Brown & Brown

EMPLOYEE BENEFITS

Individual Coverage Health Reimbursement Arrangements (ICHRA)

Frequently Asked Questions

August 2024

Background

On June 20, 2019, the Departments of Labor, Health and Human Services and the Treasury (the Departments) issued final regulations that permit employers to offer an HRA that can integrate with individual market medical coverage (so long as it meets certain criteria) and be utilized by employers as an alternative to the traditional group health plan coverage they may offer, if applicable.

The Departments refer to these types of arrangements as **Individual Coverage HRAs (ICHRAs)**. ICHRAs are employer-funded account-based health plans that reimburse employees, on a non-taxable basis, for qualified medical expenses and premiums for employees' individual market medical coverage.

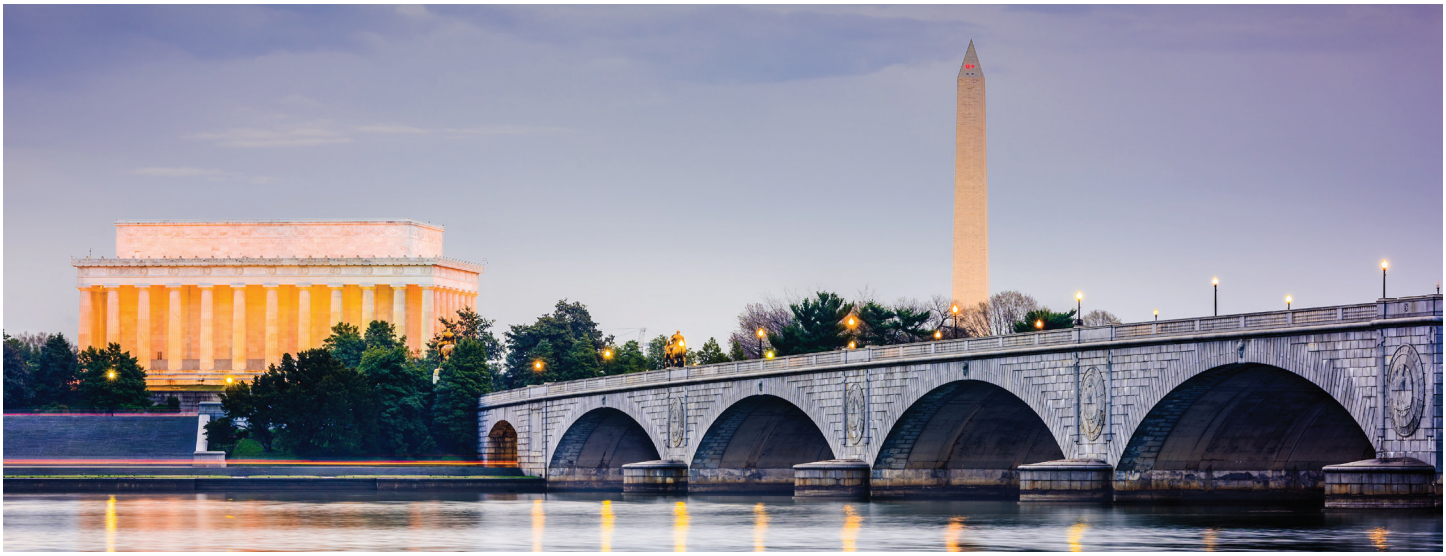
Q1 What are the benefits of offering an Individual Coverage HRA to employees?

Individual Coverage HRAs (ICHRAs) are available to employers of any size (subject to certain limitations). The plans are flexible and permit employers to decide the following:

- Maximum reimbursement amount for participating employees without a governmentally imposed minimum or maximum employer contribution amount
- Which medical expenses will be covered under the ICHRA (including individual market medical coverage premiums)
- Classes of employees to whom the ICHRA will be offered

ICHRAs may be useful to employers of all sizes, including applicable large employers (ALEs) with employees to whom coverage would not usually be extended (such as for part-time or seasonal employees) and ALEs seeking to extend coverage to a few more full-time employees to avoid employer mandate penalties under the Affordable Care Act (ACA).

ICHRAs also offer tax advantages to both employers and employees. ICHRAs are not considered wage/salary reimbursements but are considered health/welfare plan contributions, so they are treated as tax-advantaged business expenses. In addition, in most cases an employer's contributions to, and any benefits provided by, an ICHRA are excluded from an employee's taxable income. Furthermore, as long as the individual market medical coverage an employee is enrolled in is not an Exchange/Marketplace policy, the employee may pay any portion of the premium for individual market coverage not reimbursed by the ICHRA through a salary reduction agreement as part of a Section 125 cafeteria plan (if allowed under the terms of the cafeteria plan) on a pre-tax basis.



Q2 What medical expenses of an employee can be reimbursed through an ICHRA?

Employers may limit ICHRA reimbursements to individual market medical premiums and qualified medical expenses, or only allow reimbursement for qualified healthcare expenses related to excepted benefits such as vision/dental expenses (to create the option between HSA-compatible or non-HSA compatible ICHRA plans), both of which can be offered to employees within the same employee class. Further, other ways an ICHRA may be designed to be HSA-compatible include restricting ICHRA reimbursements solely to medical premiums (including premiums for individual market HDHP coverage), post-HDHP deductible expenses, or any combination of the forgoing. This is discussed further in Q8.

ICHRAs can also be used to reimburse costs associated with Medicare (Parts A, B and C) and Medicare supplemental insurance policies. ICHRAs can reimburse healthcare costs incurred by the employee and the employee's spouse, dependents and children younger than 27 years old at the end of the taxable year.

Q3 How does an employer set up an ICHRA?

ICHRAs are set up similarly to regular HRAs. All plan sponsors will need to create a plan document properly describing the rules surrounding the ICHRA, regardless of whether they are subject to ERISA. Plan sponsors that are subject to ERISA will also need to create and distribute a Summary Plan Description for the ICHRA. Also, depending on what rules the employer/plan sponsor is subject to, it must also properly deliver any applicable notices that employer health plans are generally subject to (e.g., Notice of HIPAA Privacy Practices, Medicare Part D Notice, WHCRA, CHIP Notice, COBRA General Notice, QMCSO).

An employer would also create an unfunded or notional account for each participating employee. These are bookkeeping accounts to which an employer's ICHRA contributions for each eligible employee are allocated.

Once an employee incurs qualifying expenses (premiums or other healthcare expenses associated with individual market coverage), the ICHRA would reimburse the employee up to the balance of the employee's ICHRA account.

Any portion of the premium for an employee's individual market medical coverage that is not covered by the ICHRA may be paid for by the employee on a pre-tax basis, so long as an employer's Section 125 cafeteria plan includes the ability for employees to make such payments through a salary reduction agreement and provided that the individual market coverage the employee is enrolled in is not purchased through the Exchange/ Marketplace.

Q4 What restrictions apply to Individual Coverage HRAs?

Employers are responsible for ensuring employees are eligible for reimbursements from the ICHRA by confirming that the employee (and any applicable family members) participating in the ICHRA is enrolled in individual medical insurance (purchased on or off Exchange) or enrolled in Medicare coverage. Any expenses incurred during a time in which an applicable individual is not enrolled in either individual market coverage or Medicare coverage are non-reimbursable, as that individual is not considered eligible for reimbursements from the ICHRA due to their failure to remain enrolled in individual market/Medicare coverage.

Employees enrolled only in group medical coverage, short-term limited duration coverage (STLDI) and/or an excepted benefit plan(s) are ineligible for reimbursements under an ICHRA. Additionally, sponsors offering an ICHRA cannot offer traditional group health coverage to the same class of employees offered the ICHRA.

As mentioned above, employees may not pay for Exchange/Marketplace coverage with pre-tax contributions from their paychecks. It is also important to note that the ICHRA cannot be part of a Section 125 cafeteria plan and must be funded only by the employer, similar to the rules surrounding other HRAs.

Q5 What other responsibilities does an employer/ICHRA plan sponsor have? Are there any notice or substantiation requirements?

An ICHRA plan sponsor must give written notice of information related to the ICHRA to all employees (including former employees) eligible for it. ICHRA plan sponsors may use the Federal government's model notice in the Appendix section of this document to satisfy the notice requirement. The plan sponsor must tailor the ICHRA model notice to match the specifics of the employer's ICHRA coverage throughout the notice, which requires modification of the areas of the notice, in the italicized prompts contained in brackets.

An employer may also modify the notice based on other terms of the ICHRA, such as deleting references within the notice to employees' family members if the plan sponsor excludes reimbursement to the employee for qualified expenses incurred by their family members. A plan sponsor is not required to utilize the model notice, but the Departments consider timely use of the model notice to be in good-faith compliance with the Department's notice requirement.

Employers/ICHRA plan sponsors are also responsible for requesting information from an employee to substantiate that each participant and dependent enrolled in the ICHRA is or will be enrolled in an individual health coverage for the plan year or portion of the plan year in which the employee and dependent will be covered under the ICHRA. The deadline for employees to substantiate they are/will be enrolled in individual market/Medicare coverage must occur before the first day of the ICHRA plan year, or before the first day in which participation begins (if joining the plan after the first day of the plan year). Following this initial substantiation of coverage, employees must substantiate that they remain enrolled in individual market/Medicare coverage for the month for which medical expenses (including medical premiums) were incurred prior to each expense reimbursement. Compliance with this requirement may be an issue for some employers depending on the process used for reimbursing recurring expenses such as the premiums for individual healthcare coverage.

Employers may adopt the following practices for employees to substantiate coverage:

- Requiring the participant to produce a document from a third party (such as an insurer or from the Exchange) showing the participant and any dependents covered by the ICHRA are, or will be, enrolled in medical coverage (such as an insurance card or explanation of benefits document).
- Obtaining the participant's attestation stating the participant and ICHRA-covered dependents will be enrolled in medical coverage by the date the coverage begins, along with notifying the employer of the name of the coverage provider.

Q6

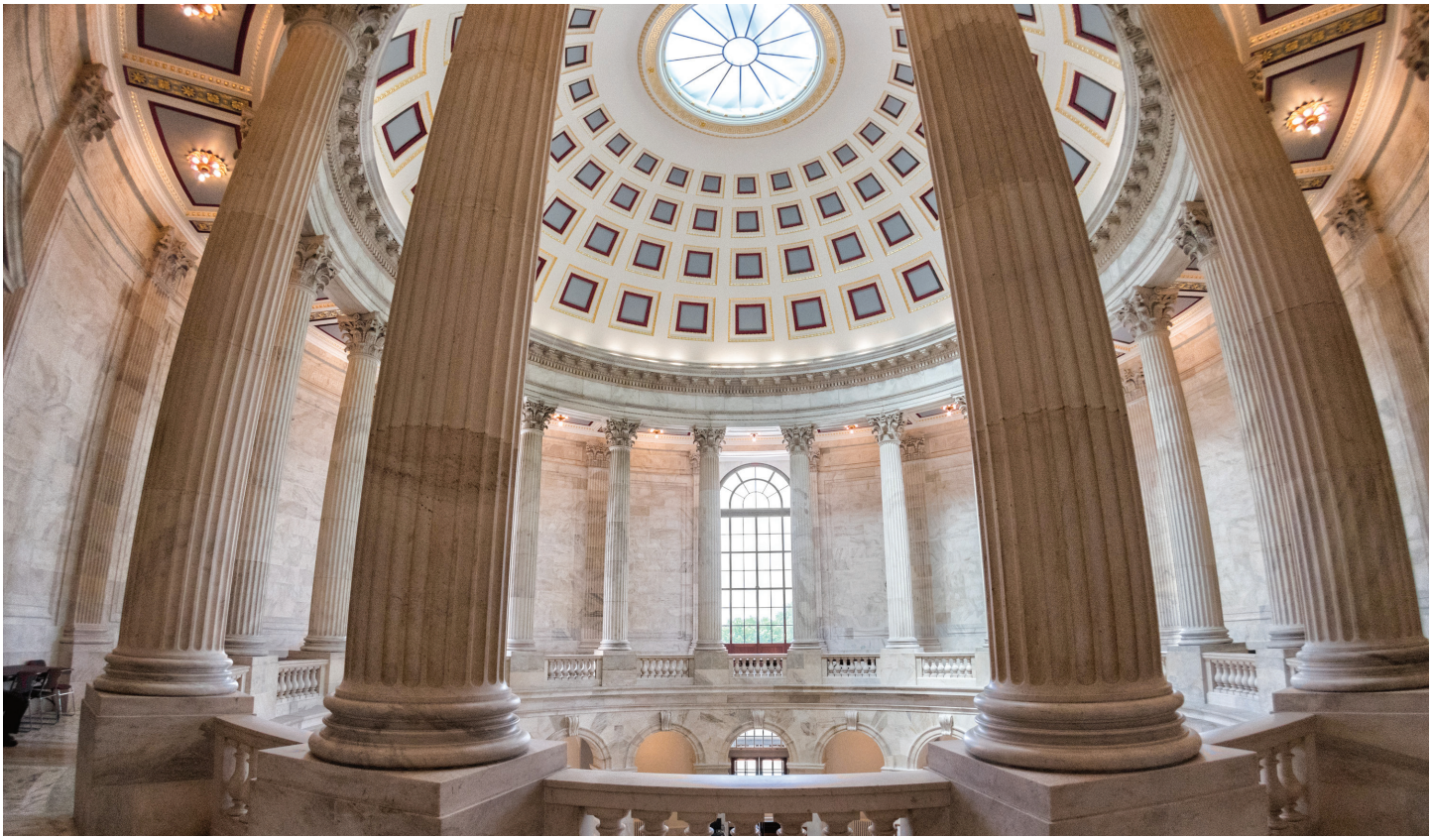
What restrictions apply to Individual Coverage HRAs?

Although the ICHRA is considered an employer group health plan subject to ERISA (if the employer is subject to ERISA), the individual market insurance policies purchased by employees and their dependents are not necessarily subject to ERISA. The individual insurance policies are not considered to be part of the employer's ERISA plan (i.e., are not subject to ERISA) as long as the following criteria are met:

- Employees are voluntarily purchasing the individual health insurance
- The employer does not select or endorse any particular carrier or coverage
- The employer does not receive cash, gifts or other consideration in connection with an employee's selection or renewal of any individual health insurance; and
- Each employee is notified annually that the individual health insurance that employees and their dependents are enrolled in is not subject to ERISA, which is the federal law governing employer-provided health coverage

Employers/health plans that do not intend for the individual market/Medicare coverage purchased by employees to be subject to ERISA should be aware that the current regulatory guidance indicates that if employees may only choose individual market/Medicare coverage through a private exchange that does not offer all medical policies available in the individual/Medicare market, the individual market/Medicare coverage would be subject to ERISA because the employer would be selecting/endorsing particular carriers/coverage.

Plan sponsors subject to ERISA will need to create both a plan document and Summary Plan Description (SPD) and ensure proper delivery of the ICHRA SPD to plan participants. Depending on what rules the employer/plan sponsor is subject to, it must also properly deliver any applicable notices that employer health plans are generally subject to (e.g., Notice of HIPAA Privacy Practices, Medicare Part D Notice, WHCRA, CHIP Notice, COBRA General Notice, QMCSO).



Q7 What class of employees can be offered an ICHRA?

Common Law Employees and Permitted Classes

ICHRAs can only be offered to common-law employees (part/full-time, seasonal, etc.), not independent contractors/sole proprietors/partners/more-than-2% shareholders in an S Corporation.

For purposes of this analysis, certain family members of a more-than-2% shareholder in an S Corporation (spouses, children, parents, grandparents) are also not considered common law employees, even if they are employed in the business. However, family members of partners in a partnership who are employed by the plan sponsor may be eligible. Employees enrolled in an ICHRA must also be enrolled in either:

1. An individual, nonexcepted benefit coverage plan purchased in the individual market, which complies with healthcare reform's restriction on lifetime and annual dollar limits and its preventive care services mandates

2. Medicare (parts A, B or C)

The class of employees offered an ICHRA cannot be offered a traditional group health plan. Medicare enrollment/eligibility is not a permitted class, and ICHRAs must be offered on the same terms and conditions to all members within that class. The same terms and conditions requirement impact the contributions the employer makes to the ICHRA (as discussed in Q8) as well as other terms and conditions of the ICHRA.

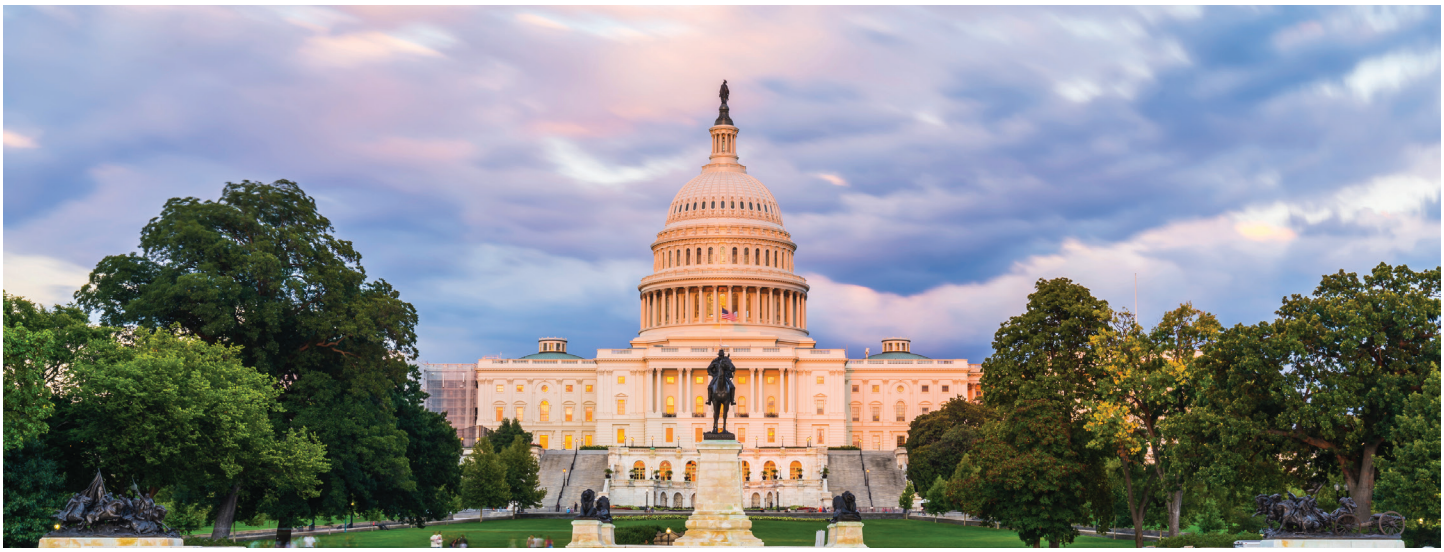
Other plan features to consider that must be offered on the same terms and conditions are waiting periods and carryover/rollover terms for the ICHRA. Variations in allowable reimbursable amounts due to a carryover, however, would be acceptable under the rules so long as the carryover was offered under the same terms and conditions to all employees within that class. Other variations that are acceptable under the ICHRA rules would be to allow employees within the same class to have a choice between an HSA-compatible ICHRA and a non-HSA-compatible ICHRA, so long as it is offered to all employees within the same class under the same terms and conditions.

The following describes the permitted classes of employees under the ICHRA rules:

Permitted classes of employees include:

- Full-time employees (an employer may define full-time employee using the ACA definition of an employee that averages 30 or more hours of service a week, or employees that are not considered a part-time employee under IRC Section 105)
- Part-time employees (an employer may define part-time employee using the ACA definition of an employee that averages less than 30 hours of service a week, or the definition of part-time employee under IRC Section 105)
- Employees paid on a salaried basis
- Non-salaried employees
- Employees whose primary site of employment is in the same rating area
- Seasonal employees (an employer may define seasonal employee using the ACA definition of an employee that works for an employer for 6 months or less during the same time of year, every year, or the definition of a seasonal employee under IRC Section 105)
- Employees included in a unit covered by a particular collective bargaining agreement in which the ICHRA sponsor participates
- Employees who have not satisfied the waiting period for coverage, if the waiting period complies with healthcare reform's waiting period requirements
- Nonresident aliens with no U.S.-based income
- Employees hired for temporary placement at an unrelated entity
- Employees who are in a combination of two or more of the classes

Employers sponsoring an ICHRA may create subclasses of employees for new-hire dates prospectively on or after January 1, 2020. This allows employers to offer new employees in a class an ICHRA, while grandfathering existing employees within the same class in a traditional group health plan.



Minimum Class-Size Requirement

There is a minimum class-size requirement for ICHRAs if the sponsor offers one class of employees an ICHRA and another class a traditional group health plan if the offer is based on:

1. Full-time or part-time status

2. Salaried or non-salaried compensation

3. Employees whose primary site of employment is in the same rating area, unless the rating is a state or combination of two or more entire states

4. A class of employees created by combining any of the preceding classes with another class

Minimum class sizes:

- For an employer with fewer than 10 employees: all employees
- For an employer with 10-100 employees: 10 employees
- For an employer with 100-200 employes: 10% of the total number of employees (rounded down to the nearest whole)
- For an employer with more than 200 employees: 20 employees

When determining minimum class size compliance, use the number of employees in the first class offered the ICHRA as of the first day of the plan year, and not those who enrolled in the ICHRA.

It is important to note that if an ICHRA is offered to a particular class of employees, it must be offered to all employees within that category (e.g., employer must offer to all part-time employees, not just those that work over 20 hours of service a week).

The classification and same terms and conditions rules apply on a single common-law employer basis, rather than a controlled/affiliated services group basis, as further defined under IRC Section 414. Therefore, these rules apply to each entity within a commonly owned group of employers, and do not treat those commonly owned employers as one single employer. These rules, therefore, allow different employers within a commonly owned group to vary classes and ICHRA eligibility within each entity within the controlled/affiliated services group.

Q8 How do employer contributions work?

Employers decide how much to fund and contribute to an ICHRA, although the HRA must be offered under the same terms and conditions to all employees in the same class, unless a new-hire subclass exists.

This means that an ICHRA must reimburse the same flat dollar amount (e.g., $1,000 per month) to all employees within the same class, rather than a percentage of cost (e.g., 80% of total premium) of the individual market coverage that is integrated with the ICHRA.[1]

Carry-overs, although different for every employee at the end of each plan year, are not considered when comparing if employees within the same class receive ICHRA contributions on the same terms and conditions so long as other requirements are met.

However, the regulations do allow employer contributions to vary based on age (by up to three times the maximum dollar amount available to the youngest participant) or family size, contingent upon the number of dependents of the employee. Any increases in the ICHRA benefit due to age or family size must be made available to all ICHRA participants in the same variation class (i.e., by age and by number of family members).

The HIPAA special enrollment rules would require an employer to allow employees to enroll in the ICHRA mid-plan year due to a HIPAA special enrollment event (e.g., birth of a child or marriage). Employees may also begin participation mid-year if they are hired mid-year or they enroll in the plan mid-year due to a mid-year change. ICHRA participants who enroll in the ICHRA mid-year (e.g., initial enrollment, special enrollment) may either receive a prorated amount under the ICHRA, or the full amount, which must be established prior to the beginning of the plan year and should apply to all employees within the same class. Correspondingly, if there is a change in the number of family members an employee has during the ICHRA plan year, the amount available under the ICHRA can stay the same or be prorated based upon the number of family members that remain on the plan, so long as the method is established prior to the beginning of the plan year and applies to all employees within the same class.

If coverage is provided to a former employee, the contribution must be provided to that former employee on the same terms and conditions as provided to the class of employees they formerly belonged to as an active employee.

[1] Whether the employer can offer an ICHRA with no annual benefit amount remains unclear. Offering a no-limit ICHRA may violate the same terms and conditions requirement for employee classes and make it difficult to administer COBRA. Cautious employers may wish to avoid such a plan design without further guidance from the Departments.

Q9 Must ICHRA balances expire every year?

Employers may adopt a carry-over feature within their ICHRA plan documents to allow employees that have not utilized all available amounts under the ICHRA at the end of a current plan year to apply the unused balances towards the reimbursement of expenses incurred in a future year. Alternatively, they may choose to omit the carry-over feature and require that amounts existing at the end of a plan year expire at the end of each plan year.

Q10 May an employer allow employees to pay any portion of the premium for their individual health insurance (not covered by the ICHRA) on a pre-tax basis under a Section 125 cafeteria plan?

Yes. Whether an employee is allowed depends on whether they purchased individual insurance coverage on or off the Exchange/Marketplace. In situations where the ICHRA does not cover the full cost of premiums of coverage purchased off the Exchange, employees may be allowed to use pre-tax cafeteria plan salary reductions to pay the outstanding portion of the premiums if the employer's cafeteria plan is designed to provide that benefit.

The amount eligible for employee pre-tax salary reduction is the individual health insurance coverage premium amount, less the ICHRA reimbursement amount. Pre-tax cafeteria plan salary reductions must be made available on the same terms to all participants (excluding former employees) within the same class of employees.

ICHRAs must be solely funded by employer contributions, so cannot be funded by salary reduction contributions made through a cafeteria plan, nor can an employee opt-out of an ICHRA in favor of higher pay.

Although the ICHRA itself is not subject to the Section 125 rules (including the irrevocable election rules), if employees are able to contribute to their individual market/Medicare coverage premium on a pre-tax basis through a Section 125 plan for the amounts in excess of the ICHRA medical premium reimbursement then the irrevocable election rule will be relevant. In this situation, the irrevocable election rules under Section 125 would apply to employee requests for a mid-plan year election change. Employers, therefore, are permitted to allow employees a mid-year election change under the various permitted election change events contained in Section 125 (e.g., change in residence).

Q11 Must employees be provided an opt-out/waiver opportunity under an ICHRA?

Employees eligible for the ICHRA must be provided an opportunity to waive/opt-out of any future reimbursements from the ICHRA on behalf of themselves and their eligible spouse/dependents during each plan year. Employees must have the option to opt-out/waive ICHRA coverage at least annually, to give them the opportunity to seek premium tax credits through the Marketplace. ICHRA coverage automatically disqualifies covered individuals from eligibility for premium tax credits.

Although an employer may establish a timeline for enrollment and opting out of the ICHRA, an opportunity to waive such coverage must be provided by an employer in advance of the first day of the plan year. For those participants who become eligible for such coverage mid-year due to eligibility, or for those becoming eligible for coverage less than 90 days prior to the plan year, this opportunity must be provided during their enrollment period.

Upon termination of employment, a terminated employee must either forfeit any remaining ICHRA balance (subject to COBRA) or be provided an opportunity to opt-out of any current and future reimbursements for themselves and any applicable spouse/dependents of the employee, after termination of employment.

Q12 Are ICHRAs subject to non-discrimination testing rules?

ICHRAs are generally subject to IRC Section 105(h) nondiscrimination rules. There are exceptions for ICHRAs that only reimburse insurance premiums and no other out-of-pocket healthcare expenses. Such premium-only ICHRAs are not subject to these nondiscrimination rules.

Under proposed IRS regulations, nondiscrimination rules that typically apply to HRAs (different contributions based upon different classes of employees, pro-ration of contributions based upon hire date or HRA carryovers) do not apply to ICHRAs, so long as all other requirements for ICHRAs are satisfied (including providing the same ICHRA reimbursement amount to all employees within the same class of employees). Sponsors of ICHRAs should monitor future regulatory developments in this area and discuss any concerns regarding the application of the Section 105(h) nondiscrimination requirements with legal counsel..

Q13 Is an employer offering an ICHRA subject to ACA reporting requirements and can an employer offer an individual coverage HRA to satisfy the employer mandate?

All employers/plan sponsors of ICHRAs are subject to the ACA reporting obligations, as ICHRAs are considered Minimum Essential Coverage (MEC) and therefore subject to IRC Section 6055 regardless of whether the employer/plan sponsor is an Applicable Large Employer (ALE).

Under the ACA, employers with an average of 50 or more full-time (FT) or full-time equivalent (FTE) employees in the previous calendar year are deemed Applicable Large Employers (ALEs) subject to the ACA Employer Mandate rules in the current year. Applicable Large Employers (ALEs) also have an obligation under IRC Section 6056 to report information related to the ICHRA to full-time employees (along with all covered individuals) under the ACA. Typically, ALEs would disclose Forms 1095-C to all full-time employees of the employer, along with covered individuals under the plan, and file all Forms 1095-C and Form 1094-C with the IRS by the appropriate deadlines. In instances where an employer/plan sponsor offers an ICHRA but is not an ALE, the employer/plan sponsor may utilize Forms 1094-B/1095-B to satisfy its disclosure and reporting obligation under the ACA.

Applicable Large Employers (ALEs) may also be subject to penalties under the ACA Employer Mandate. The employer mandate imposes a penalty (often referred to as the "Subsection A penalty") on an ALE if the employer fails to provide medical coverage to at least 95% of its FT employees and one FT employee enrolls in Exchange/Marketplace coverage and receives a premium tax credit (PTC).

Second, if an ALE provides medical coverage to at least 95% of its FT employees, an ALE may still be subject to penalties (often referred to as the "Subsection B penalty") for failing to offer both minimum value and affordable coverage to a FT employee, and that full-time employee enrolls in Exchange/Marketplace coverage and receives a premium tax credit (PTC).

When offering an ICHRA, the ICHRA will be deemed as an employer's offer of medical coverage to a FT employee under the Employer Mandate. An ALE that wishes to avoid potential Subsection A penalties under the ACA can do so by offering group health coverage, including an ICHRA to at least 95% of its FT employees.

Further, if an ALE sponsoring an ICHRA wishes to avoid potential Subsection B penalties under the ACA Employer Mandate, the ALE should review the ICHRA plan design to determine if the ICHRA is considered to provide affordable and minimum value coverage to FT employees. Whether the ICHRA is considered affordable for a FT employee is contingent upon the portion of the premium an employee would be expected to contribute towards Exchange/Marketplace coverage for the lowest-cost silver plan option that can be purchased in the Exchange/Marketplace in that region based on the employee's age. If the portion of that premium that would not be reimbursed by the ICHRA does not exceed a certain percentage of that employee's household income, the ICHRA is deemed affordable for that FT employee[2]. Furthermore, if such coverage is considered affordable to the employee under the ACA rules, the ICHRA plan would also satisfy the minimum value requirement rule under the ACA Employer Mandate. Therefore, if an ALE satisfies the affordability condition for each of its FT employees that are eligible for the ICHRA, the ALE may avoid the penalties associated with offering unaffordable coverage to full-time employees under the ACA Employer Mandate.

[2] *Multiple safe harbors to the affordability rules apply to ICHRA coverage:*

Affordability safe-harbors: An employee may apply the same affordability safe harbors that are generally applicable to health plans offered by Applicable Large Employers (i.e., W-2, rate of pay, and federal poverty line). These safe harbors can be applied uniformly to all employees, or different safe harbors for different classes of employees, so long as they are used uniformly and consistently for all employees within a class of employees under the ICHRA.

Month Look-Back: For calendar year ICHRAs, ALEs may use the premium cost for January of the prior calendar year, or for non-calendar year ICHRAs the premium cost for January of the current calendar year. However, in either situation, the premium cost must be calculated using the employee's current age for the current plan year and current location for the current month (and cannot use either from the look-back month).

Location as Primary Site of Employment: An ALE may use the applicable premium cost for the employee's primary work site, rather than an employee's residence.

Applicable Age of Participant. The age of an employee is determined as the age of the employee on the first day of the plan year, or on the date the ICHRA may become effective for an employee that becomes eligible for the ICHRA during the plan year. Therefore, the premium cost determination must be completed on an employee-by-employee basis.

Q14 Is an employer required to offer federal COBRA to ICHRA participants?

Yes. Employers subject to federal COBRA rules are responsible for providing COBRA coverage to any qualified beneficiaries enrolled in the ICHRA plan at the time of a qualifying event.

Under the substantiation requirements (described in Q5), COBRA participants must substantiate that they are enrolled in individual market coverage for every month they are entitled to medical expense reimbursement under the ICHRA.

COBRA participants must be provided an opportunity to change/renew their election at the time of open enrollment under the same conditions as similarly situated active employees. If an employer chooses to terminate a group health plan and replace it with an ICHRA, COBRA-qualified beneficiaries under the group health plan must be offered the right to continue COBRA coverage under the ICHRA despite the termination of the group health plan.

However, failure to remain enrolled in an individual market plan, or a change in an employee's classification that is not the result of a reduction in hours or termination would not be considered a COBRA qualifying event under the rules.

Q15 Is an ICHRA subject to PCORI Fees?

Yes. An ICHRA is considered a self-funded plan that provides medical care, and therefore the employer is responsible for paying the applicable PCORI Fee, along with filing a 2nd quarter Form 720. The fee is based upon the applicable fee for the year in which the ICHRA plan year ends, multiplied by the number of members enrolled in the ICHRA.

Q16 The ICHRA is age-related. Is this in violation of the Age Discrimination in Employment Act (ADEA)?

The Age Discrimination in Employment Act (ADEA) prohibits employers from engaging in discrimination against employees due to their age, as it relates to their "compensation, terms, conditions, or privileges of employment." Because an ICHRA is a "privilege of employment" with an employer, an employer cannot offer the ICHRA in a discriminatory manner as it applies to individuals that are protected in a protected class under the ADEA (age 40 and above). However, under the rules, so long as an employer offers an ICHRA contribution that is the same for each employee, it does not violate this rule under the ADEA. In addition, under the ADEA, the individual market/Medicare coverage policies purchased by employees would not be subject to the ADEA, so long as employees purchase such coverage without any employer involvement and such coverage is purchased from independent third parties not related to the employer. In this situation, even if individuals who are older may pay more for overall cost of coverage in the individual market/Medicare market, if an employer has no involvement with the choosing of these plans then the employer cannot face liability for violations under the ADEA.

Q17 How can I get more information?

- Employers and employees can contact the Department of Labor at **1-866-444-3272** or https://www.askebsa.dol.gov. More information regarding Individual Coverage HRAs and Excepted Benefits HRAs is also accessible at: https://www.dol.gov/agencies/ebsa.
- Contact the IRS Office of Chief Counsel, Health and Welfare Branch, at **1-202-317-5500** (not a toll-free number) regarding the federal tax-treatment of employer-provided health coverage.

APPENDIX

Individual Coverage HRA Model Notice

Instructions for the Individual Coverage HRA

The Departments of the Treasury, Labor, and Health and Human Services (the Departments) have issued final regulations allowing plan sponsors to offer individual coverage health reimbursement arrangements (HRAs), subject to certain requirements.[1] Among these requirements, an individual coverage HRA must provide a written notice to all employees (including former employees) who are eligible for the individual coverage HRA. The final regulations explain the requirements for the notice.[2]

Individual coverage HRAs may use this model notice to satisfy the notice requirement. To use this model notice properly, the HRA must provide information specific to the HRA (indicated with *italicized* prompts in brackets). The HRA may modify the notice based on the terms of the particular HRA. For example, if the HRA does not cover family members, the notice need not include references to family members. The use of the model notice is not required, but the Departments consider use of the model notice, when provided timely, to be good faith compliance with the notice requirement.

NOTE: Individual coverage HRAs should not include this instructions page with the individual coverage HRA model notice provided to participants.

Paperwork Reduction Act Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The Departments are seeking OMB approval for the model notice as part of the approval for OMB control numbers 1210-0160 (DOL); 1545-0123, 1545-0074 and 1545-0047 (Treasury/IRS); and 0938-1361 (HHS). The burden related to the model notice has been accounted for in the PRA sections of the related final rule which published at 84 FR 28888 (Jun. 20, 2019).

[1] See 26 CFR 54.9802-4, 29 CFR 2590.702-2, and 45 CFR 146.123.

[2] For information on when the notice must be provided, see 26 CFR 54.9802-4(c)(6)(i), 29 CFR 2590.702-2(c)(6)(i) and 45 CFR 147.123(c)(6)(ii). For the required contents for the notice, see 26 CFR 54.9802-4(c)(6)(ii), 29 CFR 2590.702-2(c)(6)(ii) and 45 CFR 147.123(c)(6)(ii). The notice must include a description of each item listed in the regulations and may include any additional information that does not conflict with the required information.

Individual Coverage HRA Model Notice

USE THIS NOTICE WHEN APPLYING FOR INDIVIDUAL HEALTH INSURANCE COVERAGE

[Enter date of notice]

You are getting this notice because your employer is offering you an individual coverage health reimbursement arrangement (HRA). Please read this notice before you decide whether to accept the HRA. In some circumstances, your decision could affect your eligibility for the premium tax credit. Accepting the individual coverage HRA and improperly claiming the premium tax credit could result in tax liability.

This notice also has important information that the Exchange (known in many states as the "Health Insurance Marketplace") will need to determine if you are eligible for advance payments of the premium tax credit. An Exchange operates in each state to help individuals and families shop for and enroll in individual health insurance coverage.

You may also need this notice to verify that you are eligible for a special enrollment period to enroll in individual health insurance coverage outside of the annual open enrollment period in the individual market.

I. The Basics

What should I do with this notice?
Read this notice to help you decide if you want to accept the HRA.

Also, **keep this notice** for your records. You will need to refer to it if you decide to accept the HRA and enroll in individual health insurance coverage, or if you turn down the HRA and claim the premium tax credit on your federal income tax return.

What's an individual coverage HRA?
An individual coverage HRA is an arrangement under which your employer reimburses you for your medical care expenses (and sometimes your family members' medical care expenses), up to a certain dollar amount for the plan year. If you enroll in an individual coverage HRA, **you must also be enrolled** in individual health insurance coverage or Medicare Part A (Hospital Insurance) and B (Medical Insurance) or Medicare Part C (Medicare Advantage) (collectively referred to in this notice as Medicare) for each month you are covered by the HRA. If your family members are covered by the HRA, **they must also be enrolled** in individual health insurance coverage or Medicare for each month they are covered by the HRA. *[Explain where the participant can find information on which medical care expenses are reimbursed by the HRA.]*

The individual coverage HRA you are being offered is employer-sponsored health coverage. This is important to know if you apply for health insurance coverage on the Exchange.

Note: There are different kinds of HRAs. The HRA being referred to throughout this notice, and your employer is offering you, is an **individual coverage HRA**. It is not a qualified small employer health reimbursement arrangement (QSEHRA) or any other type of HRA.

What are the basic terms of the individual coverage HRA that my employer is offering?
[Add general description of the HRA, including the following specific information:]

(1) The maximum dollar amount available for each participant in the HRA is [insert dollar amount(s) and describe applicable terms for any variation based on family size or age]. [NOTE: If the HRA varies amounts based on family size, add the following: Note that the self-only HRA amount available for the plan year, which is the amount you should tell the Exchange is available to you, is [insert dollar amount(s) and describe any applicable variation based on age]. If you apply for individual health insurance coverage through the Exchange, this is the amount the Exchange will use to figure out if your HRA is considered affordable. [Add any rules regarding the proration of the maximum dollar amount that applies to any participant (or dependent, if applicable) who is not eligible to participate in the HRA for the entire plan year].

(2) Your family members [insert are/aren't] eligible for the HRA. [Revise as needed if some, but not all, family members are eligible.]

(3) In general, your HRA coverage will start *[insert date plan year begins]*. However, if you become eligible for the HRA less than 90 days before the beginning of the plan year or during the plan year, your HRA coverage will start *[insert explanation of earliest date coverage could start and the latest date HRA coverage could start and other information about the enrollment procedures, and applicable timing, for these employees.]*

(4) The HRA plan year begins on *[insert date]* and ends on *[insert date]*.

(5) Amounts newly made available under the HRA will be made available on *[insert date(s)]*.

Note: You will need this information if you apply for health insurance coverage through the Exchange.

Can I opt out of the individual coverage HRA?
Yes. You can opt out of the HRA for yourself (and your family members, if applicable). *[Insert information on how and when participants may opt out.] [Add statement as to whether, upon termination of employment, the participant's HRA is forfeited, or the participant is given the chance to opt out at that time.]*

If I accept the individual coverage HRA, do I need to be enrolled in other health coverage too?
Yes. You (and your family members, if applicable) must be enrolled in individual health insurance coverage or Medicare for each month you (or your family members) are covered by the HRA. You may not enroll in short-term, limited-duration insurance or only in excepted benefits coverage (such as insurance that only provides benefits for dental and vision care) to meet this requirement.

II. Getting Individual Health Insurance Coverage

How can I get individual health insurance coverage?
If you already have individual health insurance coverage, you do not need to change that coverage to meet the HRA's health coverage requirement. If you do not already have individual health insurance coverage, you can enroll in coverage through the Exchange or outside of the Exchange – for example, directly from an insurance company.

Note: People in most states use HealthCare.gov to enroll in coverage through the Exchange, but some states have their own Exchange. To learn more about the Exchange in your state, visit https://www.healthcare.gov/marketplace-in-your-state/.

If you are enrolled in Medicare Part A and B or Medicare Part C, your enrollment in Medicare will meet the HRA's health coverage requirement. For information on how to enroll in Medicare, visit www.medicare.gov/sign-up-change-plans.

When can I enroll in individual health insurance coverage
Generally, anyone can enroll in or change their individual health insurance coverage during the individual market's annual open enrollment period from November 1 through December 15. (Some state Exchanges may provide additional time to enroll.) If your individual coverage HRA starts on January 1, you (and your family members, if applicable), generally should enroll in individual health insurance coverage during open enrollment.

In certain circumstances, such as when your individual coverage HRA starts on a date other than January 1 or if you are newly hired during the HRA plan year, you (and your family members, if applicable) can enroll in individual health insurance coverage outside of open enrollment using a special enrollment period.

If you qualify for a special enrollment period, make sure you enroll on time:

- If you are newly eligible for HRA coverage that would start at the beginning of the HRA plan year, you generally need to enroll in individual health insurance coverage within the 60 days before the first day of the HRA plan year.
- If the HRA was not required to provide this notice 90 days before the beginning of the plan year, or you are newly eligible for HRA coverage that would start mid-plan year (for example, because you are a new employee), you may enroll in individual health insurance coverage up to 60 days before the first day that your HRA can start or up to 60 days after this date. **Enroll in individual health insurance coverage as soon as possible** to get the most out of your individual coverage HRA.

Note: If you enroll in individual health insurance coverage through this special enrollment period, you may need to submit a copy of this notice to the Exchange or the insurance company to prove that you qualify to enroll outside of the open enrollment period. For more information on special enrollment periods, visit HealthCare.gov or the website for the Exchange in your state.

Do I need to get new individual health insurance coverage each year if I want to enroll in my individual coverage HRA each year?

Yes. Individual health insurance coverage is typically sold for a 12-month period that is the same as the calendar year and ends on December 31. If your HRA starts on January 1, you will either need to get new individual health insurance coverage or re-enroll in your individual health 12 insurance coverage. If your HRA has a plan year that starts on a day other than January 1, because your individual health insurance coverage will stay in effect until December 31, you do not need to get new individual health insurance coverage or re-enroll until the next open enrollment period.

If you are enrolled in Medicare, your Medicare coverage generally will remain in place year to year.

Do I need to substantiate my (and my family member's) enrollment in individual health insurance coverage or Medicare to the individual coverage HRA?

Yes. You must substantiate that you (and your family members, if applicable) will be enrolled in individual health insurance coverage or Medicare for the period you will be covered by the HRA. *[Add description of when the HRA requires this substantiation to be provided and to whom it should be provided].* Also, each time you seek reimbursement of a medical care expense from the HRA, you must substantiate that you had (or have) (or the family member whose medical care expense you are seeking reimbursement for, if applicable had (or has)) individual health insurance coverage or Medicare for the month during which the expense was incurred. *[Add description of the reasonable substantiation procedures established or provide information on where to find information about those procedures.]*

What happens if I am (or one of my family members is) no longer enrolled in individual health insurance coverage or Medicare?

If you (or a family member, if applicable) are no longer enrolled in individual health insurance coverage or Medicare, the HRA will not reimburse you for medical care expenses that were incurred during a month when you (or your family member, as applicable) did not have individual health insurance coverage or Medicare. This means that **you may not seek reimbursement for medical care expenses incurred when you (or your family member, if applicable) did not have individual health insurance coverage or Medicare.**

Note: You must report to the HRA if your (or your family member's) individual health insurance coverage or Medicare has been terminated retroactively and the effective date of the termination.

III. Information About the Premium Tax Credit

What is the premium tax credit?
The premium tax credit is a tax credit that helps eligible individuals, and their families pay their premiums for health insurance coverage purchased through the Exchange. The premium tax credit is not available for health insurance coverage purchased outside of the Exchange. Factors that affect premium tax credit eligibility include enrollment in Exchange coverage, eligibility for other types of coverage, and household income.

When you enroll in health insurance coverage through the Exchange, the Exchange will ask you about any coverage offered to you by your employer, including through an HRA. Your ability to claim the premium tax credit may be limited if your employer offers you coverage, including an HRA.

The Exchange also will determine whether you are eligible for advance payments of the premium tax credit, which are amounts paid directly to your insurance company to lower the cost of your premiums. For more information about the premium tax credit, including advance payments of the premium tax credit and premium tax credit eligibility requirements, see irs.gov/aca.

If I accept the individual coverage HRA, can I claim the premium tax credit for my Exchange coverage?
No. You may not claim the premium tax credit for your Exchange coverage for any month you are covered by the HRA. Also, you may not claim the premium tax credit for the Exchange coverage of any family members for any month they are covered by the HRA.

If I opt out of the individual coverage HRA, can I claim the premium tax credit for my Exchange coverage?
It depends.

- If you opt out of the HRA and the HRA is considered **unaffordable** you **may claim** the premium tax credit for yourself, and any family members enrolled in Exchange coverage if you are otherwise eligible.
- If you opt out of the HRA and the HRA is considered **affordable**, you **may not claim** the premium tax credit for yourself or any family members.

If you are a former employee, the offer of an HRA will not prevent you from claiming the premium tax credit (if you are otherwise eligible for it), regardless of whether the HRA is considered affordable and as long as you do not accept the HRA.

How do I know if the individual coverage HRA I've been offered is considered affordable?
The Exchange website will provide information on how to determine affordability for your individual coverage HRA. To find your state's Exchange, visit: https://www.healthcare.gov/marketplace-in-your-state/.

Do I need to provide any of the information in this notice to the Exchange?
Yes. Be sure to have this notice with you when you apply for coverage on the Exchange. If you are applying for advance payments of the premium tax credit, you will need to provide information from the answer to "What are the basic terms of the individual coverage HRA my employer is offering?" on page *[page number]*. You will also need to tell the Exchange whether you are a current employee or former employee.

If I'm enrolled in Medicare, am I eligible for the premium tax credit?
No. If you have Medicare, you are not eligible for the premium tax credit for any Exchange coverage you may have.

IV. Other Information You Should Know

Who can I contact if I have questions about the individual coverage HRA?
Contact: *[Add contact information (including a phone number) for an individual or a group of individuals who participants may contact in order to receive additional information regarding the HRA.]*

[For use by an HRA subject to ERISA that meets the safe harbor set forth in 29 CFR 2510.3- 1(l): **Is the individual health insurance coverage I pay for with my individual coverage HRA subject to ERISA?]**

The individual health insurance coverage that is paid for with amounts from your individual coverage HRA, if any, is not subject to the rules and consumer protections of the Employee Retirement Income Security Act (ERISA). You should contact your state insurance department for more information regarding your rights and responsibilities if you purchase individual health insurance coverage.

Individual Coverage HRA Model Attestation:

Annual Coverage Substantiation Requirement

Instructions: You have been offered an individual coverage health reimbursement arrangement (HRA) to help you pay for medical care expenses. To enroll in this individual coverage HRA, you must be enrolled in individual health insurance coverage, Medicare Part A (Hospital Insurance) and B (Medical Insurance), or Medicare Part C (Medicare Advantage). You should have received a notice that describes the individual coverage HRA that you are being offered. If you have not, or if you have questions about the individual coverage HRA, contact *[add contact information].*

If you plan to enroll in the individual coverage HRA, you must complete this form to confirm that you will have individual health insurance coverage, Medicare Part A and B, or Medicare Part C while you are covered by the HRA. If your family members will also be covered by the individual coverage HRA, you need to fill out the applicable section of this form on their behalf.

You must sign and date the form. Your family members do not need to sign or date the form. Please return the completed form to *[add instructions for returning the form].* You must return the form by *[add deadline for returning the form.]*

I attest to the following:

I, _____ (insert name), am covered (or will be covered) by the following health coverage: _____ (insert name of insurance company or indicate "Medicare").

This health coverage began (or will begin) on _____ (insert name of insurance company or indicate "Medicare").

Instructions: Complete the following if you plan to enroll a family member in the individual coverage HRA. If more than one family member will be covered by the individual coverage HRA, fill out a form for each family member. *[This section may also be copied to allow a participant to list all family members on a single form.]*

The following family member, _____ (insert name), is covered (or will be covered) by the following health coverage: _____ (insert name of insurance company or indicate "Medicare").

This health coverage began (or will begin) on _____ _____ (insert name of insurance company or indicate "Medicare").

I hereby affirm that the above information is true and accurate.

Signed: _____

Date: _____

Individual Coverage HRA Model Attestation:

Ongoing Substantiation Requirement

Instructions: To receive reimbursement for medical care expenses under your individual coverage health reimbursement arrangement (HRA), you must complete this form for each request for reimbursement.

The individual coverage HRA will reimburse you for a medical care expense incurred during a month only if you have (or had) individual health insurance coverage, Medicare Part A (Hospital Insurance) and B (Medical Insurance), or Medicare Part C (Medicare Advantage) during that month. Similarly, the individual coverage HRA will reimburse you for a medical care expense your family member incurred during a month only if the family member has (or had) individual health insurance coverage, Medicare Part A and B, or Medicare Part C during that month. In this form, you are attesting that you (or your family member) meet this requirement. *[If this form is not combined with the form used to seek reimbursement of medical care expenses, add a statement that the reimbursement form is separate.]*

You must sign and date this form. Your family member does not need to sign or date the form. Please return the completed form to *[add instructions for returning the form, including any applicable deadline].*

Complete the following if you're requesting reimbursement of your medical care expense from the individual coverage HRA.

I attest to the following:

I, _____ (insert name), am requesting reimbursement for a medical care expense

incurred during _____ (insert month, year), and for that month I am (or was) covered under the

following health coverage: _____ (insert name of insurance company or indicate "Medicare").

Instructions: Complete the following if you're requesting reimbursement of a family member's medical care expense from the individual coverage HRA.

I, _____ (insert name), am requesting reimbursement for a medical care expense

incurred by _____ (insert name of family member), during _____ (insert month, year), and

for that month, this family member is (or was) covered under the following health coverage:

_____ (insert name of insurance company or indicate "Medicare"). I hereby affirm that the above information is true and accurate.

Signed: _____

Date: _____

How Brown & Brown Can Help

Connect with your Brown & Brown service team to learn more about how we can help find solutions to fit your unique needs.

Brown & Brown

Find Your Solution at BBrown.com

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