRA to its employees that is integrated with individual health insurance coverage or newly begins providing a QSEHRA to its employees. HHS anticipates that many employers that choose to offer an HRA integrated with individual health insurance coverage or to provide a QSEHRA will do so on a calendar year basis, which will allow employees to enroll in or change individual health insurance coverage during the annual open enrollment period. However, HHS is aware that employers may begin offering HRAs and providing QSEHRAs to their employees at any time during the calendar year and has determined that employers are best suited to determine which twelve-month period to use for their plan year. In addition, the new special enrollment period would apply to individuals who newly gain access to and enroll in an HRA integrated with individual health insurance coverage or who are provided a QSEHRA outside of open enrollment, for example, because the employee is hired after the start of the calendar year.

HHS notes that for some situations in which an employee would newly gain access to an HRA integrated with individual health insurance coverage or would newly be provided a QSEHRA, access to coverage already exists under current authority in 45 CFR 155.410 or 155.420(d). For example, if an employer begins offering an HRA integrated with individual health insurance coverage or begins providing a QSEHRA effective January 1, employees may already enroll in or change individual health insurance coverage during the annual open enrollment period described in 45 CFR 155.410 with such coverage becoming effective January 1 (to coincide with the availability of the HRA or QSEHRA). Similarly, if an employer previously offered another type of group health plan coverage and decides to stop offering that coverage after the start of the calendar year to some or all of its employees (or the plan year ends after the start of the calendar year) and instead begins offering those employees an HRA integrated with individual health insurance coverage or begins providing a QSEHRA to them, the employees might already qualify for a special enrollment period due to a loss of MEC in accordance with 45 CFR 155.420(d)(1). In addition, an employee without a prior offer of employer coverage who is enrolled in Exchange

coverage with advance payments of the PTC and cost-sharing reductions (CSRs) currently may qualify for the special enrollment periods in 45 CFR 155.420(d)(6)(i) or (ii) upon gaining access to an HRA integrated with individual health insurance coverage or being provided a QSEHRA after the start of the calendar year, if that results in the loss of eligibility for advance payments of the PTC or a reduction or loss of eligibility for CSRs. However, if this same employee was enrolled in Exchange coverage without advance payments of the PTC or CSRs, he or she would not qualify for this special enrollment period upon gaining access to an HRA integrated with individual health insurance coverage or being provided a QSEHRA after the start of the calendar year, and would instead need the proposed new special enrollment period in 45 CFR 155.420(d)(14) in order to change Exchange coverage.

Because access to and enrollment in health coverage varies by employers and among employees, as does employees' current ability to qualify for a special enrollment period should they gain access to an HRA integrated with individual health insurance coverage or be provided a QSEHRA, HHS has concluded that it is necessary to establish a new special enrollment period as proposed under 45 CFR 155.420(d)(14) so that all employees (and their dependents) who gain access outside of the individual market open enrollment period (for example, after the start of the calendar year) and enroll in HRAs integrated with individual health insurance coverage or are provided QSEHRAs, regardless of their prior coverage situations, may utilize this employee benefit by enrolling in or changing their enrollment in individual health insurance coverage at that time.

HHS proposes to establish a coverage effective date for the special enrollment period in 45 CFR 155.420(d)(14) of the first day of the first month following the individual's plan selection, which is proposed at 45 CFR 155.420(b)(2)(vi). HHS has concluded that a first-of-the-following-month coverage effective date is appropriate for this special enrollment period because it aligns with the coverage effective date option elected by the Federally-facilitated Exchanges (FTEs) for qualified individuals, enrollees, or dependents, including employees, who qualify for a special enrollment period for loss of MEC under 45 CFR 155.420(d)(1). This coverage effective date also aligns with the coverage effective date option elected by the FTEs for the special enrollment period at 45 CFR 155.420(d)(6)(iii), applicable when

employees enrolled in employer-sponsored coverage are determined newly eligible for advance payments of the PTC based in part on a finding that they are ineligible for coverage in an eligible-employer sponsored plan in accordance with 26 CFR 1.36B-2(c)(3). HHS has concluded that these existing qualifying events, also known as triggering events, and the new proposed qualifying event are similar to one another and affect potentially overlapping populations and, therefore, should entitle qualifying individuals to the same coverage start dates.

Similarly, HHS proposes to offer the option for advance availability, in addition to subsequent availability, for the proposed special enrollment period in 45 CFR 155.420(d)(14), which would allow qualified individuals, enrollees, and dependents to qualify for this special enrollment period up to 60 days in advance of the qualifying event, as described in paragraph 45 CFR 155.420(c)(2) of the proposed rules. Under this advance availability in combination with 45 CFR 155.420(b)(2)(vi), if an individual's plan selection is made before the date of the qualifying event, then coverage would be effective the first day of the month following the date of the qualifying event, or, if the triggering event is on the first day of a month, on the date of the triggering event. In cases where the qualifying event is the first day of the month, for example, if an individual will gain access to an HRA that can be integrated with individual health insurance coverage on April 1, so long as a plan is selected prior to that date (before or on March 31), the effective date of this new coverage will be the date of the qualifying event (April 1). Advance availability allows individuals who are aware of an upcoming change in eligibility or coverage status to report this change to the Exchanges ahead of time, select a plan, and enroll with a coverage effective date that helps minimize a potential gap in coverage. Because participants whose employers begin offering HRAs integrated with individual health insurance coverage or begin providing QSEHRAs generally must be notified at least 90 days prior to the plan year, participants would have advance knowledge of either benefit. Therefore, HHS has concluded that it makes sense to allow the participant to report this upcoming change to the Exchanges in advance, if desired. Individuals may alternatively elect to report the qualifying event up to 60 days after the date of the qualifying event and qualify for the special enrollment period during the regular

special enrollment period window, in accordance with 45 CFR 155.420(c)(1).

In addition, in order to allow participants and their dependents the flexibility to adequately respond to gaining access to an HRA integrated with individual health insurance coverage or to being provided a QSEHRA, HHS also proposes to amend 45 CFR 155.420(a)(4)(iii) to exclude Exchange enrollees who would qualify for the proposed special enrollment period in 45 CFR 155.420(d)(14) from plan enrollment restrictions upon qualifying for this special enrollment period.

Lastly, since these proposed rules would allow 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 both on and off Exchange), HHS proposes to include this special enrollment period in the limited open enrollment periods available off Exchange, in accordance with current regulations at 45 CFR 147.104(b)(2). Therefore, an employee or an employee's dependent who gains access to an HRA integrated with individual health insurance coverage or who is provided a QSEHRA may elect to enroll in or change to different Exchange or off-Exchange individual health insurance coverage.

HHS seeks comments on these proposals. If an employer begins offering an HRA or providing a QSEHRA to its employees during the calendar year outside of the Exchange annual open enrollment period, subsequent plan years likely will also begin during the calendar year. Therefore, HHS also seeks comments about whether the proposed new special enrollment period at 45 CFR 155.420(d)(14) should be available to employees who have and are enrolled in an HRA or are provided a QSEHRA each year at the time their new health plan year starts. This would allow employees to enroll in or change to a new plan in response to updated information about their HRA or QSEHRA benefit for each of their group health plan years.

## VI. Applicability Date

The proposed HRA integration and HRA excepted benefit provisions described in section II of this preamble, as well as the DOL clarification and the clarification by the Departments described in section IV of this preamble, are proposed to apply to group health plans and health insurance issuers for plan years beginning on or after January 1, 2020. The PTC provisions described in section III of this preamble are



proposed to be effective for taxable years beginning on and after January 1, 2020, and the HHS special enrollment period provisions described in section V of this preamble are proposed to be effective January 1, 2020. Taxpayers and others may not rely on these proposed rules. The Departments solicit comments on this proposed applicability date.

## VII. Economic Impact and Paperwork Burden

### A. Summary

The proposed rules would remove the current prohibition on integrating HRAs with individual health insurance coverage, if certain conditions are met. The proposed rules also set forth conditions under which certain HRAs would be recognized as limited excepted benefits. In addition, the Treasury Department and the IRS are proposing rules regarding PTC eligibility for individuals offered coverage under an HRA integrated with individual health insurance coverage. Further, DOL is proposing a clarification to provide HRA, QSEHRA and supplemental salary reduction arrangement plan sponsors with assurance that the individual health insurance coverage the premiums of which are reimbursed by an HRA, QSEHRA or supplemental salary reduction arrangement would not become part of an ERISA plan if certain conditions are met, and the Departments are proposing a related clarification to the definition of group health insurance coverage. Finally, HHS is proposing rules that would provide a special enrollment period in the individual market for individuals who gain access to an HRA integrated with individual health insurance coverage or who are provided a QSEHRA.

The Departments have examined the effects of the proposed 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 1 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 1 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 1 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 proposed rules. In accordance with the provisions of Executive Order 12866, the proposed rules were reviewed by OMB.

### 1. Need for Regulatory Action

This regulatory action is taken in light of Executive Order 13813 directing the Departments to consider proposing regulations or revising guidance to expand the flexibility and use of HRAs. Consistent with Executive Order 13813, the proposed rules are intended to increase the usability of HRAs to provide more Americans, including employees who work at small businesses, with more healthcare options. Such 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.

The Departments are of the view that the benefits of the proposed rules would substantially outweigh the costs of the rules. The proposed rules would increase flexibility and choices of health coverage options for employers and employees. The increased use of HRAs could potentially reduce healthcare spending, particularly less efficient spending,<sup>114</sup> and ultimately result in increased taxable wages for workers currently in firms that offer traditional group health plans. The proposed 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 Proposed HRA Integrated With Individual Health Insurance Coverage.

The expected costs, benefits and transfers of the proposed rules are summarized in Table 1 and discussed in detail later in this section of the preamble.

TABLE 1—ACCOUNTING TABLE

Costs:

Qualitative:

- Loss of health insurance and potentially poorer financial or health outcomes for some individuals who experience premium increases.

<sup>114</sup> By less efficient healthcare spending, the Departments generally mean spending that is of low

value from the consumer’s perspective, relative to its cost.

TABLE 1—ACCOUNTING TABLE—Continued

- Increased administrative costs for employers, employees, and government agencies to learn about and/or use a new health benefits option.

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.

Transfers	Estimate (billion)	Year dollar	Discount rate (percent)	Period covered
Annualized Monetized (\$/year) (Net tax revenue loss) .....	\$2.7	2020	7	2020–2028
	\$2.8	2020	3	2020–2028

Quantitative:<sup>115</sup>

- Reduced tax revenue as a result of new HRAs offered by employers previously offering no health benefits, less reduced PTC from employees in such firms.
- Increase in average individual market premiums of less than 1 percent and resulting increase in PTC.

Qualitative:

- 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.e., transfers from reduced within-firm cross-subsidization).
- Reduced tax revenue as a result of new excepted benefit HRA.

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 proposed rules. This includes PPACA, the reduction of the individual shared responsibility payment to \$0, as enacted in Public Law 115–97, the AHP final rule,<sup>116</sup> the STLDI final rule,<sup>117</sup> and all other administrative actions finalized as of the date of issuance of the proposed rules.

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 would experience worse financial or health outcomes as a result of the proposed rules.<sup>118</sup> Loss of coverage could occur if employers drop traditional group health plans and if some previously covered employees do not accept the HRA and fail to obtain their own coverage. Loss of coverage could also 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. In addition, 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. As discussed below, the Departments estimate that

choice and coverage would, on net, be increased by adoption of the proposed rules. The Departments request comments on this finding and the extent to which the proposed rules could reduce employee choice or cause some individuals to become uninsured.

*Increased administrative costs.* The proposed rules would also increase some administrative costs for employers, employees, and government entities.

All employers would have a new health benefits option about which to learn. Employers who offer HRAs integrated with individual health insurance coverage but did not offer employer-sponsored health benefits before would face increased costs of administering a health benefit. In addition, all employers that offer HRAs integrated with individual health insurance coverage would be required to establish reasonable procedures to substantiate that individuals covered by the HRA are enrolled in individual health insurance coverage; 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 HRAs integrated with individual health insurance coverage would need to establish

<sup>115</sup> The monetized estimates are of the net tax revenue loss, including reduced income and payroll tax revenue from employees who would receive HRAs and would not otherwise have a tax exclusion for a traditional group health plan, reduced PTC from individuals who would receive HRAs and would otherwise receive PTC, and increased PTC due to the increase in Exchange premiums. 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 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. The Departments request comments on the likely costs, benefits and transfers that would result from the proposed rule.

<sup>116</sup> See 83 FR 28912.

<sup>117</sup> See 83 FR 38212.

<sup>118</sup> The Departments note however that increased insurance coverage does not necessarily result in better 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/NEJMs1212321>; 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).

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 section 4980H of the Code, the employer would need to learn about the proposed PTC regulations and any other related guidance under section 4980H of the Code that the Treasury Department and the IRS may issue. As noted later in this preamble, administrative costs associated with HRAs integrated with individual health insurance coverage could be lower than costs for traditional group health plans for some employers. The Departments request comment on the extent to which employer administrative costs would be increased or decreased by the proposed rules.

As to increased administrative burden and costs for employees, employees who previously enrolled in a traditional group health plan and who now receive an HRA integrated with individual health insurance coverage would need to shop for and choose their own insurance and learn new procedures for accessing their HRA benefits. In addition, employees who receive an HRA integrated with individual health insurance coverage would 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 HRA integrated with individual health insurance coverage precludes them from claiming the PTC. For employees who previously did not receive an offer of a traditional group health plan, this would require learning the PTC eligibility rules, and for employees who previously received an offer of a traditional group health plan, this would require learning new and 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 proposed PTC regulations, an employee who is offered an HRA integrated with individual health insurance coverage would 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 HRA 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 proposed rules would 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 second lowest cost silver plan for the coverage unit offered in the Exchange for the rating area in which the employee resides. As noted earlier, the proposed PTC rule uses the premium for the lowest cost silver plan offered in the Exchange for the rating area in which the employee resides solely for purposes of PTC eligibility criterion related to an offer of an HRA integrated with individual health insurance coverage. Therefore, Exchange enrollees would need to understand which silver level plan premium applies to them for eligibility purposes and which silver level plan premium applies to their PTC calculation.

Similarly, the Federally-facilitated and State-based Exchanges would incur one-time costs to incorporate the proposed special enrollment period and the PTC regulations, if finalized, into their instructions for enrollees and Exchange employees and in automated calculations. HHS estimates that one-time costs to account for HRAs integrated with individual health insurance coverage for the FFE would be approximately \$2.7 million to \$3.6 million. In addition, the FFE call center and eligibility support contractors would incur additional annual cost of approximately \$255 million annually by 2028 to serve the expanded Exchange population. Assuming that State-based Exchanges (SBEs) would incur costs similar to the FFE, total one-time costs incurred by the 12 SBEs would be \$32.4 million to \$43.2 million. Total additional ongoing costs incurred by the call centers and eligibility support contractors for the 12 SBEs would be approximately \$85 million annually by 2028. The Departments request comments on the implementation and ongoing costs for SBEs. The IRS also would need to add information regarding employees offered HRAs integrated with individual health

insurance coverage to instructions for IRS forms for taxpayers, employee training materials, and calculation programs.

The Departments are of the view that the total increase in administrative costs is likely to be modest, and would be significantly outweighed by the benefits of the rule outlined in the next section.

#### 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 HRAs integrated with individual health insurance coverage. As explained in greater detail in the Transfers section later in this preamble, the Departments estimate that on net, the number of insured persons would increase by about 800,000 by 2028, due to the proposed 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.

*Increased choice and flexibility for employees and employers.* As a result of the proposed rules, employees would be able to purchase insurance with a tax subsidy by use of an HRA, without being locked into a specific plan or selection of plans chosen by their employer. As noted earlier in this preamble, 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 a new individual health insurance coverage that covers their preferred healthcare providers. However, the expansion of enrollment in the individual market due to the proposed rules could also induce additional insurers to provide individual market coverage. The Departments are of the view that on net, the rule would significantly increase choice and flexibility for employees. Employers also would benefit from having another choice of a tax-preferred health benefit to offer their employees, potentially enabling them 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 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. In addition, some employers offer plans

with a wide choice of providers, reflecting the diverse preferences and healthcare needs of their employees. This weakens the ability of employers and insurers to negotiate lower provider prices or otherwise manage employee care.

By expanding the ability of consumers to choose coverage that fits their preferences, the proposed rules would reduce these inefficiencies in labor markets and healthcare spending. Some employees who would be offered HRAs under the proposed rules would 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 HRAs integrated with individual health insurance coverage and corresponding increases in taxable wages. However, these benefits are uncertain and would take some time to occur.<sup>119</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.

Small employers in particular 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

<sup>119</sup> The proposed HRA integrated with individual health insurance coverage 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 proposed 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 proposed 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 below.

otherwise provide on 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 section 4980H of the Code. Qualified small employers can also pursue establishment of QSEHRAs. Thus, small employers whose employees have particularly high healthcare costs or that have little skill or interest in administering health benefits might use these other options to control costs even in the absence of the proposed rules. If so, any increased efficiency gain from providing an additional incentive for small employers to drop traditional group health plans in favor of HRAs integrated with individual health insurance coverage could be modest.

*Reduced administrative costs for some employers.* Employers that offer an HRA integrated with individual health insurance coverage rather than a traditional group health plan could experience reduced administrative costs. For example, such employers would no longer need to choose health insurance plans or self-insured health benefits for their employees and manage those plans. However, some of these costs would be borne by HRA recipients, as part of their individual market premiums.

#### Transfers

The Treasury Department performed microsimulation modeling to evaluate the coverage changes and transfers that are likely to be induced by the proposed 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>120</sup>

<sup>120</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

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 HRA, and the quality of different types of coverage (including actuarial value).<sup>121</sup> The tax preference for the HRA integrated with individual health insurance coverage is the same as that for a traditional group health plan, and this estimate assumes that employers would contribute the same amount towards an HRA integrated with individual health insurance coverage as they would contribute for a traditional group health plan.<sup>122</sup> Therefore, an employee would prefer an HRA integrated with individual health insurance coverage 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

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 section 4980H of the Code by firms that offer coverage.

<sup>121</sup> Expected health care 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 our 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>122</sup> It is possible that employers that switch from offering traditional group health plans to offering HRAs integrated with individual health insurance coverage will contribute less to HRAs than they pay for group coverage, and increase taxable wages by a corresponding amount. However, 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 HRAs integrated with individual health insurance coverage, particularly since the proposed rules generally require that HRAs integrated with individual health insurance coverage be offered on the same terms to all employees in a class of employees, as described earlier in this preamble.

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).

When evaluating the choice between an HRA integrated with individual health insurance coverage and the PTC for Exchange coverage, the available coverage is assumed to be the same, but the tax preferences are different. Hence, an employee would prefer the 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 the employee share of premiums is tax-preferred, either through a salary reduction plan or, for an individual with an HRA integrated with individual health insurance coverage, through reimbursement of premiums from the HRA, with any additional premiums paid through a salary reduction arrangement.<sup>123</sup>

In the Treasury Department's model, employees are aggregated into firms, based on tax data.<sup>124</sup> The expected health expenses of employees in the firm determine the cost of employer-sponsored insurance for the firm.<sup>125</sup> Employees effectively vote for their preferred coverage, and each employer's

<sup>123</sup> The assumption that coverage subsidized by the PTC is the same as coverage subsidized by an HRA may be incorrect to the extent that coverage on the Exchange differs from off-Exchange individual health insurance coverage. In addition, the assumption that the full premium for an employee with or without an HRA is tax preferred may be incorrect if the employer does not offer a salary reduction plan, if the employee does not elect the salary reduction, or if the employee chooses on-Exchange rather than off-Exchange coverage. Salary reductions may not be used to pay premiums for Exchange coverage. The Departments invite comments on whether these assumptions are important or likely to be incorrect.

<sup>124</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>125</sup> Some small firms 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 Treasury's model for these firms. As a result, our model likely over-estimates the extent to which small firms would adopt HRAs integrated with individual health insurance coverage. On the other hand, our assumption that administrative burdens and costs for employees and employers are about the same for HRAs integrated with individual coverage as for traditional group health plans could result in an under-estimate of the extent to which small firms with higher than average administrative costs would adopt HRAs integrated with individual health insurance coverage.

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 determines premiums for both employer coverage and individual 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 HRAs integrated with individual health insurance coverage.* Based on microsimulation modeling, the Departments expect that the proposed rules would cause some participants (and their dependents) to move from traditional group health plans to HRAs integrated with individual health insurance coverage. As previously noted, the estimates assume that for this group of firms and employees, employer contributions to HRAs integrated with individual health insurance coverage 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 welcome comments on these assumptions.

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.

Some employees who are 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 HRA integrated with individual health insurance coverage because the HRA integrated with individual health insurance coverage is determined to be affordable under the proposed PTC eligibility rules.<sup>126</sup> In addition, some employees who are offered HRAs integrated with individual health insurance coverage

<sup>126</sup> As noted below, however, the Departments' estimates assume that individuals with incomes below 200 percent of the federal poverty level are not newly firewalled from the PTC by HRA offers.

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 proposed PTC rules, even though the traditional group health plan they were previously offered is affordable under current rules.<sup>127</sup>

*Transitions from no employer-sponsored health benefit to HRAs integrated with individual health insurance coverage.* The Departments expect some employees to be offered HRAs integrated with individual health insurance coverage when they previously received no offer of an employer-sponsored health plan. As a result, taxable wages would fall and non-taxable wages would rise, reducing income tax and payroll tax revenues. In addition, some Exchange enrollees who previously claimed the PTC would 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.

*Summary of transfers and coverage changes.* The Departments estimate that once employers fully adjust to the proposed rules, roughly 800,000 firms would offer HRAs integrated with individual health insurance coverage. The Departments further estimate that it would take employers and employees about five years to fully adjust to the proposed 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 1.0 million individuals receiving an HRA integrated with individual health insurance coverage in 2020, growing to 10.7 million in 2028. Conversely, the number of individuals in traditional group health plan coverage would fall by an estimated 0.6 million (0.4 percent) in 2020 and 6.8 million (4.5 percent) in 2028. Similarly, the number of individuals in individual health insurance coverage without an HRA would fall by an estimated 0.3 million (2.2 percent) in 2020 and 3.2 million (23.2 percent) in 2028. The number of uninsured persons would fall by an estimated 0.1 million in 2020 and by an

<sup>127</sup> The number of persons newly eligible for the PTC is expected to be very small. Under the assumption that employers contribute the same amount towards an HRA as they would for traditional group 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).

estimated 0.8 million (1.3 percent) in 2028.<sup>128</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 HRA integrated with individual health insurance coverage 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 less than 1 percent as a result of the proposed rules, throughout the 2020–

2028 period examined. The Treasury Department model is nationally representative and does not necessarily reflect the expected experience for every market. The premium increase resulting from adverse selection could be larger in some markets, and premiums could fall in other markets. The Departments invite comments on the extent to which firms with healthy or less healthy risk pools would utilize HRAs integrated with individual health insurance coverage.

Income and payroll tax revenues would be expected to fall by about \$500

million in fiscal year 2020 and \$13.0 billion in 2028, as firms newly offer tax-preferred health benefits in the form of HRAs integrated with individual health insurance coverage. At the same time, total PTC would be expected to fall by about \$100 million in 2020 and by about \$6.9 billion in 2028. In total, the proposed rule is estimated to reduce tax revenue by about \$400 million in fiscal year 2020, \$6 billion in fiscal year 2028, and \$29.8 billion over the nine-year period through fiscal year 2028.<sup>129</sup>

TABLE 2—ESTIMATED EFFECTS OF HRAS INTEGRATED WITH INDIVIDUAL HEALTH INSURANCE COVERAGE ON INSURANCE COVERAGE AND TAX REVENUES, 2020–2028

Calendar year	2020	2021	2022	2023	2024	2025	2026	2027	2028
Change in Coverage [Millions]: <sup>a</sup>									
Individual health insurance coverage with HRA .....	1.0	2.5	5.0	7.7	10.3	10.4	10.6	10.7	10.7
Traditional group health plan Individual health insurance coverage without HRA .....	-0.6	-1.6	-3.3	-4.9	-6.6	-6.7	-6.7	-6.8	-6.8
Uninsured .....	-0.3	-0.7	-1.5	-2.2	-3.0	-3.0	-3.1	-3.2	-3.2
	-0.1	-0.2	-0.3	-0.5	-0.7	-0.7	-0.7	-0.7	-0.8
Fiscal year	2020	2021	2022	2023	2024	2025	2026	2027	2028
Change in Revenue [Billions]:									
Premium Tax Credit Reduction .....	0.1	0.5	1.7	3.2	4.8	5.4	6.0	6.5	6.9
Other Income and Payroll Tax Reduction .....	0.5	1.5	3.3	5.7	8.3	9.6	11.1	12.2	13.0
Net Revenue Reduction .....	0.4	1.0	1.5	2.4	3.4	4.2	5.0	5.8	6.0

**Notes:**

a. Millions of covered lives, annualized.

The Departments acknowledge that the extent to which firms would offer HRAs integrated with individual health insurance coverage and the results on individual market risk pools and premiums, federal tax revenues, and private costs and benefits are highly uncertain. The Departments invite comment on the estimates and assumptions discussed previously in this preamble.

The Departments particularly emphasize that these estimates assume that every employee in a firm would be

offered either an HRA integrated with individual health insurance coverage 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 such an 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>130</sup> In other words, the estimates assume that the proposed rules would 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.

HRA participation and transfers including individual market premium increases would likely be higher if these assumptions are incorrect. Because the number of individuals in traditional group health plans is large relative to the number of individuals in individual health insurance coverage, relatively

<sup>128</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 Treasury'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>129</sup> These revenue estimates do not account for the possibility that the proposed rules would lead to increased taxable wages.

<sup>130</sup> The Departments imposed two constraints on the microsimulation that could be consistent with allowing the HRA offer to vary across 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 HRA or to uninsured status as a result of the proposed rule. This is consistent with assuming that employers with low-wage workers currently receiving Medicaid or the PTC do not begin to offer 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 would move to other jobs that would allow them to retain their current coverage. This assumption reduces the amount of PTC savings generated by the proposal, and also reduces the tax revenue cost of providing 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 proposed rule, even if individual plan premiums are substantially higher than the cost of their traditional group health plan coverage. This is consistent with assuming that employers would provide larger HRAs to older employees or to employees in higher-cost markets than they would provide to other employees in their firms, in order to ensure affordable coverage. It is also consistent with assuming that employees would move to other firms, if they face large premium or cost-sharing increases when their employers switch from traditional group coverage to HRAs integrated with individual health insurance coverage.

small changes in employer offers of coverage can result in large changes in individual market premiums.<sup>131</sup> Consider the following illustrative, simplified example. The Departments estimate that about 80 percent of individuals in employer-sponsored coverage are relatively healthy and 20 percent are relatively unhealthy. Relatively healthy persons in the employer market have health costs equal to about a quarter of average single enrollee costs in the individual market and unhealthy persons in the employer market have health costs that are about three times the cost of the average person in the individual market.<sup>132</sup> Thus, if 5 million individuals moved from the employer market to the individual market, and these 5 million were representative of the average for the employer market with a ratio of healthy to unhealthy of 4 to 1, then individual market premiums would fall by about 3 percent. If, however, a disproportionate number of unhealthy employees enter the individual market, premiums in the individual market would rise. For example, if 3 million healthy and 2 million unhealthy enrollees entered the individual market, premiums would increase by an estimated 14 percent.

The Departments seek comment on the extent to which employers would offer different benefits to different classes of employees, including the classes based on rating area and all other classes, and on combinations of the classes, and the resulting effect on individual market premiums.

The Departments also emphasize that these estimates assume that employers would contribute the same amount to HRAs integrated with individual health insurance coverage 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 HRAs under the proposed rule 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. Higher cost-sharing and narrower provider networks could cause individuals to be more cost-conscious consumers of healthcare.

In addition, the estimates assume that the entire 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 HRA balances over from year to year, and that some employers would allow employees to continue to spend accumulated HRA funds even after separating from their employer. Moreover, HRA benefits are subject to COBRA protections, such that some employees would 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, HRAs may only be used for healthcare. In addition, unlike HSAs, 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. The Departments welcome comment on the extent to which HRA balances would likely be allowed to accumulate over time and accessed after employees separate from employment, and the extent to which employees would be incentivized to become more cost-conscious consumers of healthcare.

These estimates further assume that all individual health insurance coverage integrated with an HRA would be treated as subject to and compliant with sections 2711 and 2713 of the PHS Act. The proposed rules prohibit an HRA from being integrated with STLDI and excepted benefits, which are not subject to the market requirements. Grandfathered coverage in the individual market is not subject to the annual dollar prohibition in section 2711 of the PHS Act or to the preventive services requirements in section 2713 of the PHS Act. However, the proposed rules would not require employees or employers to confirm that individual health insurance coverage integrated with an HRA is not grandfathered coverage. Requiring such confirmation would be administratively burdensome

and the Departments expect that the number of employees who might use an HRA to buy such coverage would be extremely small, because individuals can only renew and cannot newly enroll in grandfathered individual health insurance coverage.

### 3. Impact of Excepted Benefit HRA

The proposed 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 after 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, 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, state, or other continuation coverage), or Medicare parts 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.

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 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. The Departments welcome comments on the costs and benefits of the proposed excepted benefit HRA and the extent to which firms and employees would be likely to adopt such HRAs.

### C. Regulatory Alternatives

In developing the proposed 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.

<sup>131</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.

<sup>132</sup> Estimates are derived from RTI MarketScan claims data for 2014. These data indicate that 80 percent of persons in the employer market have no Hierarchical Condition Codes (HCCs) while 20 percent had one or more HCCs. Persons with no HCCs had costs equal to 24 percent of average single enrollee costs in the individual market and persons with one or more HCCs had costs equal to three times the average individual market enrollee cost.

However, the Departments determined that the adverse selection concerns that gave rise to the prohibition could be adequately addressed by including appropriate mitigating conditions in the proposed integration rules. Further, the Departments determined that eliminating the prohibition on integrating HRAs with individual health insurance coverage would increase the usability of HRAs which would provide more Americans, including employees who work at small businesses, with additional healthcare options. Such changes would 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 adding additional options for employers.

*Alternative approaches for safeguards intended to prevent health discrimination and adverse selection under the proposed integration rules.* In developing the safeguards designed to prevent adverse selection, the Departments considered whether such safeguards are needed and alternatives for the design of such safeguards. As explained in more detail earlier in this preamble, although the Departments considered that it is possible that the consequences of HRA expansion for the individual market could be positive, the Departments determined that allowing HRAs to be integrated with individual health insurance coverage is more likely to result in opportunities for employers to discriminate by encouraging higher risk employees to obtain coverage in the individual market in order to reduce the cost of traditional group health plan coverage provided by the employer to lower risk employees. Such an arrangement could worsen adverse selection and raise premiums in the individual market if HRAs integrated with individual health insurance coverage are used disproportionately by higher risk employees. Thus, there is risk with permitting HRAs to be integrated with individual health insurance coverage without appropriate safeguards.

Accordingly, to significantly temper these concerns, the proposed integration rules prohibit a plan sponsor from offering the same class of employees both a traditional group health plan and an HRA integrated with individual health insurance coverage (or a choice between the two). In addition, to the extent a plan sponsor offers an HRA integrated with individual health insurance coverage to a class of employees, the proposed integration

rules require that the HRA be offered on the same terms to all employees within the class, subject to certain exceptions.

In designing these safeguards, the Departments considered various alternatives, including prohibiting an employer that offers an HRA integrated with individual health insurance coverage from offering a traditional group health plan to any of its employees. The Departments instead decided to allow employers to offer either a traditional group health plan or an HRA integrated with individual health insurance coverage (but not a choice between the two) to different classes of employees, based on the determination that such a rule provides an appropriate safeguard against the adverse selection concerns while also providing employers sufficient flexibility, which is intended to allow employers of all sizes to take advantage of the expansion provided in the proposed integration rules.

As explained in more detail earlier in the preamble, the Departments also considered various options for defining the classes of employees that may be used in applying these safeguards. The Departments considered whether employers should be allowed to offer or vary HRAs integrated with individual health insurance coverage for classes of employees based on a very general standard (like the one that applies under the HIPAA nondiscrimination rules, with a broad employment-based classification standard) or a more finite list of classes of employees that have been used in other rules for various employee benefits purposes (for example, under section 105(h) and/or section 4980H of the Code). The Departments' view is that a broad and open-ended standard would not be sufficient to mitigate the risk of adverse selection that more defined categories would help address those concerns. Earlier in the preamble, the Departments solicit comments on all aspects of these classes of employees, including whether these are the appropriate classes of employees, whether alternate classes, such as the categories of similarly situated individuals under the HIPAA nondiscrimination provisions, are preferable, whether additional classes are required and whether allowing benefits to vary based on classes of employees could lead to adverse selection.

Earlier in this preamble, the Departments also seek comment on whether the ability to integrate an HRA with individual health insurance coverage has the potential to increase participation in and strengthen the viability of states' individual market risk

pools. Further, the Departments also invite comment on whether the proposed integration safeguards are appropriate and narrowly tailored to prevent adverse selection and health status discrimination or whether less restrictive safeguards would suffice.

*Allowing integration with coverage other than individual health insurance coverage under the proposed rules.* The Departments considered whether to allow HRAs intended to satisfy the individual health insurance coverage integration test also to be integrated with non-HRA group coverage, such as a group health plan maintained by the employer of the participant's spouse, in addition to individual health insurance coverage, because, like individual health insurance coverage, group health plan coverage is generally subject to and compliant with sections 2711 and 2713 of the PHS Act. The Departments decided against proposing such a rule because allowing such integration would add significant complexity to the individual health insurance coverage integration test, as described earlier in this preamble. However, earlier in this preamble, the Departments request comments regarding whether the Departments should allow for such integration and, if so, with respect to compliance with section 2711 of the PHS Act, how such an integration test should be designed to take into account that, while most individual health insurance coverage is required to cover all EHBs, large group market and self-insured group health plans are not required to cover all EHBs. Earlier in this preamble the Departments also request comments on the demand for such a rule and any problems such a rule may raise.

In addition, the Departments considered whether to propose a rule to permit HRAs to be integrated with other types of non-group coverage other than individual health insurance coverage, such as STLDI. However, while all new individual health insurance coverage that is currently sold is non-grandfathered coverage (and most coverage that is renewed in also non-grandfathered) and is therefore generally subject to and compliant with sections 2711 and 2713 of the PHS Act, other types of coverage, such as STLDI, are not subject to and therefore may not be compliant with sections 2711 and 2713 of the PHS Act, in which case, integration would not be sufficient to ensure that the combined benefit package satisfies these requirements. Earlier in this preamble, the Departments request comments on whether integration with STLDI (which is not required to satisfy sections 2711



and 2713 of the PHS Act) should be permitted, whether integration should be permitted with any other type of coverage that satisfies sections 2711 and 2713 of the PHS Act, how such integration rules should be structured, as well as comments on what, if any, potential benefits and problems might arise from allowing these types of HRA integration. Earlier in this preamble the Departments also seek comments on whether allowing such integration would raise any concerns about health status discrimination leading to additional adverse selection in the individual market.

*Alternatives for annual limits on amounts made available under the excepted benefit HRA and alternatives for indexing such amount.* With regard to the excepted benefit HRA, in the proposed rules, the Departments propose that the amounts newly made available for a plan year may not exceed \$1,800 (indexed for inflation after 2020). For this purpose, inflation is defined in the proposed rules by reference to C–CPI–U, published by the Department of Labor.

In proposing this limit, the Departments considered various alternative amounts, including the limits on employer contributions to excepted benefit health FSAs (set at \$500 in 1997 if there are no employee contributions to the health FSA, although it might be much higher if there are employee contributions). The Departments considered the relationship between \$500 and the average cost of insurance in 1997. The Departments also considered a limit of 15 percent-of-the-cost-of-coverage-under-the-primary-plan test, which is the limit used for both supplemental excepted benefits in the group market and limited wraparound coverage, as a benchmark to ensure that the benefits are limited in amount. In considering how such a limit could be an appropriate limit for excepted benefit HRAs, the Departments considered 15 percent of the cost of group coverage for both employee-only and family coverage. However, the Departments also considered how to determine the primary plan in circumstances in which the participant does not enroll in a traditional group health plan, and concluded that such a determination

would likely be difficult for employers. The Departments also considered using the cost of coverage for the second lowest cost silver plan in various markets.

These methodologies produced a wide range of possible excepted benefit HRA limits from \$1,100 to \$2,850. Consistent with the principle of promoting HRA use and availability, rather than proposing a complex test for the limit on amounts newly made available in the excepted benefit HRA, the Departments are proposing a maximum of \$1,800 (indexed for inflation after 2020) on amounts newly made available for a plan year that approximates the midpoint amount yielded by the various methodologies considered. Earlier in this preamble, the Departments request comments on this amount, and whether an alternate amount or formula for determining the maximum dollar limit for an excepted benefit HRA would be more appropriate and, if so, what that alternative would be and why. Further, earlier in this preamble, the Departments seek comment on whether the maximum dollar limit should be adjusted depending on whether a participant has dependent(s) and, if so, by what amount the maximum dollar limit should be adjusted to in that case.

With regard to indexing the dollar limit on amounts made newly available under the excepted benefit HRA, in proposing to index the amount by C–CPI–U, the Departments considered whether or not to index the amount, including the difficulties of administering an HRA with a changing amount, and the cost, including the cost to the Departments to publish the amount and provide notice every year, as balanced with the decreasing real value of a set HRA limit. The Departments determined that the benefit of indexing the amount outweighs the increased complexity for the Departments and for stakeholders. Earlier in this preamble, the Departments invite comments on the measure of inflation used, including whether the amount should be indexed to inflation (and if there are any administrability concerns associated with indexing), if C–CPI–U is the correct measure of inflation, or whether an alternate measure, such as the overall

medical care component for CPI–U, or the method specified under section 9831(d)(2)(D) of the Code for QSEHRAs, should be used.

*D. Paperwork Reduction Act—  
Department of Health and Human  
Services*

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-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 we 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 our 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 ICRs.<sup>133</sup> Table 2 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.

<sup>133</sup> See May 2017 Bureau of Labor Statistics, Occupational Employment Statistics, National Occupational Employment and Wage Estimates at [https://www.bls.gov/oes/current/oes\\_nat.htm](https://www.bls.gov/oes/current/oes_nat.htm).

TABLE 1—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

## 2. ICRs Regarding Substantiation of Individual Health Insurance Coverage

Under the proposed regulations, an HRA must implement reasonable procedures to verify that individuals whose medical care expenses are reimbursable by the HRA are, or will be, enrolled in individual health insurance coverage (other than coverage that consists solely of excepted benefits) for the plan year.

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 proposed regulations 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 participant and, if applicable, any dependent(s) whose medical care expenses are requested to be reimbursed were enrolled in individual health insurance coverage (other than coverage that consists solely of excepted benefits) 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 this requirement, the HRA may require that the participant submit an attestation or a document provided by a third party (for example, an explanation of benefit or insurance card) as substantiation. The associated cost would be negligible and is, therefore, not estimated.

## 3. ICRs Regarding Notice Requirement

These proposed regulations include a requirement that an HRA provide written notice to eligible participants. The HRA would 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 participant is first eligible to participate in the HRA.

The proposed written notice would be required to include certain relevant

information, including a description of the terms of the HRA, including the amount made available that is used in the affordability determination under the Code section 36B proposed 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 for a participant who opts out of and waives an HRA if the HRA is not affordable under the proposed PTC regulations; 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 advance payments of the PTC of the availability of the HRA, the amount of the HRA, the number of months the HRA is available to participants during the plan year, whether it is available to their dependents and whether they are a current or former employee; 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 met; and a statement that it is the responsibility of the participant to inform the HRA if the participant or any dependent whose medical care expenses are reimbursable by the HRA is no longer enrolled in individual health insurance coverage. The written notice may include other information, as long as the additional information does not conflict with the required information. The written notice would not need to include information specific to a participant.

The Departments estimate that for each HRA plan sponsor, a compensation and benefits manager would need 2 hours (at \$125 per hour) and a lawyer would need 1 hour (at \$136.44 per hour) to prepare the notices. The total burden for an HRA plan sponsor would be 3 hours with an equivalent cost of approximately \$386. This burden would be incurred the first time the plan sponsor provides an HRA that is integrated with individual health insurance coverage. In subsequent years, the burden to update the notice in

expected to be minimal and therefore is not estimated.

HHS estimates that in 2020, an estimated 1,203 state and local government entities would offer HRAs that are integrated with individual health insurance coverage.<sup>134</sup> The total burden to prepare notices would be approximately 3,610 hours with an equivalent cost of approximately \$464,984. In 2021 approximately 1,805 additional state and local government entities would offer HRAs that are integrated with individual health insurance coverage for the first time and would 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 would offer HRAs that are integrated with individual health insurance coverage for the first time and would incur a burden of approximately 9,024 hours with an equivalent cost of approximately \$1.16 million.

HRA plan sponsors would provide the notice to eligible participants every year. HHS estimates that HRA plan sponsors would provide printed notices to approximately 90,162 eligible participants<sup>135</sup> in 2020, 225,405 eligible participants in 2021 and 450,810 eligible participants in 2022. The Departments anticipate that the notices would be approximately 2 pages long and the cost of materials and printing

<sup>134</sup> U.S. Department of the Treasury, Office of Tax Analysis simulation model suggests that in 2020, approximately 80,000 employers will offer HRAs, with 1.0 million individuals receiving an HRA integrated with individual health insurance coverage. These numbers would increase to 200,000 employers and 2.5 million individuals in 2021 and to 400,000 employers and 5 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>135</sup> U.S. Department of the Treasury, Office of Tax Analysis simulation model provides estimates of the number of participants and dependents receiving an HRA integrated with individual health insurance coverage. Number of eligible participants is estimated based on the assumption that 75 percent of eligible participants would enroll in their employers' plans. See Section 3 of the Kaiser "2017 Employer Health Benefits Survey". <https://www.kff.org/health-costs/report/2017-employer-health-benefits-survey/>.

would be \$0.05 per page, with a total cost of \$0.10 per notice. It is assumed that these notices would be provided along with other benefits information with no additional mailing cost. 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, in 2020, state and local government entities providing HRAs that are integrated with individual health insurance coverage would print

approximately 41,475 notices at a cost of approximately \$4,147. In 2021, approximately 103,686 notices would be printed at a cost of \$10,369 and in 2022, approximately 207,373 notices would be printed at a cost of a \$20,737.

TABLE 2—PROPOSED 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	90,162	3,610	\$464,984	\$4,147
2021 .....	1,805	225,405	5,415	697,476	10,369
2022 .....	3,008	450,810	9,024	1,162,461	20,737
3 year Average .....	2,005	255,459	6,016	774,974	11,751

TABLE 3—PROPOSED 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)(5), § 146.123(c)(6)	0938–0702	2,005	255,459	3	6,016	\$128.81	\$774,974	\$11,751	\$786,724

HHS intends to amend the information collection currently approved under OMB control number 0938–0702 “Information Collection Requirements Referenced in HIPAA for the Group Market, Supporting Regulations 45 CFR 146, and forms/instructions” (CMS-10430), to account for this additional burden.

4. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule 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.

We invite public comments on these information collection requirements. If you wish to comment, please identify the rule (CMS–9918–P) and, where applicable, the ICR’s CFR citation, CMS ID number, and OMB control number.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, you may make your request using one of following:

1. Access CMS’s 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.

See this rule’s **DATES** and **ADDRESSES** sections for the comment due date and for additional instructions.

*E. Paperwork Reduction Act—Department of Labor and Department of the Treasury*

As part of its 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 is 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 (29 CFR 2590.702–2(c)(5)); and (2) HRA Notice to

Participants (29 CFR 2590.702–2(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.

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)(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 tax-exempt organization form instructions will be updated in the next revision. The estimated annual burden per respondent, estimated annual burden per recordkeeper, or estimated number of respondents is updated annually.

The Departments have submitted a copy of the proposed rule, Health Reimbursement Arrangements and Other Account-Based Group Health Plans, to OMB in accordance with 44 U.S.C. 3507(d) for review of its information collections. The Departments and OMB are particularly interested in comments that:

- Evaluate whether the collection of information is necessary for the proper performance of the functions of the

agency, including whether the information will have practical utility;

- Evaluate the accuracy of the agency's estimate of the burden of the collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

In addition to filing comments on the information collections with the agencies on the same basis as any other aspect of this rule, interested parties may file comments on the information collection requirements with the Office of Management and Budget (OMB). The method for submitting comments to the agencies is explained earlier in the Addresses section of the document. Comments to OMB should be sent to the Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503; Attention: Desk Officer for the Employee Benefits Security Administration. Notwithstanding the 60-day comment period to submit comments to the agencies, in order to ensure consideration, OMB requests that comments be submitted within 30 days of publication of this proposed rule. In addition, comments should identify the applicable OMB control number. PRA Addressee: Address requests for copies of the ICR to 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>.

Below is a description of the information collections and their burden.

#### 1. Verification of Enrollment in Individual Health Insurance Coverage

In order for an HRA to be integrated with individual health insurance, among other requirements, the HRA must implement, and comply with, reasonable procedures to verify that participants and dependents are, or will be, enrolled in individual health insurance coverage during the plan year.

This requirement can be satisfied by providing a document from a third party, like an issuer, verifying coverage. As an alternative procedure, this requirement could 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 (which may be in the form of a written attestation) that the participant and, if applicable, the dependent whose medical care expenses are requested to be reimbursed, continue to be enrolled in individual health insurance coverage for the month during which the medical care expenses were incurred. The attestation may be part of the form used for requesting reimbursement.

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 proposed regulations regarding verification of enrollment in individual health insurance coverage, 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 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.

#### 2. HRA Notice to Participants

These proposed regulations 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 proposed regulations; (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 proposed PTC regulations; 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.

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 participant is first eligible to participate in the HRA.

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 two pages, with total materials and printing cost of \$0.10 per notice (\$0.05 per page). The Departments estimate that 78,797 private employers would <sup>136</sup> newly offer HRAs integrated with individual health insurance coverage in 2020 <sup>137</sup> as a result of the proposed rules in the first year. Therefore, the Departments estimate for the total hour burden for these HRAs to prepare the notices would be 236,390 hours with an equivalent cost of \$30,450,216.

<sup>136</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 would offer HRAs integrated with individual health insurance coverage and one million individuals would enroll in 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>137</sup> Comparable numbers for 2021 are 118,195 private employers would newly offer HRAs integrated with individual health insurance coverage and 1,441,262 eligible participants in all HRAs would receive notices, and for 2022 196,992 private employers would newly offer HRAs integrated with individual health insurance coverage and 2,882,523 eligible participants in all HRAs would receive notices.

All HRAs integrated with individual health insurance coverage are required to annually send the notice to all eligible participants (those eligible to enroll). The Departments estimate that there would be 576,505 eligible

participants at private employers in 2020 that would need to receive the notice.<sup>138</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 265,192 notices will be printed at a cost of \$26,519. Tables 1 and 2 provide estimates for years 2020, 2021 and 2022.

TABLE 1—BURDEN TO PREPARE HRA NOTICE FOR THE FIRST TIME-PRIVATE SECTOR EMPLOYERS

Year	Number of employers newly offering HRAs	Legal cost per hour	Number of hours for legal	Benefit manager cost per hour	Number of hours for benefit manager	Total hour burden	Total equivalent cost
(a)	(b)	(c)	(d) = 1 * (b)	(e)	(f) = 2 * (b)	(g) = (d) + (f)	(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 2—BURDEN TO PROVIDE NOTICE TO ALL ELIGIBLE PRIVATE SECTOR PARTICIPANTS

Year	Total number of notices	Number of notices sent by mail	Cost per notice	Total cost burden
(a)	(b)	(c)	(d)	(e) = (c) * (d)
2020 .....	576,505	265,192	\$0.10	\$26,519
2021 .....	1,441,262	662,980	0.10	66,298
2022 .....	2,882,523	1,325,961	0.10	132,596

3. Notice to Participants That Individual Health Insurance Coverage Policy is not Subject to Title I of ERISA

In the proposed 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. HRA plan sponsors are required to notify participants of this fact. For an HRA, this notice requirement is met if annually the notice requirement in 29 CFR 2590.702–2(c)(6) is met, which is part of the HRA Notice to Participants. Therefore, this notice requirement imposes no additional burden. For QSEHRAs and for HRAs not subject to 29 CFR 2590.702–2(c)(6) but that reimburse premiums for individual health insurance coverage, this notice requirement is met if the plan sponsor annually includes language provided in the rule in the Summary Plan Description. DOL estimates that this burden will be de minimis, because the required text is provided by DOL and the required information can be included with other notices.

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–new (DOL), 1545–0123, 1545–0074, and 1545–0047 (Treasury).  
*Affected Public:* Private Sector.  
*Total Respondents:* 131,328 three-year average.  
*Total Responses:* 1,633,430 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:* \$37,569 for each agency (combined total is \$75,138). 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 proposed rule is

not likely to have a significant economic impact on a substantial number of small entities, section 603 of RFA requires that the agency present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rulemaking describing the impact of the rule on small entities and seeking public comment on such impact. 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 proposed rules to produce costs or benefits in excess of 3 to 5 percent of revenues for small entities. Entities that choose to offer an HRA integrated with individual health insurance coverage instead of a traditional group health

<sup>138</sup>Number of eligible participants is estimated based on Treasury estimates of the number of individuals enrolled in HRAs integrated with individual coverage, 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 Section 3 of the Kaiser “2017 Employer Health Benefits

Survey”. <https://www.kff.org/health-costs/report/2017-employer-health-benefits-survey/>.

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 HRA integrated with individual health insurance coverage would bear modest administrative costs. However, offering an HRA that is integrated with individual health insurance coverage is entirely voluntary on the part of employers, and no employer that would experience substantial costs would be expected to offer an HRA integrated with individual health insurance coverage. In addition, the proposed 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 603 of the RFA. The proposed 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 proposed rules could reduce administrative costs, such as billing costs and the costs of helping patients obtain public health benefits. The proposed rules could also reduce the cost of uncompensated care born by small rural hospitals and other healthcare providers (and shift such costs to insured persons). However, the Departments have determined that the proposed 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 rules have been submitted to the Chief Counsel for Advocacy of the SBA for comment on its impact on small business.

#### *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 proposed 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 2018, that

threshold is approximately \$150 million. The proposed rules do not include any Federal mandate that may result in expenditures by state, local, or tribal governments, or the private sector, that may impose an annual burden that exceeds 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 regulations. In the Departments’ view, the proposed rules do not have federalism implications.

#### *J. Congressional Review Act*

The proposed rules are 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, upon finalization, 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.” The proposed rules, if finalized as proposed, are expected to be an Executive Order 13771 deregulatory action.

#### *Statutory Authority*

The Department of the Treasury regulations are proposed to be adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor regulations are proposed 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 proposed to be 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.

Signed at Washington DC, this 16th day of October, 2018.

Preston Rutledge,

Assistant Secretary, Employee Benefits Security Administration, Department of Labor.

Dated: October 17, 2018.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: October 18, 2018.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Amendments to the Regulations

Accordingly, 26 CFR parts 1 and 54 are proposed to be 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-2 is amended by:

a. Redesignating paragraph (c)(3)(i) as paragraph (c)(3)(i)(A) and revising the subject heading of newly designated paragraph (c)(3)(i)(A).

b. Adding a new paragraph (c)(3)(i) subject heading and paragraph (c)(3)(i)(B).

c. Adding a sentence at the end of paragraphs (c)(3)(ii) and (c)(3)(v)(A)(1) and (2).

d. Revising paragraphs (c)(3)(v)(A)(3) and (5).

e. Adding a sentence at the end of paragraph (c)(3)(vi).

f. Adding paragraph (c)(5).

g. Revising paragraph (e)(1).

h. Adding paragraph (e)(3).

The revisions and additions read as follows:

§ 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. An employee who is offered an HRA or other account-based group health plan that would be integrated with individual health insurance coverage, within the meaning of §§ 54.9802-4 and 54.9815-2711(d)(4) of this chapter, if the individual enrolls in individual health insurance coverage, 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 on 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 amount.* For purposes of paragraph (c)(5)(ii) 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 newly made 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 on 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).

(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 9.86%.

(A) *Example 1. Determination of affordability.* (1) 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) 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 9.86 percent and A's household income is \$230 ( $\$28,000 \times .0986 = \$2,761$ ;  $\$2,761/12 = \$230$ ). Because A's required HRA contribution of \$300 exceeds \$230 (1/12 of the product of 9.86 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) 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) 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 of 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 9.86 percent and B's household income for 2020 is \$230 ( $\$28,000 \times .0986 = \$2,761$ ;  $\$2,761/12 = \$230$ ). Because B's required HRA contribution of \$200 does not exceed \$230 (1/12 of the product of 9.86 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) The facts are the same as in 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) 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 or B's household income.

(D) *Example 4. Affordability determined for part of a taxable year (part-year period).*

(1) 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) 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 of 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 9.86 percent and C's household income is \$230 ( $\$28,000 \times .0986 = \$2,761$ ;  $\$2,761/12 = \$230$ ). Because C's required HRA contribution of \$200 does not exceed \$230, 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) 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) 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. 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 at the end of paragraphs (c)(3)(ii), (c)(3)(v)(A)(1), (c)(3)(v)(A)(2), (c)(3)(v)(A)(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. 3.** 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 also issued under 26 U.S.C. 9833.

\* \* \* \* \*

■ **Par. 4.** 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. 5.** 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 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 part. For ease of reference, the term “HRA” is used in this section to include other account-based group health plans.

(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 part. 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 HRA on eligibility for the premium tax credit under section 36B. In addition, this section provides conditions that an HRA integrated with individual health insurance coverage must satisfy in order to comply with the nondiscrimination provisions in section 9802 and section 2705 of the PHS Act (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 part and will not be considered to discriminate in violation of section 9802 and PHS Act section 2705 solely because it offers an HRA integrated with individual health insurance coverage, provided that the conditions of this paragraph (c) are satisfied.

(1) *Enrollment in individual health insurance coverage.* 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 2713 for each month that the individual(s) are covered by the HRA. For this purpose, 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. The HRA must also provide that, subject to applicable COBRA or other continuation of coverage requirements,

if any individual covered by the HRA ceases to be covered by such 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. In addition, subject to applicable COBRA or other continuation of coverage requirements, if the participant and all of the dependents covered by the participant's HRA cease to be covered by such individual health insurance coverage, the participant must forfeit 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 HRA integrated with individual health insurance coverage, the plan sponsor may not also offer a traditional group health plan to the same class of employees. For this purpose, 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 HRA integrated with individual health insurance coverage or a traditional group health plan to any participant.

(3) *Same terms requirement.* To the extent a plan sponsor offers an HRA integrated with individual health insurance coverage 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)(i) and (ii) of this section and except that the HRA will not fail to be treated as provided on the same terms even 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. Also, amounts that are not used to reimburse medical care expenses (as defined in § 54.9815–2711(d)(6)(ii) of this part) 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; therefore, an HRA shall fail to be treated as provided on the same terms unless such a 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) in the class of employees. Further, the HRA shall not fail to be treated as provided on the same terms because the maximum dollar amount made available to participants in a class of employees to reimburse medical care expenses for any plan year increases:

(i) As the age of the participant increases, so long as the same maximum dollar amount attributable to the increase in age is made available to all participants in that class of employees who are the same age; or

(ii) 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.

(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 from the HRA at least annually, and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the participant is permitted to permanently opt out of and waive future reimbursements from the HRA.

(5) *Reasonable procedures for verification and substantiation—(i) General rule for verification of individual health insurance coverage for the plan year.* The HRA must implement, and comply with, reasonable procedures to verify that participants and dependents are, or will be, enrolled in individual health insurance coverage for the plan year. The reasonable procedures may include a requirement that a participant substantiate enrollment by providing either:

(A) A document from a third party (for example, the issuer) 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

(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 verification 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 (which may be in the form of a written attestation) that the participant and if applicable, the dependent whose medical care expenses are requested to be reimbursed continue to be enrolled in individual health insurance coverage for the month during which the medical care expenses were incurred. The attestation may be part of the form used for requesting reimbursement.

(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 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 the month, as applicable.

(6) *Notice requirement—(i) Timing.* The HRA must provide a written notice to each participant at least 90 days before the beginning of each plan year or, for a participant who is not eligible to participate at the beginning of the plan year (or who is not eligible to participate at the time the notice is provided at least 90 days before the beginning of the plan year), no later than the date on which the participant is first eligible to participate in the HRA.

(ii) *Content.* The notice must include all the information described in this paragraph (c)(6)(ii) (and may include any additional information as long as it does not conflict with the required information set forth in paragraph (c)(6)(ii)(A) through (H) of this section).

(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 family coverage)), any rules regarding the proration of the maximum dollar amount applicable to any participant

who is not eligible to participate in the HRA for the entire plan year, whether the participant's family members are eligible for the HRA, a statement that the HRA is not a qualified small employer health reimbursement arrangement, a statement that the HRA requires the participant and any dependents to be enrolled in individual health insurance coverage, a statement that the participant is required to substantiate the existence of such enrollment, a statement that the coverage enrolled in cannot be short-term, limited-duration insurance or excepted benefits, and, if the requirements under 29 CFR 2510.3-1(l) are met, a statement that the individual health insurance coverage enrolled in is not subject to the Employee Retirement Income Security Act (ERISA).

(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 the Exchange (as defined in 45 CFR 155.20) for any month that the HRA is affordable under § 1.36B-2(c)(5) of this chapter, and a statement that, if the participant is a former employee, the offer of the HRA does not render the participant ineligible for the premium tax credit regardless of whether it is affordable under § 1.36B-2(c)(5) of this chapter;

(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 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 family coverage) as set forth in the written notice in accordance with paragraph (c)(6)(ii)(A) of this section, the number of months in the plan year the HRA is available to the participant, whether the HRA is also available to the participant's dependents, 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 and, if so, the months the participant is allowed the premium tax credit.

(G) A statement that the HRA may not reimburse any medical care expense unless the substantiation requirement set forth in paragraph (c)(5) of this section is satisfied.

(H) A statement that it is the responsibility of the participant to inform the HRA if the participant or any dependent whose medical care expenses are reimbursable by the HRA is no longer enrolled in individual health insurance coverage.

(d) *Classes of employees—(1) 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)(1). If the HRA is offered to former employees, former employees are considered to be in the same class in which they were in immediately before separation from service. (See paragraph (d)(2) of this section for additional rules regarding the definition of "full-time employees," "part-time employees," and "seasonal employees.")

(i) Full-time employees, defined to mean either full-time employees under section 4980H and the regulations thereunder (§ 54.4980H-1(a)(21) of this part) 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 to mean either employees who are not full-time employees under section 4980H and § 54.4980H-1 and -3 of this part or part-time employees as described in § 1.105-11(c)(2)(iii)(C) of this chapter;

(iii) Seasonal employees, defined to mean seasonal employees as described in either § 54.4980H-1(a)(38) of this part or § 1.105-11(c)(2)(iii)(C) of this chapter;

(iv) Employees included in a unit of employees covered by a collective bargaining agreement in which the plan

sponsor participates (as described in § 1.105–11(c)(2)(iii)(D) of this chapter);

(v) Employees who have not satisfied a waiting period for coverage (if the waiting period complies with § 54.9815–2708 of this part);

(vi) Employees who have not attained age 25 prior to the beginning of the plan year (as described in § 1.105–11(c)(2)(iii)(B) of this chapter);

(vii) Non-resident aliens with no U.S.-based income (as described in § 1.105–11(c)(2)(iii)(E) of this chapter);

(viii) Employees whose primary site of employment is in the same rating area as defined in 45 CFR 147.102(b); or

(ix) A group of participants described as a combination of two or more of the classes of employees set forth in paragraphs (d)(1)(i) through (viii) of this section. (For example, part-time employees included in a unit of employees covered by a collective bargaining agreement could be one class of employees and full-time employees included in a unit of employees covered by the same collective bargaining agreement could be another class of employees.)

(2) *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 section 105(h) and § 1.105–11 of this chapter or of section 4980H and § 54.4980H–1 and –3 of this part 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 either section 105(h) or 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 in which the definitions will apply.

(e) *Examples.* The following examples illustrate the provisions of paragraphs (c)(2) and (3) of this section. In each example, the HRA may reimburse any medical care expenses, including premiums for individual health insurance coverage.

(1) *Example 1.* (i) *Facts.* For 2020, Plan Sponsor X offers the following to its employees. Full-time employees in rating area A are offered \$2,000 each in an HRA. Part-time employees in rating area A are offered \$500 each in an HRA. All employees in rating area B are offered a traditional group health plan.

(ii) *Conclusion.* The requirements of paragraphs (c)(2) and (3) of this section are satisfied in this *Example 1*.

(2) *Example 2.* (i) *Facts.* For 2020, Plan Sponsor Y offers the following to its employees. Employees covered by a collective bargaining agreement in which Plan Sponsor Y participates are offered a traditional group health plan (as required by

the collective bargaining agreement). All other employees (non-collectively bargained employees) are offered 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. Non-collectively bargained employees who have not attained age 25 by January 1, 2020 are not offered an HRA or a traditional group health plan.

(ii) *Conclusion.* The requirements of paragraphs (c)(2) and (3) of this section are satisfied in this *Example 2*.

(3) *Example 3.* (i) *Facts.* For 2020, Plan Sponsor Z offers the following amounts in an HRA to its employees who have completed the plan’s waiting period, which complies with the requirements for waiting periods in § 54.9815–2708 of this part: \$1,500, if the employee is the only individual covered by the HRA; \$3,500, if the employee and one additional family member are covered by the HRA; and \$5,000, if the employee and more than one additional family member are covered by the HRA.

(ii) *Conclusion.* The requirements of paragraphs (c)(2) and (3) of this section are satisfied in this *Example 3*.

(f) *Applicability date.* This section applies to plan years beginning on or after January 1, 2020.

■ **Par. 6.** 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. For this purpose, 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 paragraphs (c)(1) or (2):

(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 Employee Health Benefits Program (FEHBP) plan options as defined by 45 CFR 156.100(a)(3), and including coverage of additional required benefits under 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 meet 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 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 meet the requirements of PHS Act section 2713 and § 54.9815–2713(a)(1) of this part. For this purpose, 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 meets 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 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 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 § 1.36B-6 of this chapter;

(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 § 1.36B-6 of this chapter 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 this purpose, 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.* An HRA or other account-based group health plan is integrated with individual health insurance coverage (and treated as complying with PHS Act sections 2711 and 2713) if the HRA or other account-based group health plan meets the requirements of § 54.9802-4(c) of this part.

(5) *Integration with Medicare parts 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 requirements of this paragraph (d)(5) 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 [APPLICABILITY DATE OF FINAL RULE], 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 7.** 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 of these regulations for the circumstances in which benefits provided under a health FSA are excepted benefits. For purposes of this paragraph, 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.

(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 August 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 August for the preceding calendar year. Any such increase that is not a multiple of \$50 shall be rounded to the next lowest multiple of \$50.

(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.

(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 Medicare parts B 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.

(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)).

\* \* \* \* \*

**DEPARTMENT OF LABOR  
Employee Benefits Security  
Administration**

**29 CFR Chapter XXV**

For the reasons stated in the preamble, the Department of Labor proposes to amend 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**

■ 8. 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).

■ 9. In § 2510.3–1, add paragraph (l) to read as follows:

**§ 2510.3–1 Employee welfare benefit plan.**

\* \* \* \* \*

(l) *Health reimbursement arrangements (HRAs) and other account-based group health plans 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 less 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 or that is not covered by a QSEHRA 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 nongroup health insurance premiums is limited solely to individual health insurance coverage, as defined in § 2590.701–2 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 meet 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 or the QSEHRA that such an arrangement supplements.

#### PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

■ 10. 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).

■ 11. 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.

\* \* \* \* \*

■ 12. Add § 2590.702–2 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 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.

(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. 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 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 HRA integrated with individual health insurance coverage must satisfy in order to comply with the nondiscrimination provisions in section 702 of ERISA and section 2705 of the PHS Act (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 offers an HRA

integrated with individual health insurance coverage, provided that the conditions of this paragraph (c) are satisfied.

(1) *Enrollment in individual health insurance coverage.* 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 2713 for each month that the individual(s) are covered by the HRA. For this purpose, 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. The HRA must also provide that, subject to applicable COBRA or other continuation of coverage requirements, if any individual covered by the HRA ceases to be covered by such 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. In addition, subject to applicable COBRA or other continuation of coverage requirements, if the participant and all of the dependents covered by the participant's HRA cease to be covered by such individual health insurance coverage, the participant must forfeit 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 HRA integrated with individual health insurance coverage, the plan sponsor may not also offer a traditional group health plan to the same class of employees. For this purpose, 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 HRA integrated with individual health insurance coverage or a traditional group health plan to any participant.

(3) *Same terms requirement.* To the extent a plan sponsor offers an HRA integrated with individual health insurance coverage 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)(i) and (ii) of this

section and except that the HRA will not fail to be treated as provided on the same terms even 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. Also, amounts that are not used to reimburse medical care expenses (as defined in § 2590.715–2711(d)(6)(ii) of this part) 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; therefore, an HRA shall fail to be treated as provided on the same terms unless such a 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) in the class of employees. Further, the HRA shall not fail to be treated as provided on the same terms because the maximum dollar amount made available to participants in a class of employees to reimburse medical care expenses for any plan year increases:

(i) As the age of the participant increases, so long as the same maximum dollar amount attributable to the increase in age is made available to all participants in that class of employees who are the same age; or

(ii) 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.

(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 from the HRA at least annually, and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the

participant is permitted to permanently opt out of and waive future reimbursements from the HRA.

(5) *Reasonable procedures for verification and substantiation—(i) General rule for verification of individual health insurance coverage for the plan year.* The HRA must implement, and comply with, reasonable procedures to verify that participants and dependents are, or will be, enrolled in individual health insurance coverage for the plan year. The reasonable procedures may include a requirement that a participant substantiate enrollment by providing either:

(A) A document from a third party (for example, the issuer) 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

(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 verification 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 (which may be in the form of a written attestation) that the participant and if applicable, the dependent whose medical care expenses are requested to be reimbursed continue to be enrolled in individual health insurance coverage for the month during which the medical care expenses were incurred. The attestation may be part of the form used for requesting reimbursement.

(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 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 the month, as applicable.

(6) *Notice requirement—(i) Timing.* The HRA must provide a written notice to each participant at least 90 days before the beginning of each plan year or, for a participant who is not eligible to participate at the beginning of the



plan year (or who is not eligible to participate at the time the notice is provided at least 90 days before the beginning of the plan year), no later than the date on which the participant is first eligible to participate in the HRA.

(ii) *Content.* The notice must include all the information described in this paragraph (c)(6)(ii) (and may include any additional information as long as it does not conflict with the required information set forth in paragraph (c)(6)(ii)(A) through (H) of this section).

(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 family coverage)), any rules regarding the proration of the maximum dollar amount applicable to any participant who is not eligible to participate in the HRA for the entire plan year, whether the participant's family members are eligible for the HRA, a statement that the HRA is not a qualified small employer health reimbursement arrangement, a statement that the HRA requires the participant and any dependents to be enrolled in individual health insurance coverage, a statement that the participant is required to substantiate the existence of such enrollment, a statement that the coverage enrolled in cannot be short-term, limited-duration insurance or excepted benefits, and, if the requirements under § 2510.3-1(l) of this chapter are met, a statement that the individual health insurance coverage enrolled in is not subject to the Employee Retirement Income Security Act (ERISA).

(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 the Exchange (as defined in 45 CFR 155.20) for any month that

the HRA is affordable under 26 CFR 1.36B-2(c)(5), and a statement that, if the participant is a former employee, the offer of the HRA does not render the participant ineligible for the premium tax credit regardless of whether it is affordable under 26 CFR 1.36B-2(c)(5).

(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 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 family coverage) as set forth in the written notice in accordance with paragraph (c)(6)(ii)(A) of this section, the number of months in the plan year the HRA is available to the participant, whether the HRA is also available to the participant's dependents, 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 and, if so, the months the participant is allowed the premium tax credit.

(G) A statement that the HRA may not reimburse any medical care expense unless the substantiation requirement set forth in paragraph (c)(5) of this section is satisfied.

(H) A statement that it is the responsibility of the participant to inform the HRA if the participant or any dependent whose medical care expenses are reimbursable by the HRA is no longer enrolled in individual health insurance coverage.

(d) *Classes of employees*—(1) *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)(1). If the HRA is offered to former employees, former employees are considered to be in the same class in which they were in immediately before separation from service. (See

paragraph (d)(2) of this section for additional rules regarding the definition of “full-time employees,” “part-time employees,” and “seasonal employees.”)

(i) Full-time employees, defined to mean either full-time employees under section 4980H of the Code and the regulations thereunder (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 to mean either employees who are not full-time employees under section 4980H of the Code and 26 CFR 54.4980H-1 and -3 or part-time employees as described in 26 CFR 1.105-11(c)(2)(iii)(C);

(iii) Seasonal employees, defined 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);

(iv) 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));

(v) Employees who have not satisfied a waiting period for coverage (if the waiting period complies with § 2590.715-2708 of this part);

(vi) 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));

(vii) Non-resident aliens with no U.S.-based income (as described in 26 CFR 1.105-11(c)(2)(iii)(E));

(viii) Employees whose primary site of employment is in the same rating area as defined in 45 CFR 147.102(b); or

(ix) A group of participants described as a combination of two or more of the classes of employees set forth in paragraphs (d)(1)(i) through (viii) of this section. (For example, part-time employees included in a unit of employees covered by a collective bargaining agreement could be one class of employees and full-time employees included in a unit of employees covered by the same collective bargaining agreement could be another class of employees.)

(2) *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 section 105(h) of the Code and 26 CFR 1.105-11 or of section 4980H of the Code and 26 CFR 54.4980H-1 and -3 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 either section 105(h) of the Code or 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 in which the definitions will apply.

(e) *Examples.* The following examples illustrate the provisions of paragraphs (c)(2) and (3) of this section. In each example, the HRA may reimburse any medical care expenses, including premiums for individual health insurance coverage.

(1) *Example 1.* (i) *Facts.* For 2020, Plan Sponsor X offers the following to its employees. Full-time employees in rating area A are offered \$2,000 each in an HRA. Part-time employees in rating area A are offered \$500 each in an HRA. All employees in rating area B are offered a traditional group health plan.

(ii) *Conclusion.* The requirements of paragraphs (c)(2) and (3) of this section are satisfied in this *Example 1*.

(2) *Example 2.* (i) *Facts.* For 2020, Plan Sponsor Y offers the following to its employees. Employees covered by a collective bargaining agreement in which Plan Sponsor Y participates are offered a traditional group health plan (as required by the collective bargaining agreement). All other employees (non-collectively bargained employees) are offered 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. Non-collectively bargained employees who have not attained age 25 by January 1, 2020 are not offered an HRA or a traditional group health plan.

(ii) *Conclusion.* The requirements of paragraphs (c)(2) and (3) of this section are satisfied in this *Example 2*.

(3) *Example 3.* (i) *Facts.* For 2020, Plan Sponsor Z offers the following amounts in an HRA to its employees who have completed the plan's waiting period, which complies with the requirements for waiting periods in § 2590.715–2708 of this part: \$1,500, if the employee is the only individual covered by the HRA; \$3,500, if the employee and one additional family member are covered by the HRA; and \$5,000, if the employee and more than one additional family member are covered by the HRA.

(ii) *Conclusion.* The requirements of paragraphs (c)(2) and (3) of this section are satisfied in this *Example 3*.

(f) *Applicability date.* This section applies to plan years beginning on or after January 1, 2020.

■ 13. 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. For this purpose, 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 paragraphs (c)(1) or (2):

(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 Employee Health Benefits Program (FEHBP) plan options as defined by 45 CFR 156.100(a)(3), and including coverage of additional required benefits under 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 meet 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 meet the requirements of PHS Act section 2713

and § 2590.715–2713(a)(1) of this part. For this purpose, 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 meets 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 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 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 26 CFR 1.36B-6;

(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 26 CFR 1.36B-6, 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 this purpose, 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.* An HRA or other account-based group health plan is integrated with individual health insurance coverage (and treated as complying with PHS Act sections 2711 and 2713) if the HRA or other account-based group health plan meets the requirements of § 2590.702-2(c) of this part.

(5) *Integration with Medicare parts 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

requirements of this paragraph (d)(5) 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 [APPLICABILITY DATE OF FINAL RULE], 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.

■ 14. 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 of these regulations for the circumstances in which benefits provided under a health FSA are excepted benefits. For purposes of this paragraph, 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.

(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 August 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 August for the preceding calendar year. Any such increase that is not a multiple of \$50 shall be rounded to the next lowest multiple of \$50.

(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.

(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 Medicare parts B 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.

(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)).

\* \* \* \* \*

## Department of Health and Human Services

### 45 CFR Chapter 1

For the reasons stated in the preamble, the Department of Health and Human Services proposes to amend 45 CFR parts 144, 146, 147, and 155 as set forth below:

## PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

■ 15. The authority citation for part 144 is revised to read as follows:

**Authority:** 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92.

■ 16. 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

■ 17. 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.

■ 18. Add § 146.123 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 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.

(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. 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 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 HRA

integrated with individual health insurance coverage must satisfy in order to comply with the nondiscrimination provisions in section 2705 of the PHS Act) 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 offers an HRA integrated with individual health insurance coverage, provided that the conditions of this paragraph (c) are satisfied.

(1) *Enrollment in individual health insurance coverage.* 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 2713 for each month that the individual(s) are covered by the HRA. For this purpose, 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. The HRA must also provide that, subject to applicable COBRA or other continuation of coverage requirements, if any individual covered by the HRA ceases to be covered by such 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. In addition, subject to applicable COBRA or other continuation of coverage requirements, if the participant and all of the dependents covered by the participant's HRA cease to be covered by such individual health insurance coverage, the participant must forfeit 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 HRA integrated with individual health insurance coverage, the plan sponsor may not also offer a traditional group health plan to the same class of employees. For this purpose, 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 HRA integrated with individual health insurance coverage or a traditional group health plan to any participant.

(3) *Same terms requirement.* To the extent a plan sponsor offers an HRA integrated with individual health insurance coverage 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)(i) and (ii) of this section and except that the HRA will not fail to be treated as provided on the same terms even 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. Also, amounts that are not used to reimburse medical care expenses (as defined in § 147.126(d)(6)(ii) of this subchapter) 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; therefore, an HRA shall fail to be treated as provided on the same terms unless such a 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) in the class of employees. Further, the HRA shall not fail to be treated as provided on the same terms because the maximum dollar amount made available to participants in a class of employees to reimburse medical care expenses for any plan year increases:

(i) As the age of the participant increases, so long as the same maximum dollar amount attributable to the increase in age is made available to all participants in that class of employees who are the same age; or

(ii) 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.

(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 from the HRA at least annually, and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the participant is permitted to permanently opt out of and waive future reimbursements from the HRA.

(5) *Reasonable procedures for verification and substantiation—(i) General rule for verification of individual health insurance coverage for the plan year.* The HRA must implement, and comply with, reasonable procedures to verify that participants and dependents are, or will be, enrolled in individual health insurance coverage for the plan year. The reasonable procedures may include a requirement that a participant substantiate enrollment by providing either:

(A) A document from a third party (for example, the issuer) 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

(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 verification 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 (which may be in the form of a written attestation) that the participant and if applicable, the dependent whose medical care expenses are requested to be reimbursed continue to be enrolled in individual health insurance coverage for the month during which the medical care expenses were incurred. The attestation may be part of the form used for requesting reimbursement.

(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 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 the month, as applicable.

(6) *Notice requirement—(i) Timing.* The HRA must provide a written notice to each participant at least 90 days before the beginning of each plan year or, for a participant who is not eligible to participate at the beginning of the plan year (or who is not eligible to participate at the time the notice is provided at least 90 days before the beginning of the plan year), no later than the date on which the participant is first eligible to participate in the HRA.

(ii) *Content.* The notice must include all the information described in this paragraph (c)(6)(ii) (and may include any additional information as long as it does not conflict with the required information set forth in paragraph (c)(6)(ii)(A) through (H) of this section).

(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 family coverage)), any rules regarding the proration of the maximum dollar amount applicable to any participant who is not eligible to participate in the HRA for the entire plan year, whether the participant's family members are eligible for the HRA, a statement that the HRA is not a qualified small employer health reimbursement arrangement, a statement that the HRA requires the participant and any dependents to be enrolled in individual health insurance coverage, a statement that the participant is required to substantiate the existence of such enrollment, a statement that the

coverage enrolled in cannot be short-term, limited-duration insurance or excepted benefits, and, if the requirements under 29 CFR 2510.3-1(l) are met, a statement that the individual health insurance coverage enrolled in is not subject to the Employee Retirement Income Security Act (ERISA).

(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 the Exchange (as defined in 45 CFR 155.20) for any month that the HRA is affordable under 26 CFR 1.36B-2(c)(5), and a statement that, if the participant is a former employee, the offer of the HRA does not render the participant ineligible for the premium tax credit regardless of whether it is affordable under 26 CFR 1.36B-2(c)(5);

(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 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 family coverage) as set forth in the written notice in accordance with paragraph (c)(6)(ii)(A) of this section, the number of months in the plan year the HRA is available to the participant, whether the HRA is also available to the participant's dependents, 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 and, if so, the months the participant is allowed the premium tax credit.

(G) A statement that the HRA may not reimburse any medical care expense unless the substantiation requirement set forth in paragraph (c)(5) of this section is satisfied.

(H) A statement that it is the responsibility of the participant to inform the HRA if the participant or any dependent whose medical care expenses are reimbursable by the HRA is no longer enrolled in individual health insurance coverage.

(d) *Classes of employees—(1) 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)(1). If the HRA is offered to former employees, former employees are considered to be in the same class in which they were in immediately before separation from service. (See paragraph (d)(2) of this section for additional rules regarding the definition of "full-time employees," "part-time employees," and "seasonal employees.")

(i) Full-time employees, defined to mean either full-time employees under section 4980H of the Code and the regulations thereunder (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 to mean either employees who are not full-time employees under section 4980H of the Code and 26 CFR 54.4980H-1 and -3 or part-time employees as described in 26 CFR 1.105-11(c)(2)(iii)(C);

(iii) Seasonal employees, defined 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);

(iv) 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));

(v) Employees who have not satisfied a waiting period for coverage (if the waiting period complies with § 147.116 of this subchapter);

(vi) 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));

(vii) Non-resident aliens with no U.S.-based income (as described in 26 CFR 1.105-11(c)(2)(iii)(E));

(viii) Employees whose primary site of employment is in the same rating area as defined in § 147.102(b) of this subchapter; or

(ix) A group of participants described as a combination of two or more of the classes of employees set forth in paragraphs (d)(1)(i) through (viii) of this section. (For example, part-time employees included in a unit of employees covered by a collective bargaining agreement could be one class of employees and full-time employees included in a unit of employees covered by the same collective bargaining agreement could be another class of employees.)

(2) *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) of the Code and 26 CFR 1.105–11 or of section 4980H of the Code and 26 CFR 54.4980H–1 and –3 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 either section 105(h) of the Code or 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 in which the definitions will apply.

(e) *Examples.* The following examples illustrate the provisions of paragraphs (c)(2) and (3) of this section. In each example, the HRA may reimburse any medical care expenses, including premiums for individual health insurance coverage.

(1) *Example 1.* (i) *Facts.* For 2020, Plan Sponsor X offers the following to its employees. Full-time employees in rating area A are offered \$2,000 each in an HRA. Part-time employees in rating area A are offered \$500 each in an HRA. All employees in rating area B are offered a traditional group health plan.

(ii) *Conclusion.* The requirements of paragraphs (c)(2) and (3) of this section are satisfied in this *Example 1*.

(2) *Example 2.* (i) *Facts.* For 2020, Plan Sponsor Y offers the following to its employees. Employees covered by a collective bargaining agreement in which Plan Sponsor Y participates are offered a traditional group health plan (as required by the collective bargaining agreement). All other employees (non-collectively bargained employees) are offered 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. Non-collectively bargained employees who have not attained age 25 by January 1, 2020 are not offered an HRA or a traditional group health plan.

(ii) *Conclusion.* The requirements of paragraphs (c)(2) and (3) of this section are satisfied in this *Example 2*.

(3) *Example 3.* (i) *Facts.* For 2020, Plan Sponsor Z offers the following amounts in an HRA to its employees who have completed the plan’s waiting period, which complies with the requirements for waiting periods in § 147.116 of this subchapter: \$1,500, if the employee is the only individual covered by the HRA; \$3,500, if the employee and one additional family member are covered by the HRA; and \$5,000, if the employee and more than one additional family member are covered by the HRA.

(ii) *Conclusion.* The requirements of paragraphs (c)(2) and (3) of this section are satisfied in this *Example 3*.

(f) *Applicability date.* This section applies to plan years beginning on or after January 1, 2020.

■ 19. 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, 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.

(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 August 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 August for the preceding calendar year. Any such increase that is not a multiple of \$50 shall be rounded to the next lowest multiple of \$50.

(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.

(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 parts B 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.

(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) of this part, regardless of any health factor (as described in § 146.121(a)).

\* \* \* \* \*

#### **PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS**

■ 20. 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.

■ 21. 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. For this purpose, 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 paragraphs (c)(1) or (2):

(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 Employee Health Benefits Program (FEHBP) plan options as defined by 45 CFR 156.100(a)(3), and including coverage of additional required benefits under 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 meet 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 meet the requirements of PHS Act section 2713 and § 147.130(a)(1) of this subchapter. For this purpose, 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 meets 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 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 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 26 CFR 1.36B-6;

(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 26 CFR 1.36B-6, 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 this purpose, 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.* An HRA or other account-based group health plan is integrated with individual health insurance coverage (and treated as complying with PHS Act sections 2711 and 2713) if the HRA or other account-based group health plan meets the requirements of 45 CFR 146.123(c).

(5) *Integration with Medicare parts 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 requirements of this paragraph (d)(5) 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 [APPLICABILITY DATE OF FINAL RULE] 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 July 1, 2018.

#### **PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT**

■ 22. 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.

■ 23. Section 155.420 is amended

■ a. By revising paragraph (a)(4)(iii) introductory text;

■ b. By adding paragraph (b)(2)(vi);

■ c. By revising paragraph (c)(2);

■ 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 gains access to a health reimbursement arrangement or other account-based group health plan integrated with individual health insurance coverage or is provided a qualified small employer health reimbursement arrangement, 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 the coverage effective

date is on the first day of the following month.

\* \* \* \* \*

(c) \* \* \*

(2) *Advanced availability.* A qualified individual or his or her dependent who is described in paragraph (d)(1), (d)(6)(iii), or (d)(14) of this section has 60 days before or after the triggering event to select a QHP. At the option of the Exchange, a qualified individual or his or her dependent who is described in paragraph (d)(7) of this section; who is described in paragraph (d)(6)(iv) of this section and becomes newly eligible for advance payments of the premium tax credit as a result of a permanent move to a new State; or who is described in paragraph (d)(3) of this section and becomes newly eligible for enrollment in a QHP through the

Exchange because he or she newly satisfies the requirements under § 155.305(a)(2), has 60 days before or after the triggering event to select a QHP.

\* \* \* \* \*

(d) \* \* \*

(14) The qualified individual, enrollee, or dependent gains access to and enrolls in a health reimbursement arrangement or other account-based group health plan (as defined in 45 CFR 147.126(d)(6)(i)) that will be integrated with individual health insurance coverage, in accordance with 45 CFR 146.123(c), or is provided a qualified small employer health reimbursement arrangement, as defined in section 9831(d)(2) of the Internal Revenue Code.

[FR Doc. 2018-23183 Filed 10-23-18; 8:45 am]

**BILLING CODE 4830-01-P; 4510-29-P; 4120-01-P**