The following comments are the views of the individual members of the Committee on Employee Benefits of the Section of Taxation who prepared them and do not represent the position of the American Bar Association or the Section of Taxation.

These comments were prepared by individual members of the Committee on Employee Benefits of the Section of Taxation. Principal responsibility was exercised by Riva Johnson. Substantive contributions were made by John Hickman, Mark Stember, Ron Snyder, Ira Golub, Mark Wincek and Ann Habernigg. The Comments were reviewed by Greta E. Cowart, David Mustone and Taina E. Edlund of the Committee on Employee Benefits, by the Quality Assurance Group of the Employee Benefits Committee, which is chaired by Diane J. Fuchs and whose members are former chairs of the Committee; by T. David Cowart of the Section’s Committee on Government Submissions; and by Thomas A. Jorgensen, Council Director for the Committee on Employee Benefits.

Although many of the members of the Section of Taxation who participated in preparing these Comments have clients who would be affected by the federal tax principles addressed by these Comments or have advised clients on the application of such principles, no such member (or the firm or organization to which such member belongs) has been engaged by a client to make a government submission with respect to, or otherwise to influence the development or outcome of, the specific subject matter of these Comments.

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EXECUTIVE SUMMARY OF HEALTH REIMBURSEMENT ACCOUNT ("HRA") COMMENT

This Comment responds to the request for comments contained in Notice 2002-45, 2002-28 IRB 93 ("Notice"). The Comment also applies to Revenue Ruling 2002-41, 2002-28 IRB 75 ("Ruling").

The Comment provides some suggestions for additional guidance on issues that were not addressed in either the Ruling or the Notice, including (1) the interaction of the COBRA and HRA rules, (2) the splitting of an account between multiple COBRA beneficiaries and (3) the calculation of the COBRA premium for a HRA. The Comment also addresses some areas for which additional guidance is needed. For example, the Comment suggests an additional option for handling the HRA account of a deceased participant.

Issues addressed in this comment include:

1. How the value of HRA coverage should be measured for purposes of complying with the requirement that the maximum amount available under an HRA not substantially exceed the value of HRA coverage. The Comment proposes that this determination be handled in a flexible manner consistent with how value is determined under section 4980B of the Internal Revenue Code (the “Code”) for COBRA continuation coverage purposes.

2. How HRAs should be treated under the nondiscrimination rules of Code section 105(h). One of the key issues here is how balances that are carried over from year-to-year should be treated. If carryover balances are to be counted in subsequent years, it will be nearly impossible to satisfy the “benefits” test under section 105(h). In keeping with how the nondiscrimination rules are applied in similar context, the Comment proposes that any carried-over amounts only be counted in the year that those amounts were first contributed or credited. The Comment also addresses other important issues in applying the nondiscrimination rules to HRAs.
COMMENTS ON HEALTH REIMBURSEMENT ARRANGEMENTS

The Service has issued two pieces of guidance regarding health reimbursement arrangements, Revenue Ruling 2002-41, 2002-28 IRB 75 (the “Ruling”), and Notice 2002-45, 2002-28 IRB 93 (the “Notice”). We commend the Service in addressing many of the important issues raised by HRAs in a positive manner that will help foster their development. However, as acknowledged in the Notice, the Ruling and Notice raise a number of other issues. Some of these are addressed below.

1. **Handling of Multiple COBRA Beneficiaries under an HRA.** The Notice provides that an HRA complies with COBRA continuation healthcare requirements by (a) continuing the maximum reimbursement amount for the covered employee at the time of the qualifying event and (b) increasing that account in the same manner as is done for similarly situated active participants during the COBRA continuation period. Where multiple qualified beneficiaries are involved, the Notice does not address whether the account balance should be split between the electing beneficiaries or the maximum reimbursement amount should be made available to each qualified beneficiary.

**Recommendations:**

a. To prevent an economic “windfall” for COBRA beneficiaries, the portion of the HRA account balance that was carried over from prior years should be divided equally among all electing qualified beneficiaries at the time of the qualifying event. Likewise, the current year HRA increment should be divided among all electing qualified beneficiaries at the time of the qualifying event.

b. Each qualified beneficiary who has elected continuation coverage should receive any future annual contributions or credits made during the continuation coverage period at the same time and in the same amount as similarly situated employee participants.

**Discussion:**

a. Under insured medical plans, each qualified beneficiary is generally entitled to separately elect full coverage and pay separately calculated premiums for that coverage. Code § 4980B(f). The logic of this rule breaks down for individual accounts that “contain” contributions or credits carried over from prior years. In general, insurance coverage is for a defined period with no “rollover” effect. Thus, if the carried over HRA accumulations are credited in full to each electing qualified beneficiary, this will effectively result in a “windfall” for those beneficiaries due solely to prior usage. This could be a significant deterrent for employers who are interested in implementing plans of this sort. A more equitable approach that is consistent with COBRA
policy is to credit each electing COBRA beneficiary with a pro rata share of the portion of the HRA account balance carried over from prior years. This approach is similar to how family deductibles and limits are handled under the COBRA regulations. See Treas. Reg. § 54.4980B-5, Q&A-2(c) (deductibles) and Q&A-3 (limits). For example, the regulations require that (i) the utilization of plan limits be tracked on a person-by-person basis and (ii) each person is to be credited with the deductible each has utilized. The approach proposed here also finds support in Rev. Rul. 96-8, 1996-1 C.B. 286, which addresses the calculation of COBRA premiums. That Ruling provides that where various members of a family separately elected COBRA coverage, it would be reasonable to charge the family rate rather than a “single” rate for each individual. Such an aggregated approach when applied to the carryover HRA account balance would ensure that each electing qualified beneficiary in a family has the same coverage as before the qualifying event without receiving a windfall benefit. Likewise, in the year of the qualifying event, HRA account contributions or credits up to the date of the qualifying event also should be apportioned among the electing qualified beneficiaries. As in the case of carryover account balance, this approach is equitable and will avoid a “windfall” for beneficiaries. Indeed, the current year contribution or credit up to the date of the qualifying event is properly viewed as part of the carryover account balance.

b. Each electing qualified beneficiary should be entitled to receive any contributions or credits made for similarly situated employees during the period that they continue coverage. The proposed approach also is analogous to how open enrollment rights are handled under the COBRA regulations. See Treas. Reg. § 54.4980B-5, Q&A-4. While this approach may increase the cost of providing the HRA benefit, it is more understandable and easier to administer. At the same time, it is in keeping with the general requirement that the qualified beneficiary be accorded the same coverage provided to similarly situated employees.

2. Calculation of the COBRA Premium for HRAs. The Notice provides that the permitted premium is determined in accordance with the existing rules under Code section 4980B. Section 4980B(f)(4) provides that, for a self-funded plan, the applicable premium is equal to a reasonable estimate of the cost of providing the coverage for the period for similarly situated beneficiaries determined on an actuarial basis (and in accordance with other factors set forth in regulations). (If a plan administrator elects, a self-funded plan also may calculate the applicable premium based on past costs). For healthcare FSAs, the regulations provide that the cost of providing COBRA coverage under such an arrangement can be based on the maximum FSA contribution for the period. See Treas. Reg. § 54.4980B-2, Q&A-8(c), (f).

Recommendation: HRA sponsors should be able to use any method of calculating the applicable COBRA premium for an HRA.
Discussion: Use of the maximum HRA contribution for the period should be considered a reasonable method for determining the applicable COBRA premium for such an arrangement. This method parallels the rules for insured plans, and thereby permits parity with other kinds of health plans (without regard to carryover of prior accumulations peculiar to HRAs). Thus, like an FSA, it is reasonable to assume that the annual cost will, over the coverage period, be expected to equal the sum of the annual contributions or credits for the period.

Alternatively, the plan administrator also should be able to use any other reasonable method for determining the annual COBRA premium based upon the expected usage of the HRA account for the coverage period. This would enable the plan administrator to charge a premium that more accurately reflects the cost of providing HRA benefits for that period.

3. Handling of an HRA Upon the Participant’s Death. By definition, an HRA is an employer-funded arrangement that reimburses the employee, up to a specified maximum, for eligible medical expenses (as defined by Code section 213(d)) incurred by the employee and his/her spouse and dependents during the coverage period, with the remainder (if any) to be carried over to subsequent coverage periods (see Part I of the Notice). Thus, unlike traditional health plans, HRAs involve an on-going account balance for participants.

Recommendation: A plan sponsor should be able to provide, through plan design, that the HRA account balance of a deceased participant may be (a) used for the eligible medical expenses of the employee prior to his/her death, (b) used for the medical expenses of the employee’s surviving spouse or children and grandchildren, or (c) forfeited.

Discussion: Section II of the Notice provides that an HRA may not pay a death benefit without regard to the incurrence of medical expenses. This means that: (i) the remaining amounts may only be used for the eligible medical expenses of the deceased participant or his/her spouse or eligible dependents; and (ii) in the absence of eligible medical expenses, unused amounts cannot be distributed in cash to the surviving family members, but must be forfeited. Accordingly, to the extent provided under the plan document, it should be permissible to use the outstanding HRA account balance of a deceased participant to reimburse the past or future medical expenses of the spouse and dependents. This would, in any event, occur by operation of law to the extent the survivors elect COBRA continuation coverage. Alternatively, it should be permissible to provide that the unused amounts will (in the absence of a COBRA election) be forfeited upon the participant’s death.

4. Treatment of an HRA as a FSA. Part I of the Notice provides that an HRA will be treated as a flexible spending arrangement (FSA) as defined in Code section 106(c)(2), if the maximum amount of reimbursement which is reasonably
available to a participant under the HRA is not substantially in excess of the value of coverage under the HRA. However, neither Code section 106(c)(2), nor the Notice indicate how the value of HRA coverage is to be valued in this context.

Recommendation: An HRA should be deemed to be considered an FSA if the maximum amount available for reimbursements equals the HRA account balance. Alternatively, any reasonable method of measuring the “value of coverage” should be acceptable, so long as the same method is used for all participants in the HRA for the period involved. As for those HRA arrangements to which a single lifetime contribution/credit is made, the HRA’s value should be determined at the inception and apply for the life of the arrangement.

Discussion: Deeming an HRA to be an FSA where the maximum amount of the available reimbursement equals the HRA account balance would be more straightforward and administratively simple than determining the value of coverage under the HRA. Such an approach would provide certainty regarding the treatment of the FSA while avoiding undue expense and complexity. If such an approach is not adopted, alternatives for measuring the value of HRA coverage should include any of the following (i) the amount made available to the participant for reimbursement in the measurement year (not including unused amounts from prior years that are carried over), (ii) the cost to purchase a supplemental health insurance policy to provide a benefit similar to the HRA (assuming one is available), or (iii) a value that is actuarially-determined. At the same time, it should be permissible to use any method in a measurement period (and to change from period to period) so long as the same method is consistently applied to all HRA participants in the same period. As for HRA arrangements involving a single lifetime contribution/credit, determining the HRA’s value at the inception is consistent with how the rule is applied to major medical plans containing lifetime limits. Thus, a major medical plan is not treated as an FSA if a particular participant’s lifetime limitation falls to less than 500% of the premium cost of the coverage in a later year.

5. Code Section 105(h) Issues. Part V of the Notice provides that to the extent that an HRA is a self-insured medical reimbursement arrangement, the Code section 105(h) nondiscrimination rules would apply. Code section 105(h)(2) provides that a self-insured medical reimbursement plan is not discriminatory if (i) the plan does not discriminate in favor of highly compensated individuals as to eligibility to participate (the “Eligibility Test”) and (ii) the benefits provided under the plan do not discriminate in favor of participants who are highly compensated individuals (the “Benefits Test”).

(a) The Benefits Test - Use of Annual Contributions. In general, Treasury Regulation § 1.105-11(c)(3)(i) provides that the benefits subject to reimbursement under a self-insured plan must not discriminate in favor of highly compensated individuals. At the same time, the regulations provide that the plan may establish maximum reimbursement limits, so long as the
limit is uniformly applied to all participants and is not be modified by reason of a participant’s age or years of service. Because the highly compensated group is quite large under Code section 105(h) (as it includes the top 25% of the workforce compensation-wise), a key question in this context is whether an HRA can run afoul of the Benefits Test due to the carry over of prior HRA balances.

**Recommendation:** In determining whether an HRA program meets the Code section 105(h) Benefits Test, only those employer contributions or credits made during the testing period should be considered.

**Discussion:** In general, HRA balances that are carried over from prior testing periods have already been tested once for nondiscrimination purposes and, therefore, should be disregarded in applying the Benefits Test in subsequent periods. Otherwise, continued compliance could well turn on prior utilization and, thereby create considerable uncertainty for employers in this context. Instead, only those HRA allocations made during the testing period should be considered. This is consistent with how tax-qualified, defined contribution retirement arrangements are tested under comparable nondiscrimination provisions set out in Code section 401(a)(4). See Treas. Reg. § 1.401(a)(4)-2(c). Thus, the only allocations that should be counted in applying the Benefits Test in any testing period are those HRA allocations that first become available in that period. For example, retiree HRAs that provide a single lifetime contribution/credit at retirement should be tested in this manner (even though the amount is intended to be available for retiree’s lifetime).

(b) **Aggregation and Disaggregation of Plans for Code Section 105(h)**

**Testing.** Treasury Regulation § 1.105-11 provides that the Eligibility and Benefits Tests are performed on a plan-by-plan basis. Treasury Regulation § 1.105-11(b) defines an individual self-insured medical reimbursement plan as a separate written arrangement under which eligible medical expenses are reimbursed on a self-insured basis. Treasury Regulation § 1.105-11(c)(4)(i) provides special rules for aggregation and disaggregation of covered plans.

**Recommendation:** Future guidance should confirm that, to the extent permitted under Treasury Regulation § 1.105-11(c)(4)(i), a plan sponsor may (i) aggregate its HRA program with any other HRA or other self-insured medical reimbursement arrangement subject to Code section 105(h) or (ii) disaggregate an HRA program for testing purposes to the extent permitted under the regulations.

**Discussion:** Treasury Regulation § 1.105-11(c)(4)(i) provides that an employer may designate two or more plans as constituting a single plan that is intended to satisfy the Eligibility and Benefits Tests, in which case
the designated programs are to be tested as a single plan. This aggregation rule is permissive, as it will occur only if the employer so elects. The regulations also provide that a single plan document may be used by an employer for two or more “plans,” so long as the employer designates the various plans covered by the document and the applicable provisions of each. Thus, a single separate written plan document may be split into more than one plan for Code section 105(h) testing purposes. To the extent that an HRA program is subject to Code section 105(h), there is nothing in the regulations or the Notice that would suggest that these rules should not apply to HRAs.

(c) **HRA Reimbursement of Insurance Premium Reimbursements.** In general, HRAs may provide for the reimbursement of either health insurance premiums or unreimbursed out-of-pocket medical expenses incurred for the HRA participant and his or her eligible dependents. However, some HRAs are limited solely to reimbursing premiums for health insurance or like coverage, while others limit a portion of the HRA account solely to the reimbursement of insurance premiums. Under the Section 105(h) regulations, a program which only provides for the reimbursement of premiums for individual/group health insurance is not “self-insured” and hence, not subject to Code section 105(h). See Treasury Regulation § 1.105-11(b)(2). At the same time, the regulations also provide that only the portion of a plan that reimburses expenses will be considered self-insured and, hence, covered by Code section 105(h). Id.

**Recommendation:**

1. Future guidance should confirm that the Code section 105(h) rules are not applicable to HRA arrangements that only provide for the reimbursement of health insurance premiums

2. Future guidance also should confirm that in case of an HRA arrangement under which both premiums and expenses are reimbursed, Code section 105(h) will not apply to any portion of the HRA that can only be used to reimburse premiums.

**Discussion:**

1. If the HRA plan document limits reimbursement to health insurance premiums for the participant and his/her dependents, it appears that the arrangement should not be treated as a “self-insured” reimbursement arrangement by virtue of Treasury Regulation § 1.105-11(b)(2). Thus, this sort of HRA arrangement should be treated as exempt from the requirements of Code section 105(h).
(2) To the extent that a portion of the HRA is restricted solely to reimbursing bona fide insurance premiums, the same approach also should apply. Thus, consistent with the Code section 105(h) regulations, only that portion of the HRA that is available for the reimbursement of out-of-pocket expenses should be considered to be self-insured and, hence, subject to Code section 105(h). In short, the regulations should be read as exempting the portion of the HRA which is limited to the premium reimbursements. On the other hand, if the entire HRA balance is available for either premium or expense reimbursements, it appears that the entire HRA should be treated as “self-insured” (even if premiums are regularly reimbursed under the arrangement) because there are ultimately no limits or restrictions on expense reimbursements.

6. Ordering Rules for Health FSA and HRA Payouts. In general, the Notice provides that the eligible medical expenses of an individual covered under both a health FSA and HRA must first be reimbursed from the HRA (until exhausted). The Notice also permits an employer to opt out of this rule and provide that the FSA is to be exhausted first before reimbursement under the HRA is to begin in any year. However, to do so, the Notice requires that the HRA plan document must be amended to make this change before the beginning of the FSA’s corresponding plan year.

Recommendation: Future guidance should provide that the “default” reimbursement rule permit eligible expenses to be reimbursed from the FSA first and then from the HSA. The optional rule should permit the employer to elect out of the “default” rule and provide that the HRA is to be exhausted first before reimbursement under the FSA is to begin in any year. The guidance should clarify that the HRA need not be amended each year to implement this ordering rule. At the same time, to the extent authorized by the plan document, it should be permissible for the plan administrator to elect in or out of the optional rule.

Discussion: Restructuring the “default” rule would be preferable in order to avoid an undue forfeiture of amounts in an FSA due to the application of the “use it or lose it” rule applicable to FSAs. Because the Notice does not prohibit reimbursement to first be made from an FSA (and, indeed, allows this approach under the existing optional rule in the Notice) we believe that this should be an acceptable approach. Thus, under the restructured approach the employer would need to elect that reimbursements first be made from the HRA. An annual election of the optional rule should not be required (unless the plan is drafted in this manner). Instead, FSA sponsors should be able to make an on-going election of the optional rule via a single plan amendment. This is in keeping with customary drafting practice for plan documents generally. Similarly, for those FSA sponsors who would like greater flexibility in this context, it would be simpler and more cost effective if the authority to make this election from year to
year could be delegated to the plan administrator in the plan document, provided that the plan administrator makes such election in writing before the beginning of FSA plan year. While we acknowledge the desirability of making a written election, we believe that this policy objective can be satisfied without an annual plan amendment if the plan delegates the authority to make an annual written election to the plan administrator.

7. **Requiring Minimum Level of Participation in a Health FSA.** In general, the Notice provides that if the maximum reimbursement under a purported HRA varies based on the amount an employee elects to contribute to a health FSA, the arrangement will not be considered to be an HRA. It is unclear whether this rule would preclude a plan sponsor from conditioning an employee’s HRA eligibility on an employee’s election to participate in the sponsor’s health FSA.

**Recommendation:** Future guidance should provide that a plan sponsor may condition an employee’s eligibility for annual HRA benefits on participation in a health FSA, so long as any applicable nondiscrimination requirements are otherwise met and the employer does not establish an unreasonably high minimum required contribution for participating in the FSA.

**Discussion:** Allowing an employer to so condition an employee’s eligibility for HRA benefits on FSA participation would enable employers to better encourage employees to be responsible for their health costs. This would be accomplished by limiting the annual HRA contributions or credits to those employees who are willing to make a separate financial commitment (via the employee’s election to participate in a FSA) in order to participate in the reimbursement program. In these circumstances, the FSA and HRA do not interact in a way that results in an impermissible use of salary reductions to fund the HRA. Nor is there any real correlation between the HRA maximum and the amount of the FSA election, at least where the employer has not established an unreasonably high minimum required contribution for participating in the FSA.

8. **Earnings on Account Balances.** Neither the Ruling nor the Notice address how earnings credited to an HRA account balance should be treated.

**Recommendation:** Future guidance should provide that the crediting of actual earnings or, in the case of a notional account, a reasonable predetermined rate of return, to HRA account balances should not be treated as an additional HRA contribution.

**Discussion:** In general, an HRA program can be set up as either a notional account or an actual account arrangement. To the extent these accounts are funded through a trust (or similar funding vehicle), the account balances would be “plan assets” which must be prudently managed and which can only be used to pay plan benefits and expenses. Thus, earnings under these HRA arrangements would generally be credited to participant accounts. In the case of notional
accounts, an employer may wish to credit a predetermined rate of return to the participant account in a similar fashion.

To the extent that the credited amounts represent actual earnings or, in the case of a notional account, a reasonable pre-determined rate of return, those amounts should not be treated as additional contributions for HRA purposes. This is consistent with the position that the IRS has taken in other contexts. For example, earnings under a tax-qualified defined contribution retirement plan will ordinarily not be treated as a “contribution” for purposes of Code section 415(c). See Treas. Reg. § 1.415-6(b)(2) The same is also generally true for corrective payments of “lost” earnings made to such plans. See, e.g., Rev. Rul. 2002-45, 2002-29 I.R.B. 116. At the same time, “earnings” credited to previously counted benefits under a nonqualified defined contribution deferred compensation arrangement, whether based on a predetermined actual investment or a reasonable rate of interest, will not be treated as additional contribution credits for purposes of Code section 3121(v)(2). See Treas. Reg. §§ 31.3121(v)(2)-1(a)(2)(iii), 1(d)(2)(i). There is no policy reason why a comparable approach cannot be applied to HRAs.