Defined Contribution Health Plans—A Green Light for Health Reimbursement Arrangements

BY MARK L. STEMBER

This past July, the Treasury and the Internal Revenue Service (IRS) gave a bright green light to innovative health plan designs that use employer-funded, defined contribution accounts to pay employee and dependent health care expenses. Termed a **health reimbursement arrangement** *(HRA) by the Treasury/IRS guidance, an HRA account may be used to pay both out-of-pocket health care expenses and health coverage premium costs. Any unused HRA balances may be carried forward from year to year. The guidance dispelled the gloomy expectations for defined contribution health plans based on early comments by various Treasury officials and restrictive existing guidance for health flexible spending accounts (FSA). Indeed, the new guidance stands out for its reasonable positions and its inherent flexibility—flexibility that should spark innovation through plan design freedom.*

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In order to release the guidance before most employers made their decisions regarding the structure of their health plans for 2003, the guidance was released as a combination of a revenue ruling and an IRS notice. [Rev. Rul. 2002-41 and IRS Notice 2002-45, 2002-28 I.R.B. (July 15, 2002), referred to hereinafter as the guidance] Alternatively, if the guidance had been issued as proposed regulations rather than as administrative pronouncements, the Treasury would have had to most likely coordinate with the Department of Labor (DOL), which would have severely delayed its release. However, even before the guidance was issued, some employers had already instituted a form of an HRA for their 2002 health plan year. Those minority of employers that started before the release of the guidance did so with some trepidation and therefore did not publicize the fact that they were doing it. The early pioneers may not have done it wrong, but may not have done it particularly right either. The remainder of this article discusses the structure of an HRA and summarizes its key features as set forth in the guidance.

HRAs in a Nutshell

An HRA is an arrangement that (1) is financed or paid for solely by the employer, (2) is not provided pursuant to an employee salary reduction election or otherwise under an Internal Revenue Code (Code) Section 125 cafeteria plan, and (3) reimburses only

- Code Section 213 medical expenses;
- Expenses incurred after the HRA is adopted and after an individual's coverage begins;
- Expenses that are substantiated; and
- Expenses that are not deducted by the employee under Code Section 213 and not reimbursed by another plan.

As with other employer-provided accident and health plans, coverage under and reimbursements of expenses from an HRA are generally excludable from an employee's income under Code Sections 105 and 106. However, to qualify for this exclusion, an HRA may only provide benefits that reimburse expenses for medical care under Code Section 213(d). Allowable reimbursements under Code Section 213(d) include reimbursements for

- Medical, dental, and vision expenses;
- Premiums for accident or health insurance coverage, including Consolidated Omnibus Budget Reconciliation Act (COBRA) premiums; and
- Long-term care premiums.

However, an HRA may not be used to pay for disability insurance premiums because such expense is

not covered by Code Section 105(b). In addition, most HRAs will also satisfy the definition of an FSA in Code Section 106(c)(2), because the maximum amount that may be reimbursed under the HRA will be less than 500 percent of the value of the HRA coverage (i.e., the amount of the employer contribution). In fact, most maximum HRA reimbursements will be equal to 100 percent of the employer contribution. Therefore, qualified long-term care services as defined in Code Section 7702B may not be reimbursed from an HRA.

Eligibility for HRA Coverage

An HRA may reimburse medical expenses of current or former employees (including retirees) and the employees' spouses and dependents. However, an HRA may not cover self-employed individuals as defined in Code Section 401(c). [*See* I.R.C. § 105(g)] Based on informal comments by IRS officials, an HRA may be specifically offered only to retirees, and the HRA coverage amount may be limited to the retiree's cost of postretirement health insurance premiums. In addition, an HRA may also cover domestic partners. If the employer verifies that the domestic partner qualifies as a Code Section 152 dependent of the employee, then the coverage may be provided on a tax-free basis under Code Sections 105 and 106. Alternatively, if the domestic partner does not qualify as a dependent of the employee, HRA coverage for the domestic partner may be provided if the value of the HRA coverage for the nondependent domestic partner is taxed to the employee as compensation. This is in line with the IRS's approach to taxing regular group health insurance coverage provided to domestic partners. [*See* Ltr. Ruls. 9109060, 200108010]

Financing HRA Coverage

Under the guidance, employees have individual HRA accounts to which the employer credits hypothetical dollar amounts. Thus, the individual account is merely an unfunded liability of the employer that is subject to the claims of general creditors. While the guidance addressed only unfunded HRAs, the general concepts should also apply to funded HRAs as well. However, funding an HRA brings into play the trust requirements of the Employee Retirement Income Security Act of 1974 (ERISA) and the related DOL regulations. The taxation of earnings on a funded HRA will depend upon the tax status of the funding vehicle (e.g., if a voluntary employees' beneficiary association (VEBA) is used, the earnings will generally be tax free).

Amounts credited to an HRA must be provided solely by the employer and may not be attributable, directly or indirectly, to employee salary reduction. It appears that there are no dollar limits on the amount that the employer can credit under an HRA. In addition, amounts may be contributed in a lump sum (such as at retirement or on an annual basis) or periodically based on the employee's payroll period. In contrast to health FSAs, an employer may establish an HRA that only allows employees access to HRA amounts as they are credited to the account (i.e., uniform coverage is not required) and the HRA is not required to use 12-month coverage periods. Therefore, the annual use-it-or-lose-it rule applicable to health FSAs is not required for an HRA and unused HRA amounts simply continue to be carried over from year to year until they are used by the employee (or forfeited based on the design of the HRA). However, unused HRA amounts may not be rolled over to an individual retirement account (IRA) or a medical savings account (MSA) because such rollover would violate the rule that the HRA only reimburse medical care expenses. [*See* IRS Notice 2002-45, Part II]

Coordinating HRA Coverage With a Cafeteria Plan

Although HRA credits must be financed solely by the employer and may not be attributable to employee salary reduction or so-called cashable credits under a flex plan, the guidance does allow an HRA to be provided in conjunction with a cafeteria plan as well as another specified group health plan that is financed through employee salary reduction. However, in order to ensure that no salary reduction for the specified health plan is being used to directly finance the HRA, the salary reduction for the specified health plan may not exceed the specified health plan's cost. Solely for this purpose, the guidance indicates that cost may be determined under the COBRA rules for determining the COBRA applicable premium, which is the cost to the health plan for such coverage (both employee and employer contributions), but *without* the 2 percent add-on for administration. For example, if the applicable COBRA premium (without the 2 percent administrative add-on) for family group health plan coverage is $2,400 per year, the annual salary reduction for the employee may not exceed $2,400.

In addition, the HRA also must not be indirectly financed through employee salary reduction. Indirect financing through salary reduction is deemed to occur

if the HRA may pay for premiums under another health plan that alternatively could be paid for by employee salary reduction, or if health FSA forfeitures are credited to the HRA. Indirect financing also occurs if the HRA maximum reimbursement amount increases in correlation with an increase in the salary reduction for the companion health plan. The existence of a correlation between the HRA maximum reimbursement amount and the amounts of employee salary reduction is a determination that is made based on all the facts and circumstances. Thus, an exact number correlation would violate the indirect financing rule, but a slight correlation may not, depending on the circumstances. If family coverage requires more salary reduction and results in a larger HRA amount than employee-only coverage, informal comments by IRS officials indicate that these facts and circumstances would be looked upon favorably, as long as the employer was not violating the basic rule that salary reduction cannot exceed the cost of coverage for the regular health plan. Further, if the HRA maximum reimbursement decreases as the employee salary reduction increases, such a "negative correlation" appears not to violate the indirect financing rule.

Example. Pioneer Corporation offers family group health plan coverage with an annual cost of $4,500 in conjunction with an HRA. Employees have a choice to reduce their pretax salary by either $2,500 or $3,500 to pay for the group health coverage. Pioneer Corporation pays the remaining cost of $2,000 or $1,000 for the coverage. Employees who elect to reduce their salary by $2,500 receive a $1,000 credit in their HRA account, and employees who elect $3,500 of salary reduction receive a $2,000 credit in their HRA account. Although the maximum allowable salary reduction ($4,500) is not exceeded, a portion of the salary reduction is indirectly related to the HRA because the increase in the salary reduction election correlates to a larger HRA credit. Therefore, this arrangement violates the rule that an HRA may not be indirectly funded through employee salary reduction and therefore does not qualify as an HRA under the guidance.

Coordinating HRA Coverage With Other Group Health Plans

An HRA may be offered independently of another health plan, or the employer may require employees to participate in a combination of an HRA and another group health plan. If an HRA is combined with another health plan, there are no rules regarding the type of plan that may accompany the HRA. That is, the other health plan is not required to be a "high deductible" plan, in contrast to the requirement for medical savings accounts (MSAs). In addition, informal comments by IRS officials indicate that an employer could also offer an HRA and an MSA at the same time. However, in such situation, the HRA could only provide coverage for benefits not covered under the high deductible health plan accompanying the MSA. For example, the HRA could provide coverage for dental and vision benefits if the high-deductible plan does not cover those benefits.

Employers will need to be aware that offering a choice between regular group health coverage on one hand, or regular group health coverage coupled with HRA coverage on the other hand, has a potential for raising adverse selection concerns. This stems from the fact that if offered a choice, high users of the regular group health coverage will elect to remain covered by only the group health plan, while low users will elect the HRA coupled with the regular group health plan coverage. Because of this choice, high users will continue to cost the employer the same, while low users have the potential to cost the employer more because they have the additional HRA balance that carries over each year. For this reason, some employers have made the decision that unless they require all their employees to have an HRA coupled with regular group health coverage, their overall health costs will not decrease.

Coordinating HRA Coverage With a Health FSA

As discussed above, most HRAs will be considered an FSA under Code Section 106(c), because the maximum amount that may be reimbursed under the HRA will be less than 500 percent of the employer contribution. Although an HRA meets this statutory definition of an FSA, the guidance provides that the proposed regulations relating to health FSAs under Code Section 125 will not apply to an HRA and that future guidance will modify these regulations accordingly. [*See generally* Prop. Treas. Reg. § 1.125-2, Q&A-7] This means that the following rules that are applicable to health FSAs will not be applicable to an HRA:

- **Prohibition against deferred compensation.** This is otherwise referred to as the "use-it-or-lose-it" rule. The nonapplication of this rule to HRAs means that unused amounts may be carried over to subsequent years.
- **Uniform coverage rule.** Because this rule does not apply to HRAs, the maximum amount that may

be reimbursed by the HRA may be limited to the current balance of the HRA, rather than making the entire credit during the annual period of coverage available from day one before it is credited.

• **Annual period of coverage rule.** Because the annual period of coverage is not applicable to an HRA, an HRA may reimburse in a subsequent year qualifying medical expenses that were incurred in prior years. The only requirements being that the HRA must have been adopted by the employer and the individual must have enrolled in the HRA prior to incurring the expense.

In general, a medical expense may not be reimbursed from a health FSA if the expense has been reimbursed or is reimbursable under another health plan. [Prop. Treas. Reg. § 1.125-2, Q&A-7(b)(5)] Therefore, if an HRA is offered in addition to a health FSA, and both plans cover the same medical expenses, amounts available under an HRA must be exhausted first before reimbursements may be made from the health FSA. However, this would mean that the HRA carryover potential for those employees who participate in both an HRA and a health FSA would be limited. Therefore, the guidance indicates that the plan sponsor may provide in the HRA plan document (and presumably in the health FSA plan document as well), before the beginning of the plan year of the health FSA, that coverage under the HRA is available only after an employee exhausts his or her health FSA for the year. This would allow employees to take maximum advantage of the HRA's carryover potential. In addition to the above rules, claims for reimbursement from an HRA must be substantiated pursuant to rules that are similar to health FSAs.

HRA Accounts and Termination of Employment

When an employee terminates employment (including at retirement and death), the HRA either may provide that the employee forfeits the balance in his or her HRA account or may continue to reimburse qualifying medical expenses incurred after termination. If the termination is caused by the employee's death, the employer may allow the employee's surviving spouse and dependents to use up the balance in the HRA account, and the estate may also claim reimbursement for pre-death expenses incurred by the employee. As a practical matter, most HRAs will not cause the balance to be forfeited upon termination, because such a design would have the opposite effect that HRAs are intended to have (i.e., to encourage employees to spend less on health care by allowing them to carry over their individual HRA balances).

The guidance provides that all benefits received under the HRA are taxable if any person has the right to receive cash or any other taxable or nontaxable benefit under the HRA other than reimbursement of qualifying medical expenses. Therefore, an arrangement that distributes the unused HRA amount at termination either as a death benefit or as a severance payment will not qualify as an HRA. Furthermore, the IRS will examine other arrangements outside the HRA to determine whether the above rule is violated. For example, if an employee receives a bonus in the year of termination and the amount of the bonus is related to the HRA balance, the arrangement will be deemed to violate the HRA rules.

Application of COBRA to HRAs

The guidance indicates that an HRA is a group health plan that is subject to the COBRA continuation coverage requirements. If an individual elects COBRA continuation coverage, an HRA complies with the COBRA requirements (1) by providing for the continuation of the maximum reimbursement amount (usually the employee's HRA account balance) at the time of the COBRA qualifying event and (2) by increasing such amount at the same time and by the same increment that the employer would normally credit an HRA account for non-COBRA beneficiaries. For example, if the HRA credits $500 per quarter to each employee's HRA account, a qualified beneficiary electing COBRA coverage must also receive the same credit during the COBRA coverage period.

HRA premiums are determined under existing COBRA rules. However, the guidance establishes what appears to be a safe harbor by providing that if the applicable premium is the same for all qualified beneficiaries regardless of the total reimbursement amounts available from the HRA, the HRA will be deemed to comply with the COBRA premium requirements. The example listed in the guidance provides that if the annual credit amount is $1,000 per employee and the HRA account balance for two different qualified beneficiaries is $500 and $5,000, the applicable premium must be the same for each individual. While the guidance does not explain what the applicable premium would be in this example, informal comments by IRS officials indicate that in such a case the premium reasonably could be the actuarially determined cost that the employer is expected to incur for an average active participant during the year.

Application of the Nondiscrimination Rules to HRAs

Because an HRA is not an insured benefit, it will be subject to nondiscrimination testing under Code Section 105(h). In general, Code Section 105(h) would require the HRA to (1) not discriminate in favor of highly compensated individuals as to eligibility to participate, and (2) provide benefits that do not discriminate in favor of highly compensated individuals. This means that a self-insured HRA may not base the maximum reimbursement amount on compensation, age, or years of service. [Treas. Reg. § 1.105-11(c)(3)] The guidance does not explain how a plan sponsor should test an HRA for nondiscrimination. However, informal comments by IRS officials indicate that it is probably permissible to test based on the annual increment credited to the HRA, rather than the HRA's total account balance (which would include carryovers).

Application of Other Benefits Laws to HRAs

Although not addressed in the guidance, an HRA would ordinarily be a group health plan that is subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This would mean that HRAs are subject to the portability, special enrollment, nondiscrimination, and privacy rules of HIPAA. Informal comments by IRS officials reflect that the HIPAA nondiscrimination requirements may bar HRAs from reimbursing individual health insurance premiums because such coverage varies in cost based on the insured's health. However, this issue is still open and will not be addressed or resolved until a consensus with the DOL and the Department of Health and Human Services (HHS) is achieved.

An HRA will also most likely constitute an employee welfare benefit plan covered by ERISA, which means that (among other things) an HRA would be subject to the DOL's new claims procedures for group health plans. However, because HRAs are structured as reimbursement arrangements, most likely the claims for HRA benefits will be treated as a post-service claim under the new regulations, thereby only requiring an initial benefit determination within 30 days of filing a claim. [*See* DOL Reg. § 2560.503-1] In addition, as an employee welfare benefit plan under ERISA, an HRA would also be subject to annual Form 5500 reporting requirements, if the HRA did not qualify for one of the regulatory exemptions (e.g., the exemption for unfunded welfare plans with fewer than 100 participants at the beginning of the plan year). [*See* DOL Reg. § 2520.104-20(a), (b)]

Establishing an HRA

Although the guidance does not include a requirement for a written plan document, because an HRA is not an insured benefit Code Section 105(h) requires the adoption of a written plan document. [Treas. Reg. § 1.105-11(b)(1)(i)] Similarly, because an HRA should also constitute an employee welfare benefit plan under ERISA, a written plan document, as well as the distribution of summary plan descriptions (SPDs) to participants, will be required by ERISA. Except for the general rule on HRA versus health FSA ordering of claims, the guidance contains very few default rules regarding the operation of an HRA plan. Therefore, as with other group health plan documents, the HRA plan document should establish rules regarding the operation of the HRA, including employer credits, eligibility, participation, reimbursement, and substantiation of claims.

Looking Ahead

An HRA's ability to carry over unused balances and to reimburse the premium costs of health and long-term care coverage gives HRAs a fundamentally different role than health FSAs. Freed from the use-it-or-lose-it requirement of health FSAs, HRAs can be structured to encourage employees to become responsible managers of their HRA balance. Employers have considerable latitude in designing HRAs, which will ensure that this innovative form of health plan design can be used to fill a range of roles and that it will continue to evolve in the years ahead.