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A New Day for the HRA

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Overview

The Departments of Labor, Treasury, and Health and Human Services have released final rules removing the prohibition on pairing HRAs with individual health policies. The final rules also allow certain HRAs and other account-based group health plans to qualify as limited excepted benefits. These rules are generally effective for plan years beginning on or after January 1, 2020.

Background

In response to President Trump's October 12, 2017, Executive Order 13813, the Secretaries of Labor, Treasury, and Health and Human Services (collectively, the Departments) have issued final rules (the Final Rules), model notices, model attestations and frequently asked questions (the FAQs) that will give employers greater flexibility to offer new types of health reimbursement arrangements (HRAs) for plan years beginning on and after January 1, 2020. The Final Rules provide for two new types of HRAs: the individual coverage HRA and the excepted benefit HRA.

Late last year, the Departments proposed rules (the Proposed Rules) to liberalize the use of HRAs by removing and clarifying several Affordable Care Act (ACA) barriers.

During the 2-month comment period, the Departments received more than 500 comments from employers, health insurance issuers, state regulators, state exchanges, unions, and individuals. In light of these comments, the Final Rules largely adopt the Proposed Rules with a few key clarifications detailed below.

Individual Coverage HRAs (ICHRA)

The Final Rules permit employers to offer an ICHRA to employees and former employees as an alternative to traditional group health plan coverage, subject to certain conditions. To satisfy the Final Rules, the individual coverage HRA must meet the following requirements:

- ***All individuals covered by the ICHRA must be enrolled in individual market health coverage or Medicare.*** Just as under the Proposed Rules,

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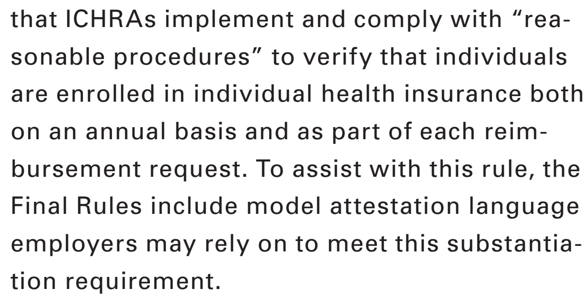
the Final Rules require that an individual (and any dependents) maintain qualifying individual health coverage for each month each individual is covered by the ICHRA. Plan sponsors may continue to apply the existing statutory structure with respect to what expenses may be reimbursed from the ICHRA or they may choose to narrow the scope of permitted reimbursements.

- ***No choice between ICHRA and traditional group health plan coverage.*** The Final Rules clarify that employers are prohibited from offering a class of employees a choice between an ICHRA and traditional coverage under a group health plan.
    - The Final Rules provide for 10 enumerated employee classes and give employers the flexibility to determine additional classes based on a combination of two or more classes. To address potential adverse selection into the individual market, the Final Rules also prescribe minimum employee class sizes that scale depending on employer size (*e.g.,* 10 employees for an employer with 100 employees, 20 employees for an employer with 200 employees). The minimum class size applies at the common law employer level (versus as a controlled group), and is applied on an annual basis.
    - In response to industry comments to the Proposed Rules regarding typical benefit offerings, the Final Rules permit a class distinction between hourly and salaried employees, include a "new hire" subclass, and eliminate "employees under age 25" as a permitted employee class. The Final Rules also clarify that an employer may distinguish between collectively bargained agreements when defining a class.
- ***Same-terms.*** Just like the Proposed Rules, the Final Rules require that an ICHRA be offered on the "same terms" (including both the amount and the same terms and conditions) to all employees within a certain class.
    - The Final Rules include the Proposed Rules' provision allowing increases in ICHRA contribution amounts based on participant age or family size without violating the same-terms requirement. Unlike the Proposed Rules, the Final Rules cap age-based contributions for older employees at three-times the contribution level of the youngest ICHRA participant (similar to the ACA's 3:1 age rating rules).
    - The Final Rules allow employers to offer an ICHRA to some, but not all, former employees within an employee class. However, the Final Rules also clarify that employers who offer ICHRAs to former employees in a class must comply with the "same-terms" requirement. For example, the Final Rules note that a plan sponsor would not comply with the "same-terms" requirement if it provided an employee class with larger or smaller ICHRA amounts based on years of service or status as a former employee.
    - The preamble to the Final Rules specifically notes that "benign discrimination" is also prohibited. Employers may not offer more generous benefits only to certain employees in a class of employees (*e.g.,* a higher contribution for employees battling heart disease).
- ***Opt-out provisions.*** The Final Rules clarify that employers may establish time frames for enrollment of an ICHRA, and that ICHRAs must generally allow participants to opt out of and waive future reimbursements from an ICHRA upon enrollment, at least once annually, and upon termination of employment. This provision is important for individuals who may want to retain premium tax credit (PTC) eligibility.
- ***Substantiation and verification.*** The Final Rules include the Proposed Rules' requirement



that ICHRAs implement and comply with "reasonable procedures" to verify that individuals are enrolled in individual health insurance both on an annual basis and as part of each reimbursement request. To assist with this rule, the Final Rules include model attestation language employers may rely on to meet this substantiation requirement.

- ***Notice requirement.*** In order to ensure that individuals eligible for ICHRAs understand how such coverage could potentially impact their PTC eligibility, the Final Rules expand the detailed notice requirement outlined in the Proposed Rules and include a model notice that must be provided at least 90 days in advance of each plan year. In addition, plan sponsors of an ICHRA must provide a summary of benefits and coverage (SBC) that describes the coverage, including cost sharing, exceptions, reductions and limitations on coverage, and other information.

Excepted Benefit HRAs (EBHRA)

As an alternative to the ICHRA option, the Final Rules recognize certain HRAs as limited excepted benefits. An EBHRA allows participants to obtain reimbursement for certain qualified expenses even if they choose not to enroll in their employer's group health plan coverage. In a departure from the Proposed Rules, the Final Rules also provide that an EBHRA cannot reimburse short-term plan premiums if (a) the HRA is offered by a fully insured or partially insured small employer, and (b) the Departments find that reimbursement for short-term plan premiums has significantly harmed the small group market in the employer's state. If such a finding is made, the Departments must formally publish this finding in the Federal Register. The Final Rules largely adopt the Proposed Rules' standards and require the following for an EBHRA:

- ***Otherwise not an integral part of the plan.*** In order to satisfy existing statutory requirements for excepted benefits, the HRA must not be an "integral part" of the employer's group health plan. This means that a plan sponsor must offer other group health plan coverage to the employees who are also offered the EBHRA for a particular plan year. The "other" coverage must not be another account-based group health plan or coverage consisting solely of excepted benefits.
- ***Limited in amount.*** An EBHRA would be limited to annual contributions of $1,800 per year (indexed for inflation after 2020, with the indexed amount announced by June 1 of each year at the same time the HSA and HDHP announcements are made).
- ***Prohibition on reimbursement of premiums for certain types of coverage.*** An EBHRA may not reimburse premiums for individual health insurance coverage, coverage under a group health plan (other than COBRA or other group continuation coverage), or Medicare parts A, B, C or D. The Final Rules permit reimbursement of premiums for individual coverage that consists solely of excepted benefits or coverage under a group health plan that consists solely of excepted benefits, as well reimbursement of short-term limited duration insurance premiums and COBRA premiums.
- ***Uniform availability.*** Benefits provided under an EBHRA must be made available under the same terms and conditions to all similarly situated individuals, regardless of any health factor.

ERISA Application

The Final Rules clarify that the Proposed Rules' definition of "employee welfare benefit plan" and "welfare plan" under ERISA will not include individual health insurance coverage, the premiums of which are reimbursed by an HRA, including an HRA integrated with individual health insurance coverage, a retiree-only HRA that reimburses premiums for individual health insurance coverage, or a qualified small employer health reimbursement arrangement (QSEHRA), provided certain safe harbor requirements are met. Without this clarification, individual market policies could become part of an HRA (or QSEHRA) for purposes of ERISA.

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The Southern District Finds Unambiguous Policy Language Controls NYU's Superstorm Sandy Claim

Denis O'Malley

The United States District Court for the Southern District of New York recently granted an insurer's motion for summary judgment in a case arising from Superstorm Sandy based on unambiguous policy language providing a significantly lower limit of liability for losses resulting from flood damage.

In *New York University v. Factory Mutual Insurance Co.,* 2019 U.S. Dist. LEXIS 45105 (S.D.N.Y. March 19, 2019), the court agreed with Factory Mutual (FM) that the policy's $250 million and $40 million sublimits for flood damages applied to New York University's (NYU) claim, rather than the policy's $1.85 billion overall limit.

Superstorm Sandy inflicted damage to several NYU properties, including certain buildings associated with the university's hospital and medical school. Those damages resulted in sizeable time element—or, business interruption—losses as well as losses under the policy's additional coverages. FM and NYU agreed that the policy provided coverage but disagreed over which of its limits and sublimits applied to NYU's claims. FM read the policy to limit losses attributable to flood damage at NYU's hospital and medical school to $40 million and capped its payments accordingly. NYU read the policy to apply only its overall $1.85 billion aggregate limit to the school's claims. NYU ultimately brought an action consisting of five counts for declaratory judgment and one breach of contract count claiming FM wrongfully limited coverage.

The dispute centered on which of three limits of liability applied to time element losses and losses subject to the policy's additional coverages: a $1.85 billion overall coverage limit, a $250 million subsidiary aggregate limit for losses attributable to flood (flood limit), and a $40 million sublimit for flood damage suffered at NYU's hospital and medical school (flood sublimit). Relying on the policy's unambiguous language, the court "easily dispensed with" NYU's argument that the $1.85 billion overall limit applied. The policy provided that "limits of liability in an [o]ccurrence apply to the total loss or damage at all [l]ocations and for all coverages involved, including any insured time element loss." The court found this language "unambiguous in subjecting time element claims to the limit of liability for flood, as well as its sublimit."

Moreover, the policy's time element coverage section "plainly stat[ed] that recovery for 'time element loss…is subject to the applicable limit of liability that applies to the insured physical loss or damage.'" Accordingly, the court held that NYU's time element loss claims were subject to the $40 million sublimit specific to NYU's hospital and medical school.

The court also held that NYU's claims under the policy's additional coverages were subject to the flood sublimit based on the same unambiguous policy language. Given that language, the court rejected NYU's argument that, under the *expressio unius* canon of construction, the lack of specific references to the sublimits within the policy's time element and additional coverages sections implied that only the overall $1.85 billion limit should apply to the school's claims. "Rather," the court reasoned, "consistent with the general principle [under New York law] that interpretive tools need not be deployed when the contract is unambiguous, *expressio unius* should not be applied to create ambiguity where none would otherwise exist."

The decision demonstrates how unambiguous policy language may literally make a billion dollar difference in coverage. ■

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The Top 5 Questions to Ask about a Living Benefit Rider

Thomas R. Kestler

Annuities have always been the only financial instruments that can provide an income that cannot be outlived. Historically, this meant annuitizing the contract—exchanging the lump sum account value for a guaranteed series of payments for a specified period or life. The thought of forfeiting principal for income, however, was unpleasant to most consumers and therefore annuitization was rarely used.

Living benefits—often called income riders—first appeared on variable annuity contracts to provide a "safety net" in the event the underlying accounts did not perform as hoped. Today, living benefits are available on all types of annuities.

Guaranteed minimum income benefits (GMIBs) and guaranteed minimum withdrawal benefits (GMWBs) are typically offered as riders on annuity contracts. The rider fee varies based on the type of contract (fixed or variable) and the benefit being provided. Rider costs vary between .70 percent and 1.40 percent of the account value each year.

While creating a "drag" on contract performance, they also provide peace of mind for the owner. Purchasers are assured that funds set aside for retirement income still provide a guaranteed minimum level of income no matter what happens to interest rates, the market or an index.

Income riders have two components—an accumulation phase and a distribution phase. During the accumulation phase, the company essentially keeps two sets of books on the contract.

One set of books is based on the actual performance of the underlying account(s), less the cost for the rider. The other set of books is a "phantom account" called the income base. This is merely a calculation that takes the initial premium and accumulates it at the rate specified by the rider (6.00 percent per year, for example).

When the owner reaches a point where he/she is ready to take income from the policy, the income will be based on the *greater* of the two accounts and the age at which the annuitant began taking income.

For example, if Mary (aged 60) purchases a $100,000 annuity contract with an income rider at 6 percent and 5 years later (at age 65) wishes to begin an income stream, the company would compare the actual performance of the policy to the income base.

Let's assume her cash account grew to $120,000, which would be compared to the value of the income base. At a 6 percent compound rate, her income base would have grown to $134,885; therefore, her lifetime income would be based on that greater amount. If the contract provided for a 5 percent lifetime withdrawal for a female aged 65, Mary would receive $6,744.25 per year for the rest of her life ($134,885 x 5.00 percent).

This income would serve as a series of withdrawals, but not annuitization. Her base account would continue to react to interest credits, but also reflect an annual withdrawal of $6,744.25. Upon Mary's death, her beneficiary would receive any "change" left in the account. If, at some point, these withdrawals depleted her account value, the insurance company would step in and continue the same income stream as long as Mary lives. But there would be no death benefit, because no real cash remains.

Things to consider with an annuity plus income rider:

1. **Don't place too much emphasis on the step-up rate.** An unrealistically high step-up rate will grow the income base at a quicker rate. Often, carriers will tweak the interest rate, caps, and participation rates on the underlying contract to compensate. Keep in mind that once income begins, your client is spending his/her money first and the insurance company only begins to participate after those funds have been spent.
2. **Be aware of the difference between simple interest and compound interest.** Some carriers may choose to increase the income base using simple

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Living Benefit Rider

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interest. This design only increases the income base by a fixed amount every year. Compound interest not only credits interest on principal but interest on interest. For example, a 7.2 percent compound step-up will increase the income base exactly the same amount as a 10 percent simple step-up over a 10-year period.

3. **Be sure your client understands how the rider fee is charged.** Many providers calculate the rider fee based on the income base rather than the contract account value. In the example above, if the fee for Mary's rider was 1 percent, that fee would be based on the income base of $134,855 resulting in a rider charge of $1,348.55. This would be deducted from the lower account value of $120,000. If, on the other hand, the fee was based on the account value, the rider fee would only be $1,200.
4. **Is the cost for the rider a fee or a spread?** More jargon, but this one is important. A fee is assessed *every year* no matter what. So, theoretically, your client could own a fixed or index annuity where he/or she was promised it could never lose money. That is true to an extent. The client will never lose money due to a market decline. The worst that he/she will ever do is a 0 percent return. However, if a fee is still deducted from the account, the client will see a decline in account value. A spread, on the other hand, is only deducted to the extent

Analysts: LTC Hybrid Policies Will Keep Driving Life Insurance Sales

John Hilton

It was one of the most stunning data sets discussed during the recent state insurance commissioners' summer meeting in New York City: policies sold with a long-term care rider jumped from 228,000 in 2015 to 461,000 in 2018.

Today, more than 40 carriers are selling these products with a long-term care element, said Steve Schoonveld of the Society of Actuaries (SOA). "That's a really robust market," Schoonveld told the National Association of Insurance Commissioners' Senior Issues Task Force.

Agents should keep in mind how flexible the LTC hybrid products can be in meeting several needs for clients. For example, Schoonveld described a 65-year-old couple with a good retirement nest egg, maybe as high as $400,000. "From an income point of view, they're not too bad off," he said. "But I think their two biggest risks are the early death of a spouse, and second, catastrophic health and long-term care expenses, of course.

"What should their advisor tell them? This is just one of many examples where hybrid products have become kind of dual all-purpose products."

Strong Growth

A team of SOA analysts presented a long-term care insurance (LTCi) overview using statistics compiled by LIMRA. They included data showing a 14 percent growth in average annual premium sales.

"This is very much a growing market, the share of the long-term care marketplace," said Mathew Winegar of the SOA. "Eighty-five percent of long-term care sales last year were on the hybrid product shelf, either chronic illness or acceleration of benefits."

In 2018, combination products represented 27 percent of the overall U.S. individual life insurance market, LIMRA reported.

there is a gain in the contract. If your client earns no interest, there is no fee deduction.

5. **Is the contract RMD (required minimum distribution) and free-withdrawal friendly?** This is one of those little "gotchas" that drive people crazy. Let's assume Harry, aged 52, buys an annuity with an income rider attached. He plans on letting the policy grow until his planned retirement age of 70. At age 54 he has an emergency and needs to exercise his 10 percent free withdrawal provision. At age 70, he is surprised to find out that his withdrawal at age 54 locked in that age as the payout age (rather than age 70). His payout rate would be 3.5 percent (the lifetime payout for ages 50-54) rather than his expected 5.5 percent (the lifetime payout for ages 70-74). Another "gotcha" is when any withdrawal is made prior to taking a lifetime income; the rider step-up for that year is forfeited. Be sure to choose a contract that is friendly to withdrawals prior to retirement.

Although the discussion above may seem like all insurance companies are out to get you, the truth is that benefits cost money. Carriers often curtail benefits in order to enhance other product features–like squeezing a balloon to make it pop out somewhere else. Be sure your clients understand all the trade-offs (squeeze) in order to provide this benefit. ■

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Task force members seemed especially interested in hybrid policies as a better alternative to straight LTCi, which is failing both consumers and insurers.

A popular product in the 1990s, LTCi was badly underpriced. Many insurers sought, and continue to seek, significant rate hikes to stabilize their books. For example, Blue Cross/Blue Shield of Florida policyholders were notified by mail earlier this year that annual premiums for their coverage will increase by an average of 94 percent through 2021.

From an actuarial standpoint, hybrid policies come with much less volatility for insurers, explained Robert Eaton of the SOA, because they are a blend of a traditional life insurance or annuity with LTC coverage.

'A Stronger Commitment'

The demand is not expected to abate anytime soon, the analysts said. A Lincoln Financial Group survey of clients with at least $250,000 in investable assets revealed that 57 percent listed future health/LTC expenses as their greatest retirement concern. That far outdistanced the 37 percent who listed "outliving their savings" as their greatest concern.

But the esteemed place life insurance holds in American culture is the biggest reason LTC is in a revival mode, Schoonveld said.

"Consumers know and value life insurance. They own life insurance protection, whether it's while they have kids in the house or not, and they have life insurance when they're retired as well.

"When you elevate the conversation, when you bring long-term care into the conversation with life insurance planning, you end up getting a stronger commitment to dealing with that risk. So it's allowing advisors to have that conversation." ■

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Employer Shared Responsibility ("Pay or Play")

The Final Rules stated that guidance regarding compliance with the ACA employer shared responsibility regulations will be forthcoming.

Next Steps

These Final Rules present plan design opportunities for employers of all sizes effective January 1, 2020. The differences between the various types of account-based group health plans are often subtle and the type of plan best suited to meet each employer's goals may be difficult to determine. Employers should work with their benefits counsel to understand how these new rules could potentially save costs and structure more efficient health coverage for their employee populations. ■

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