

## November 3, 2010 - HRAs and Waivers: Quick Action Required

One of the significant unresolved health care reform issues for sponsors of health reimbursement arrangements (“HRAs”) is the application of the new restrictions on annual limits. Under the Patient Protection and Affordable Health Care Act (“PPACA”), as amended, a group health plan’s ability to impose annual limits on essential health benefits is first restricted and eventually prohibited. The restrictions become applicable on the first day of the first plan year beginning on or after September 23, 2010. *For calendar year plans, this is January 1, 2011.*

**The Issue.** By their nature, HRAs impose annual limits on essential health benefits. Reimbursements a participant may receive during a year are limited, at the most, to the balance of their HRA account. Accordingly, if the new restrictions on annual limits apply to an HRA, the HRA will not be able to comply.

**Certain HRAs Are Exempt.** HRAs that are excepted benefits under HIPAA portability (“excepted benefits”) are not considered “group health plans” for this set of PPACA requirements. The annual limit rules do not apply to these types of HRAs. They include retiree HRAs (e.g., HRAs that reimburse only expenses incurred after the participant’s employment has ended) and limited scope HRAs (e.g., HRAs that reimburse only dental and/or vision expenses). In addition, HRAs with an annual limit (i.e., account balances) less than or equal to \$500 are excepted benefits if the employer also makes major medical coverage that is not an excepted benefit available to all employees who are eligible for the HRA.

In addition, the regulations identify two additional types of HRAs that are exempt from the annual limit rules. **HRAs that are “integrated” with a group health plan that is subject to the annual limit rules are exempt.** Unfortunately, the regulations do not describe the requirements to be an “integrated” HRA. **Under a conservative approach, an HRA would need to be part of the medical plan and all participants of the HRA would also need to be covered by the medical plan. Under a more aggressive approach, an HRA that is tied to a medical plan (e.g., all employees enrolled in the medical plan participate in the HRA) or coordinates with a medical plan (e.g., the HRA reimburses expenses subject to the medical plan’s out-of-pocket requirements) might be considered “integrated.”**

The regulations also indicate that health flexible spending arrangements (“health FSAs”) are not subject to the restrictions on annual limits. Many HRAs are also health FSAs. A health FSA is a benefit program that provides employees with coverage under which (1) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and (2) the maximum amount of reimbursement that is reasonably available to a participant under the HRA is less than 500 percent of the value of the HRA coverage. All HRAs reimburse specified incurred expenses. HRAs with relatively low account balances will also satisfy the second condition. However, HRAs with large account balances (i.e., account balances

that exceed 500% of the value, probably the applicable premium under COBRA, of the coverage) may not be health FSAs.

**HRAs That Are Not Exempt.** The preamble to the regulations requested comments regarding the application of the annual limit rules to HRAs that are not otherwise already exempt from the rules (i.e., “stand-alone HRAs”). **Numerous comments have been submitted providing good arguments in favor of exempting all HRAs. However, no additional guidance has been released to date, and it is not clear whether such guidance will be provided prior to January 1, 2011, the date as of which calendar plan year HRAs must begin complying with the annual limit rules.**

**Waivers.** In light of the uncertainty regarding the status of stand-alone HRAs, **plan sponsors should consider requesting a waiver of the annual limit rules.** PPACA provides that a waiver of the annual limit rules is available in certain cases. Although primarily intended for mini-med plans and limited benefit plans, we recently received confirmation from HHS that the waiver is also available for stand-alone HRAs. Accordingly, we recommend plan sponsors consider making an application for a waiver to ensure their HRAs are not out of compliance.

**Suggestion:** Because of the uncertainty regarding which HRAs are subject to the annual limit rules (e.g., the meaning of integrated, the meaning of retiree-only, etc.) and the potential significance of being wrong, plan sponsors should consider applying for waivers as a safety net in case what they think is integrated or retiree-only turns out to be a stand-alone HRA.

**Waiver Process.** A waiver may be obtained by filing a request with the Department of Health and Human Services. The request must contain specific information and must demonstrate the reason application of the annual limit rules will result in a significant decrease in access to benefits.