HRAs: The Devil Is in the Details

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In June 2002, the IRS provided guidance in the form of Revenue Ruling 2002-41 and Notice 2002-45 with respect to what are now to be referred to as “health reimbursement arrangements” (HRAs). An HRA is an employer-funded arrangement in which each participant has an individual account for the payment of insured or self-insured medical care (as defined in Code Section 213(d)), the unused year-end balance of which can permissibly be rolled over to future years. Presuming that the benefits under the plan are limited to qualified medical care expenses provided with respect to eligible participants, their spouses, and dependents (as defined in Code Section 152), those benefits will qualify for the exclusions under Code Sections 105 and 106. The IRS is to be applauded for this action and thanked for the guidance that it has provided. However, as is true of most good planning opportunities, the devil is in the details.

Background

The IRS had previously provided glimpses into the HRA world (see, e.g., Private Letter Ruling 2002-22019), but without much in the way of guidance on the details. Although people had expressed interest, the concept had not taken off. According to Kevin Knopf of the Treasury, the government was seeing more interest in this area and came out with the formal guidance because it “wanted to lead rather than follow.” The Treasury and the IRS should be applauded for their “if you build it, they will come” philosophy. Their sense was that it was important to come out with clear guidance that resolved the most-frequently asked questions of: May you roll over the unused amounts at year-end? May (or must) the plan be solely employer-funded? Do the cafeteria plan rules necessarily apply to the arrangement?

Several “pioneering” plan sponsors established HRAs (or plans resembling them) at least as far back as the mid-1990s. In light of factors such as escalating health care costs, employer cutbacks in retiree medical benefit plans, and the trend toward empowering employees to make their own informed decisions regarding the purchase of health care services (including having incentive for making intelligent decisions), there recently has been more interest expressed in establishing arrangements similar to HRAs. Therefore, this is a good time for such guidance to be released.

Overview

Revenue Ruling 2002-41 provides the rules and Notice 2002-45 provides the commentary for what the IRS has dubbed HRAs. At the same time, representatives of the Treasury and Chief Counsel (Kevin Knopf and Lorianne Masano should be thanked in particular) have hit the rubber chicken circuit to answer questions and provide additional guidance with respect to HRAs. Thank you’s should be extended to all involved for what
appears to be a sincere effort to get guidance out in time for plan sponsors and administrators to prepare for open enrollment for 2003. Although much of the supplemental guidance provided on the speaking circuit can be referred to as “regulation by rumor,” it is nonetheless welcomed.

An HRA is an arrangement that: (1) is funded solely by the employer (and is not funded directly or indirectly by the employee pursuant to salary reduction or otherwise); (2) pays or reimburses the participant for qualified medical care expenses (as defined in Code Section 213(d)) incurred by the participant (employee or former employee) or the participant’s spouse and dependents (as defined in Code Section 152); and (3) provides payments and reimbursements up to a maximum dollar amount for a specific coverage period, and any unused amounts at the end of the coverage period may be carried forward to increase the maximum amount to be paid or reimbursed in subsequent coverage periods. If these rules are met, the payments and reimbursements are generally excludable from gross income under Code Sections 105 and 106.

I won’t attempt to summarize all the additional rules and guidance provided by the Revenue Ruling and Notice or explain the ramifications. That subject is better left for a more substantive and scholarly analysis. Instead, I will try to address the principal issues identified so far.

**COBRA**

Because an HRA is considered a group health plan, it is generally subject to the continuation coverage requirements of COBRA. This includes requiring the HRA to permit a participant who would otherwise terminate coverage to elect COBRA continuation. Upon election, the participant would be entitled to continuation of the maximum reimbursement amount at the time of the qualifying event and an increase in that maximum amount at the same time and in the same amount that it is increased for similarly situated beneficiaries who have not suffered a qualifying event. As a condition to COBRA continuation coverage, the plan can require the beneficiary to pay the “applicable premium.” Under Code Section 4980B(f)(4), the applicable premium is defined as “the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualified event has not occurred.”

This is where the fun starts, because determining what that applicable premium should be is far from clear. For example, in the case where the annual reimbursement amount credited to each account under the HRA is $1,000, and the maximum reimbursement amount remaining for two similarly situated qualified beneficiaries at the time of their qualifying events is $500 for one person and $5,000 for another, how should the plan determine the applicable premium? Should the plan determine the average cost for the year as being the $1,000 that is added to each account each year, and therefore each participant is “similarly situated?” Alternatively, should it base the annual cost of the plan on the average amount withdrawn from all the accounts each year? The Notice suggests that the applicable premium should be the same for each of the individuals in the example, despite the fact that next year one beneficiary would be entitled to $1,500 worth of maximum reimbursement from his or her account, whereas the other beneficiary would be entitled to $6,000 of maximum reimbursement. Although charging them the same amount is permitted by the Notice, it hardly seems feasible.

The governmental speakers have referred to the language in the Notice as being a “safe harbor” with respect to the determination of the COBRA applicable premium, and concede that there may very well be alternative ways to determine an acceptable applicable premium.

Those in the government who have hazarded a guess on this subject suggest that it may be permissible to establish the applicable premium at a level greater than the amount added to each account, in order to consider amounts remaining in the account carried over from prior years. Alternatively, it may be appropriate for the applicable premium to be less than the amount added annually to each account, to reflect the fact that a portion may be unused at year-end and more properly considered a cost of a future year. They also suggested an actuarial computation may be more appropriate than looking at either the amount added to the account, the average amount withdrawn from the account, or the amount available in the account at the date of the qualifying event. But saying that the amount should be “actuarially determined” begs the question, because it is unclear what the determination is to be based upon, and upon this the government speakers agree.

This confusion is compounded in the case where employer contributions are not added to participant accounts in equal amounts and where it is unclear whether a similarly-situated beneficiary who had not suffered a qualified event would ever have anything added to his or her account. Such would be the case if the plan was one in which additions to the account are determined on the basis of: (1) the beneficiary’s compensation (i.e., a uniform percentage of compensation); (2) the number of hours worked by the participant (as is commonly the case under union plans where a fixed number of cents per hour worked may be added to the account); or (3) the number
of hours of untaken sick leave or vacation leave at the end of the year or termination of employment (such as plans that add to the account the amount of sick leave or vacation leave that would otherwise be forfeited by the participant). In such cases there may be no “similarly situated” beneficiaries and it may be appropriate to determine a different applicable premium for each participant.

Another significant COBRA question that the government speakers concede is very troublesome is the determination of whether it is necessary to allocate unspent HRA funds from an account if there are multiple claimants/beneficiaries and, if so, which qualified beneficiaries are entitled to their own HRA account and in what amount. Will the IRS take a position similar to that taken in the flexible spending account (FSA) context under Reg. Section 54.498013-2, Q&A-8(b), requiring each qualified beneficiary to receive an independent right to elect COBRA and receive the full amount of coverage?

To be fair, these are thorny COBRA questions rather than pure HRA questions. The authors should be complimented for coming out with what guidance is available to date rather than delaying the IRS's statement approving HRAs until such time as all the COBRA questions are resolved. This subject, however, demands prompt attention, at least in the form of interim guidance and safe harbors protecting reasonable interpretations of the law.

**HIPAA Discrimination Issue**

Another troubling issue that has reared its ugly head in the HRA context is that of potential discrimination with respect to insurance premiums. Although the plan sponsor and administrator may not have arranged for the purchase of any insurance, the concern arises where the HRA is used to pay (or reimburse for the payment of) premiums for coverage that the participant selected or arranged.

Both ERISA Section 702 and the Code (Section 9802) provide that a group health plan (and a health insurance issuer offering health insurance coverage in connection with such a plan) may not require any individual to pay a premium or contribution that is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor. The Notice points out that it does not address the application of the HIPAA nondiscrimination requirements, including the extent to which individual health insurance policies purchased and reimbursed by an HRA that are underwritten by the insurance carrier may be treated as health insurance coverage offered under a group health plan for purposes of HIPAA. (The Notice also points out that consideration should be given as to whether other requirements under HIPAA apply, such as that of providing certificates of creditable coverage.)

While it is conceded that older or sicker individuals may be charged a greater premium in the marketplace by an insurer in the case in which individual coverage is underwritten, is this discrimination on the basis of health status imposed by the plan or by the insurer with respect to the plan? Government speakers state that this is an open question, the resolution of which is far from clear. It will need to be considered by the Treasury in conjunction with the Department of Labor and Health and Human Services (HHS), and none of us should hold our breath waiting for a quick answer.

**Funded Plans and Code Section 419**

Although the Revenue Ruling and Notice seem to comprehend a plan that is unfunded, the government speakers state that they anticipate the rules to apply with equal force in the context of a funded HRA. The only difference is that funded HRAs were not provided with any guidance in the Revenue Ruling and Notice, other than the reference contained in the Notice to the fact that the Notice does not address the deduction limitations under Code Sections 419 and 419A (for employer contributions to welfare benefit funds) and under Code Section 404 (for amounts paid or accrued under plans providing for deferred benefits that are not provided through a welfare benefit fund).

There are such benefit plans currently in existence that are either HRAs as described in the Revenue Ruling and Notice or that are attempting to be so described. The vehicle typically used to fund such plans is a VEBA. The principal problem, which it appears some of these plans may have in complying with the guidelines of the Revenue Ruling and Notice, particularly in the Taft-Hartley context, is that individual accounts may be used for multiple types of benefits rather than being limited to medical care expenses as defined in Code Section 213. These plans will likely experience some anxious moments until they either adapt to the HRA guidance or are satisfied with the tax implications or risks of not adapting. Perhaps the most difficult question is what to do with account accumulations already in existence.
Funded HRAs appear, at least to this author, clearly to constitute welfare benefit funds under Code Section 419(e)(3). Therefore, the deductibility of employer contributions would appear to be subject to the limitations of Code Sections 419 and 419A. If such contributions (or the HRA itself) are determined pursuant to collective bargaining, then it appears that the exemption provided by Code Sections 419A(f)(5)(A) would be available and, therefore, the account limit rules would be inapplicable. Thus, the employer would appear to be entitled to a deduction for its contributions to the fund and the fund would be protected from potential UBIT otherwise determined under Code Sections 512(a)(3)(E).

This obviously would provide no comfort in the case where neither the HRA nor the contributions to it are determined pursuant to collective bargaining. In such cases, the deduction would generally be limited to the amount actually spent from the HRA on the basis that such payments would appear to qualify as “qualified direct cost” under Code Section 419(e)(3). Contributions remaining unspent in accounts at year end do not appear to qualify as “qualified costs” under Code Section 419(c), principally because they would not qualify as an “incurred but unpaid” claim under Code Section 419A(c)(1)(A).

Irrespective of whether the fund is maintained pursuant to collective bargaining, keep in mind that deductions may be delayed for up to a year if care is not taken to assure that the company year and fund year are properly coordinated.

In the case where distributions have not been made by year end, alternative grounds for the deductibility of employer contributions to an HRA may lie in Code Section 419A(c)(2). This would appear to be the case only where funds in the HRA are to be used exclusively to provide postretirement medical benefits, and even then such deductions would be subject to the limitations and requirements of Code Section 419A(c)(2). Otherwise it does not appear that contributions made by an employer to an HRA, even though made on an irrevocable basis, would constitute a “qualified cost” available for current deductibility.

Anecdotal evidence suggests that there is a lot of HRA interest among small employers (or at least those who service the small-employer market). If the basis for this interest is that it can help control costs, great. If, instead, the basis is that HRAs may be able to generate substantial accelerated deductions, I personally do not see it. This would appear especially to be the case in light of Code Section 419(d), which would treat an amount allocated under Code Section 419A(c)(2) for postretirement medical benefits to the account of a key employee as an annual addition to a defined contribution plan for purposes of Code Section 415(c).

Nonqualified Benefit Payments Versus Payments to Nonqualified Beneficiaries

We will need some time getting used to HRAs in order to sort out the legal issues, administrative headaches, and abuses regarding the payment of prohibited amounts. In the interim, I raise for your consideration what appears (at this early stage) to be a distinction between providing an impermissible benefit and a permissible benefit to an impermissible beneficiary.

Both the Revenue Ruling and Notice appear to take the position that in order for the HRA (i.e., the plan itself) to be considered an accident and health plan qualifying for the exclusions of Code Sections 105 and 106, the HRA may only provide benefits for expenses incurred for medical care as defined in Code Section 213(d). The Notice emphasizes that the HRA does not qualify if any person has the right to receive any benefit under the arrangement other than the reimbursement of eligible medical care expenses. It also includes an example stating that if an arrangement pays a death benefit (without regard to medical care expenses), then no amounts paid under the arrangement to any person are reimbursements for medical care expenses excluded under Code Section 105(b).

Government officials have emphasized this point in their comments concerning HRAs, pointing out that it is their position that any payments of an impermissible type negate the exclusion otherwise available to all individuals with respect to all benefit payments under the plan.

This appears to be in sharp contrast with the penalty imposed in the event the impermissible payment is of a permissible type but is provided with respect to coverage of an impermissible beneficiary. The basis for this belief is the language of the Notice, which states the rule in a slightly different manner and uses a different tone of voice when addressing the subject of whose bills, rather than what bills, can permissibly be covered by an HRA. The Notice states that medical care expense reimbursements under an HRA are excludable under Code Section 105(b) “to the extent” the reimbursements are provided to current and former employees, their spouses and dependents (as defined in Code Section 152), and the spouses and dependents of deceased employees. Use of the phrase “to the extent” implies that coverage by the HRA of medical expenses for nonqualified individuals would only result in taxable income to the covered employee (or retiree) and nobody else.
This interpretation is consistent with comments made by government officials regarding coverage of domestic partners. In the case where a domestic partner can qualify as a dependent under Code Section 152, there is no issue. However, in the case where a plan permits eligible employees to submit claims for domestic partners who do not qualify under Code Section 152, the question arises. Government officials have indicated that the coverage of such individuals would not destroy the tax exclusion generally provided with respect to the HRA. It is their position that if, instead, the value of the HRA coverage for such a domestic partner is included as compensation in the taxable income of the employee, the HRA is permitted to cover such persons. Such an approach is consistent with the notion generally of taxing the employee with respect to coverage provided to domestic partners under regular group health insurance plans.7

As an aside, it should be noted that this leniency may not exist in the case where domestic partners constitute a substantial percentage of persons covered by the HRA. If the plan is funded through a Voluntary Employees’ Beneficiary Association (VEBA), tax-exempt status may also be in jeopardy because the VEBA regulations, as well as the IRS’s interpretation of these rules, do not appear to be as lenient.8

Medicare Coordination

It is unknown whether HHS will require a Medicare-eligible person to exhaust his or her HRA before Medicare pays for a particular expense otherwise eligible for reimbursement from the HRA. Note that HHS would appear to have a much stronger argument for requiring such exhaustion than would be true in the case of an FSA, because HRAs must be entirely employer-funded.

Future Guidance

Unfortunately, no additional guidance is expected anytime soon (other than continuing “regulation by rumor”). The topic is not on the current IRS Business Plan, and government speakers have volunteered that it is not being currently addressed in pending revenue ruling projects. As pointed out above, many of the outstanding questions that are crying out for answers will require coordination with other IRS projects. Among these are: (1) COBRA, regarding the applicable premium to be charged qualified beneficiaries who would otherwise terminate coverage under the plan, whether spouses and dependents have such a right, and how to determine who is a “similarly situated” beneficiary; (2) HIPAA, regarding the issue of potential discrimination on the basis of health-related factors concerning the purchase of individual insurance policy coverage with HRA funds; and (3) Code Section 419, regarding the deductibility of employer contributions to a funded HRA.

One thing that would be helpful in the interim, however, would be if the IRS would either drop its longstanding “no ruling” policy with respect to the question of whether a plan qualifies as a medical plan under Code Section 105, or at least be willing to provide guidance regarding various HRA issues within the context of Code Section 106 private letter rulings. Perhaps additional informal guidance could be provided such as by covering HRAs in the next issue of the IRS’s CPE Technical Instruction Program.

If you build it, they will come. The public asked for it, the government has begun to build it, and people are coming. But let’s all go there in an orderly, disciplined manner. Government speakers have expressed the hope that HRAs will evolve to help solve health benefit problems with the expectation that considerable latitude will be given to accomplish this goal. Assuming this will be the case thanks.
Notes

1 For a good summary of some of the issues that such funds may face, I refer you to the Comment submitted to Treasury by Edward Crumb, 2002 TNT 172-26 (Doc. 2002-20260, August 13, 2002).

2 See Temporary Treasury Reg. § 1.419-2T.

3 See Temporary Treasury Reg. § 1.419-2T, Q&A-1.

4 Claims would appear to be treated as “incurred” for this purpose “only when an event entitling the employee to benefits, such as a medical expense ... actually occurs.” Conference Committee Report on P.L. 98-369 (Tax Reform Act of 1984).

5 See Temporary Treasury Reg. § 1.419-1T, Q&A-4.


7 Private Letter Ruling 9850011.

8 Private Letter Ruling 9850011, where the IRS stated that such coverage would not impact the VEBA’s qualified status “so long as the benefits paid with respect to nondependent domestic partners do not exceed three percent of the total benefits paid by the Fund.”