Florida HEALTH INSURANCE ADVISORS

HRAs: Individual Coverage Health Care Reimbursement Arrangement (ICHRA)

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An Individual Coverage Health Reimbursement Arrangement (ICHRA) is a health reimbursement arrangement (HRA) integrated with individual market health insurance coverage and is designed for employers who want to help their employees pay the premium cost of individual (non-group) medical insurance and Medicare, as well as other qualified medical expenses. ICHRAs contain three key elements that make them appealing to employers:

- No size restrictions. Any size employer can offer an ICHRA.
- Unlimited contribution amounts. There are no annual contribution caps.
- Flexible class options. Employers can choose to treat different classes of employees differently based on different available class distinctions.

While appealing, ICHRAs are also complex and require employers to undertake several compliance and administrative tasks on an annual and ongoing basis; these are discussed at a high level below.

Background

The prohibition against employer-paid individual health insurance was implemented many years ago under the Affordable Care Act (ACA) to discourage employers from canceling their group plans and pushing employees into the individual insurance market. In 2017 an executive order was issued directing the Departments of Treasury, Health and Human Services, and Labor to expand use of HRAs. In June of 2019 new regulations were released establishing the Individual Coverage Health Reimbursement Arrangement (ICHRA). For plan years beginning on or after January 1, 2020, instead of providing an employer sponsored group health plan, employers of all sizes can establish an ICHRA, which provides employees with non-taxed reimbursement for major medical insurance premiums purchased in the individual market (or Medicare Parts A, B or C, if eligible) and other eligible medical expenses as defined in Internal Revenue Code § 213(d).

Plan Design Flexibility

ICHRAs provide employers the ability to design and customize a plan that is tailored to their organization. While there is a great amount of flexibility, ICHRAs must be offered fairly to a group of employees in order to prevent discrimination.

Employee Classes

Subject to certain exceptions, an employer that offers an ICHRA to a class of employees generally must offer it on the same terms to each participant within a class. Before the start of a plan year, employers must determine for the plan year which classes of employees it plans to treat separately and the definition of classes it will use. Once established, employers may not change the classes or definitions for the plan year.

There are 11 different classes that can be used to divide employees into different benefit levels:

- Full-time employees
- Part-time employees
- Seasonal employees
- Employees covered by a collective bargaining agreement
- Employees who have not satisfied a waiting period for coverage
- Salaried employees
- Non-salaried employees
- Temporary employees of staffing firms
- Non-resident aliens with no US-based income
- Employees in the same geographic rating area
- Any combination of two or more classes from above

Class Size Requirements

Employers are not required to use employee classes to structure their benefits. However, classes can be used to structure eligibility requirements and to offer different benefits and allowance amounts to different employees.

If an employer chooses to offer both an ICHRA to one class of employees and group health insurance to another class of employees based on full-time or part-time status, salaried or hourly payment structure, or geographic location, classes must meet minimum size requirements. The minimum class size varies by employer size, based on employee count on the first day of the plan year:

- Employers with fewer than 100 employees must have at least 10 employees in a class.
- Employers with 100-200 employees must have at least 10 percent of the total number of employees in a class.
- Employers with more than 200 employees must have at least 20 employees in a class.

Reimbursement Allowance

There are no limits to how much an employer can offer for reimbursement under an ICHRA. Employers can choose what they want their ICHRA to reimburse:

- Insurance premiums only;
- Insurance premiums and eligible medical expenses; or
- Eligible medical expenses only.

Furthermore, employers can choose how to structure reimbursements to employees:

- Give all employees the same amount. For example, an employer can give all employees $200 per month.
- Vary reimbursements by family size**.** Since individual market plans cost more for families, employers can offer more for larger families. For example, an employer could offer $200 per month for single employees, $300 per month for married employees, and $600 per month for employees with families, or they could offer $100 per month for each additional dependent.
- Vary reimbursements by employee age. Similarly, since individual plans typically cost more for older employees, employers can elect to offer higher reimbursement amounts to older employees. Reimbursements must be structured using a 1:3 ratio from the youngest to the oldest employee. For example, an employer could give a 21 year old $100 per month and a 64 year old $300 per month.
- Vary by both family size and age. An employer can use a combination of the above options.

The above reimbursement rules can be applied to all employees or employers can choose to create different reimbursement rules for different classes of employees. For example, an employer can offer one set of reimbursement rules for full-time employees and a separate set of rules for part-time employees.

Affordability

Large employers subject to the Affordable Care Act (employers with over 50 full-time equivalent employees) are required to provide affordable health insurance to their employees or risk a potential penalty assessment. According to the IRS, an ICHRA is affordable if the remaining amount an employee has to pay for a self-only silver plan on the exchange is less than 9.83 percent for 2021 and 9.61 percent for 2022 of the employee's household income. This means an affordable contribution *must be greater than* the lowest cost silver plan an employee can purchase *minus* 9.83 percent (2021) or 9.61 percent (2022) times the employee's household income.

If there is a silver-level plan that has one rate for tobacco users and another rate for non-tobacco users, the rate provided for non-tobacco users applies to the affordability determination of the allowance provided under the ICHRA.

The formula for this calculation looks like this:

Household income *.0961 = X

X/12 = Y

Lowest-cost silver plan – Y = minimum affordable ICHRA monthly allowance

Safe Harbors

The variables discussed above in determining affordability can be challenging for employers to know or keep track of. Therefore, the IRS provides safe harbors outlined in the IRS Notice 2018-88 to assist large employers offering an ICHRA to calculate affordability with information they have reasonable access to:

- Location. Through this safe harbor, employers can use the employee's primary site of employment to determine affordability calculations, rather than the employee's residence.
- Affordability. Using this safe harbor, employers can estimate an employee's income using the employee's W-2, or rate of pay.
- Calendar year. With this safe harbor, employers who offer an ICHRA in the following calendar year can use the current year's estimates as a baseline for affordability.

To help employers determine whether an ICHRA offer is considered affordable for purposes of validating they are making affordable offers of coverage to their employees, the Centers for Medicare & Medicaid Services (CMS) provides the ICHRA Employer LCSP Premium Look-up Table. Employers considering ICHRAs are strongly encouraged to work directly with legal counsel and tax advisors that offer expertise in this area to address specific questions about determining affordability.

Premium Tax Credit

Affordability is also important for small employers because it impacts an employee's ability to receive a premium tax credit (PTC) to help pay for their premiums. If an ICHRA is affordable, employees are not eligible for the PTC. If an ICHRA is unaffordable, employees can choose either the ICHRA or the PTC.

Special Enrollment Period

ICHRAs can be established at any time during the year, which then creates a Special Enrollment Period (SEP) for employees to enroll in the individual health insurance market. Employees can enroll in an individual health insurance plan 60 days before or 60 days after the effective date of the ICHRA. This SEP will also be available annually to coincide with the renewal date of the ICHRA.

Conditions for ICHRAs

An ICHRA must satisfy the following six conditions to be considered integrated with individual health insurance coverage.

First Condition: All individuals Covered Must Be Enrolled in Individual Market Health Coverage

In complying with the first requirement, an ICHRA must require an employee and any dependents to be enrolled in individual market coverage for each month they are covered by the ICHRA. All individuals seeking reimbursement from an ICHRA must actually obtain the individual market coverage as opposed to merely being able to do so.

Individuals covered by an ICHRA who lose individual market coverage cannot be reimbursed by the ICHRA for expenses incurred after their individual market coverage has ceased. Any remaining balance in the employee's ICHRA must be forfeited, subject to any applicable continuation rules. The forfeiture requirements apply only prospectively.

Coverage under an ICHRA may be continued under COBRA's health plan continuation rules in some instances. An employee's failure to maintain individual market coverage is not a COBRA qualifying event. However, other situations such as termination of employment or a reduction in hours are COBRA qualifying events under which an employee may continue their ICHRA coverage provided they remain enrolled in individual market coverage.

Second Condition: Same Class of Employees Cannot Be Offered Choice Between Traditional Group Health Plans and ICHRAs

Employers cannot offer an ICHRA to a class of employees if they offer a traditional group health plan to the same class of employees.

A ***traditional group health plan*** generally refers to any other group health plan other than an account-based group health plan or a group health plan consisting solely of excepted benefits. Therefore, employers may offer an ICHRA and a group health plan consisting solely of excepted benefits as well as an ICHRA and a separate HRA that reimburses premiums for excepted benefits.

Third Condition: Same Terms Requirement

Employers offering an ICHRA to a class of employees must offer the arrangement in both the same amount and on the same terms and conditions to all employees within the same class, with exception.

Exception to Same Terms Requirement: Variation of Age (3:1 Limit)

Because premiums for individual market coverage obtained by HRA participants and dependents may vary, final regulations allow some variation in available amounts within a class of employees. The maximum dollar amount available under the ICHRA to the oldest participants must not be more than three times the maximum dollar amount made available to the youngest participants. However, the same maximum dollar amount related to the age increase must be made available to all participants of the same age within the same class of employees.

Employers can determine a participant's age using any reasonable method for a plan year and must use the same method for all participants in the same class of employees for the plan year. The method used must be determined prior to the start of the plan year. For example, an employer may determine each participant's age based on their age on the first day of the ICHRA's plan year.

Exception to Same Terms Requirement: Variation in Family Size

The maximum dollar amount available under the ICHRA within a class of employees may increase as the number of dependents covered increases and must be made available to all participants in the class of employees with the same number of covered dependents.

Variation Permitted Regarding Post-Employment Health Coverage

Eligibility for post-employment health coverage may vary and be subject to age, service, or other conditions. Regarding post-employment health coverage, an ICHRA is treated as provided on the same terms even if an employer:

- Offers the ICHRA only to some former employees within a class of employees (for example, all former employees employed for a minimum amount of time).
- Does not offer the ICHRA to other former employees within a class of employee.

However, if an employer offers an ICHRA to former employees in a class of employees, it must be offered on the same terms regarding all other employees in the class. Employers cannot provide some employees in a class a larger or smaller amount based on years of service or status as a former employee.

Carryover Amount Disregarded for Purposes of Same Terms Requirement

In meeting the same terms requirement, carryover amounts must satisfy two conditions:

- The method for determining whether participants have access to unused amounts in future years must be the same for all participants in a class of employees; and
- The method and formula for determining the amounts of unused funds that participants may access in future years must be the same for all participants in a class of employees.

Amounts Paid by Salary Reduction

If any participant in a class of employees is allowed to pay the part of premiums for individual market coverage not covered by the ICHRA using a cafeteria plan's salary reduction arrangement, these same terms must be made available to all participants in a class of employees (excluding former employees).

New Employees or Dependents

Employers must make the full annual amount under the ICHRA available to participants who become covered after the first day of the plan year or adopt a reasonable proration method. This will also apply to ICHRAs that vary the maximum amount available on the number of a participant's covered dependents. If the number of covered dependents changes during the plan year, the ICHRA may either:

- Make available the same amount that was available to participants in the class with the same number of dependents covered by the ICHRA on the first day of the plan year; or
- Adopt a reasonable proration of that amount for the rest of the plan year.

The method used to determine amounts made available for participants enrolling during the plan year or who have changes in the number of covered dependents during the plan year must be determined prior to the start of the plan year and must be the same for all participants in the class of employees.

Fourth Condition: Opt-Out Provision

Eligible participants must be allowed to opt-out of and waive future reimbursements from the ICHRA once (on behalf of the participant and all dependents) each plan year and must be provided prior to the first day of the plan year. The annual opt-out condition applies to all participants, including former employees, who are eligible to enroll in the ICHRA.

For the following individuals, the opt-out opportunity must be provided during the ICHRA enrollment period:

- Participants who become eligible to participate after the first day of the plan year
- Participants who become eligible fewer than 90 days before the beginning of the plan year
- A dependent who become newly eligible during the plan year

An ICHRA must allow a participant who terminates employment to either:

- Forfeit the remaining amounts in the ICHRA; or
- Permanently opt-out of and waive future reimbursements on behalf of the participant and all covered dependents.

Fifth Condition: Substantiating Individual Market Health Coverage

Only employees and dependents who have enrolled in either non-excepted benefit coverage purchased on the individual market complying with health care reform's prohibition on lifetime and annual dollar limits and preventive services mandate or Medicare (Parts A and B or Part C) can participate in an ICHRA.

Deadlines for Providing Substantiation

Reasonable procedures must be put in place for substantiating that each employee and dependent(s) covered by the ICHRA is or will be enrolled in individual coverage or Medicare Part A and B or Part C for the plan year or the portion of the plan year during which the employee is covered by the ICHRA and for each month in which reimbursement is being requested for medical expenses incurred.

Annual substantiations generally must be provided no later than the first day of the plan year. Alternatively, substantiation may be provided by the end of the ICHRA's open enrollment period.

For an employee who is ineligible to participate in the ICHRA on the first day of the plan year or who becomes eligible less than 90 days before the plan year, substantiation must be provided by the date ICHRA coverage begins.

For a covered employee who adds a new dependent during the plan year, the substantiation due date cannot be later than the date ICHRA coverage begins. If the dependent's ICHRA coverage is effective retroactively, substantiation must be provided before reimbursement of any medical expenses for the newly added dependent.

Substantiation Methods

Regulations provide for two methods of enrollment substantiation:

- A document from a third party (e.g., insurer or an Exchange) showing the employee and any dependents are covered by the ICHRA, or will be, enrolled in individual coverage. For example, this documentation could include an insurance card, explanation of benefits, or documentation from the Exchange pertaining to the applicable time period.
- The employee’s attestation, stating the employee and any dependents covered by the ICHRA are, or will be, enrolled in individual medical coverage, the date coverage began or will begin, and the name of the provider.

Note: The substantiation requirements apply to all ICHRAs offered to different classes of employees.

Ongoing Evidence of Enrollment Required

After the initial substantiation of coverage requirement is satisfied, an ongoing substantiation requirement applies to each new reimbursement request for incurred medical expenses for the same plan year.

An ICHRA may not provide reimbursement for medical expenses unless, prior to reimbursement, the employee provides substantiation of enrollment (for whom reimbursement is being sought) in individual market coverage or Medicare Part A and B or Medicare Part C for the month during which the expenses were incurred. The ongoing substantiation requirement can consist of an employee's written attestation that is part of the form used to request reimbursement or a document from a third party (e.g. insurer) showing the employee and/or dependent, as applicable, was enrolled in individual market coverage for the applicable month.

The Department of Labor (DOL) provides model attestations that may be used to satisfy both the annual coverage and ongoing substantiation requirements. Use of the model attestations is not required, and the models may be combined with other documents, such as the form the ICHRA otherwise uses to confirm that expenses sought to be reimbursed are for medical care. The model attestations may also be modified to reflect the terms of the particular ICHRA.

Note: Both the annual and ongoing substantiation requirements apply to the ICHRA, and not employees.

Sixth Condition: Notice Requirement

An individual's acceptance of an ICHRA may affect their premium tax credit (PTC) eligibility. Therefore, final regulation includes a written notice requirement intended to inform participants who are eligible to participate in an ICHRA of the arrangement's potential effect on their ability to claim the PTC. The notice includes information individuals must provide the ACA health exchange as part of the PTC application process.

Model notice language has been provided for use in complying with the notice requirement and addresses the non-employer-specific aspects, i.e., a description of the PTC consequences of being offered and accepting an ICHRA.

The Department of Health & Human Services also provides optional model language for all exchanges that can be used to satisfy the notice requirement for a special enrollment period and for complying with the requirement that the notice explain how participants may obtain assistance with determining affordability.

ICHRAs must also provide a summary of benefits coverage (SBC) in accordance with disclosure requirements added under the ACA.

Notice Timing and Delivery Rules

An ICHRA must provide the written notice to eligible employees at least 90 days prior to the start of each plan year. Employees who are not eligible to participate at the beginning of the plan year (or as of when the notice is provided at least 90 days before the start of the plan year) must be furnished notice on or before the date in which the ICHRA may first take effect for the employee.

Notice must be provided in written form and provided in a manner reasonably calculated to ensure actual receipt of the material by plan participants. The notice may be provided electronically if the DOL's safe harbor for plans using electronic disclosure is satisfied. See ERISA: Electronic Distribution of Health Plan Notices for more details regarding the DOL's safe harbor rules.

An ICHRA notice may be delivered with other plan materials provided the ICHRA notice content and timing requirements are satisfied.

Other Federal Provisions

ICHRAs are subject to ERISA's reporting and disclosure rules, so plan documents and summary plan descriptions (SPDs) are required. Form 5500 is required for any welfare benefit plan, including ICHRAs. However, the "small plan exception" may apply if there are fewer than 100 participants at the beginning of the plan year and the plan is funded out of the employer's general assets, insurance, or both.

Employers, regardless of size, that sponsor an ICHRA must complete ACA reporting. The size of the employer's organization determines which forms should be completed and filed:

- Non-ALE (fewer than 50 FTEs): Forms 1094-B and 1095-B need to be completed and filed.
- ALE employers (50 or more FTEs): Forms 1094-C and 1095-C should be used.

The annual Patient-Centered Outcomes Research Institute (PCORI) fee applies.

More Information

Employers considering ICHRAs are encouraged to work with legal counsel and tax advisors that offer expertise in this area. The rules are complex, and employers must ensure the ICHRA is designed, communicated, and administered correctly to avoid adverse tax consequences for the employer and the employee. The IRS provides valuable guidance in the Final Regulation.