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## 29 C.F.R. § 2590.702-2

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### Special rule allowing integration of Health Reimbursement Arrangements (HRAs) and other account-based group health plans with individual health insurance coverage and Medicare and prohibiting discrimination in HRAs and other account-based group health plans.

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- (a) *Scope.* This section applies to health reimbursement arrangements (HRAs) and other account-based group health plans, as defined in § 2590.715-2711(d)(6)(i) of this part. For ease of reference, the term “HRA” is used in this section to include other account-based group health plans. For related regulations, see 26 CFR 1.36B-2(c)(3)(i) and (c)(5), 29 CFR 2510.3-1(l), and 45 CFR 155.420.
- (b) *Purpose.* This section provides the conditions that an HRA must satisfy in order to be integrated with individual health insurance coverage for purposes of Public Health Service Act (PHS Act) sections 2711 and 2713 and § 2590.715-2711(d)(4) of this part (referred to as an individual coverage HRA). This section also allows an individual coverage HRA to be integrated with Medicare for purposes of PHS Act sections 2711 and 2713 and § 2590.715-2711(d)(4), subject to the conditions provided in this section (see paragraph (e) of this section). Some of the conditions set forth in this section specifically relate to compliance with PHS Act sections 2711 and 2713 and some relate to the effect of having or being offered an individual coverage HRA on eligibility for the premium tax credit under section 36B of the Code. In addition, this section provides conditions that an individual coverage HRA must satisfy in order to comply with the nondiscrimination provisions in ERISA section 702 and PHS Act section 2705 (which is incorporated in ERISA section 715) and that are consistent with the provisions of the Patient Protection and Affordable Care Act, Public Law 111-148 (124 Stat. 119 (2010)), and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 (124 Stat. 1029 (2010)), each as amended, that are designed to create a competitive individual market. These conditions are intended to prevent an HRA plan sponsor from intentionally or unintentionally, directly or indirectly, steering any participants or dependents with adverse health factors away from its traditional group health plan, if any, and toward individual health insurance coverage.
- (c) *General rule.* An HRA will be considered to be integrated with individual health insurance coverage for purposes of PHS Act sections 2711 and 2713 and § 2590.715-2711(d)(4) of this part and will not be considered to discriminate in violation of ERISA section 702 and PHS Act section 2705 solely because it is integrated with individual health insurance coverage, provided that the conditions of this paragraph (c) are satisfied. See paragraph (e) of this section for how these conditions apply to an individual coverage HRA integrated with Medicare. For purposes of this section, medical care expenses means medical care expenses as defined in § 2590.715-2711(d)(6)(ii) of this part and Exchange means Exchange as defined in 45 CFR 155.20.
- (1) *Enrollment in individual health insurance coverage—(i) In general.* The HRA must require that the participant and any dependent(s) are enrolled in individual health insurance coverage that is subject to and complies with the requirements in PHS Act sections 2711 (and § 2590.715-2711(a)(2) of this part) and PHS Act section 2713
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(and § 2590.715-2713(a)(1) of this part), for each month that the individual(s) are covered by the HRA. For purposes of this paragraph (c), all individual health insurance coverage, except for individual health insurance coverage that consists solely of excepted benefits, is treated as being subject to and complying with PHS Act sections 2711 and 2713. References to individual health insurance coverage in this paragraph (c) do not include individual health insurance coverage that consists solely of excepted benefits.

(ii) *Forfeiture.* The HRA must provide that if any individual covered by the HRA ceases to be covered by individual health insurance coverage, the HRA will not reimburse medical care expenses that are incurred by that individual after the individual health insurance coverage ceases. In addition, if the participant and all dependents covered by the participant's HRA cease to be covered by individual health insurance coverage, the participant must forfeit the HRA. In either case, the HRA must reimburse medical care expenses incurred by the individual prior to the cessation of individual health insurance coverage to the extent the medical care expenses are otherwise covered by the HRA, but the HRA may limit the period to submit medical care expenses for reimbursement to a reasonable specified time period. If a participant or dependent loses coverage under the HRA for a reason other than cessation of individual health insurance coverage, COBRA and other continuation coverage requirements may apply.

(iii) *Grace periods and retroactive termination of individual health insurance coverage.* In the event an individual is initially enrolled in individual health insurance coverage and subsequently timely fails to pay premiums for the coverage, with the result that the individual is in a grace period, the individual is considered to be enrolled in individual health insurance coverage for purposes of this paragraph (c)(1) and the individual coverage HRA must reimburse medical care expenses incurred by the individual during that time period to the extent the medical care expenses are otherwise covered by the HRA. If the individual fails to pay the applicable premium(s) by the end of the grace period and the coverage is cancelled or terminated, including retroactively, or if the individual health insurance coverage is cancelled or terminated retroactively for some other reason (for example, a rescission), an individual coverage HRA must require that a participant notify the HRA that coverage has been cancelled or terminated and the date on which the cancellation or termination is effective. After the individual coverage HRA has received the notice of cancellation or termination, the HRA may not reimburse medical care expenses incurred on and after the date the individual health insurance coverage was cancelled or terminated, which is considered to be the date of termination of coverage under the HRA.

(2) *No traditional group health plan may be offered to same participants.* To the extent a plan sponsor offers any class of employees (as defined in paragraph (d) of this section) an individual coverage HRA, the plan sponsor may not also offer a traditional group health plan to the same class of employees, except as provided in paragraph (d)(5) of this section. For purposes of this section, a traditional group health plan is any group health plan other than either an account-based group health plan or a group health plan that consists solely of excepted benefits. Therefore, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any participant or dependent.

(3) *Same terms requirement—(i) In general.* If a plan sponsor offers an individual coverage HRA to a class of employees described in paragraph (d) of this section, the HRA must be offered on the same terms to all participants within the class, except as provided in paragraphs (c)(3)(ii) through (vi) and (d)(5) of this section.

(ii) *Carryover amounts, salary reduction arrangements, and transfer amounts.* Amounts that are not used to reimburse medical care expenses for any plan year that are made available to participants in later plan years are disregarded for purposes of determining whether an HRA is offered on the same terms, provided that the method for determining whether participants have access to unused amounts in future years, and the methodology and formula for determining the amounts of unused funds which they may access in future years, is the same for all participants in a class of employees. In addition, the ability to pay the portion of the premium for individual

health insurance coverage that is not covered by the HRA, if any, by using a salary reduction arrangement under section 125 of the Code is considered to be a term of the HRA for purposes of this paragraph (c)(3). Therefore, an HRA is not provided on the same terms unless the salary reduction arrangement, if made available to any participant in a class of employees, is made available on the same terms to all participants (other than former employees, as defined in paragraph (c)(3)(iv) of this section) in the class of employees. Further, to the extent that a participant in an individual coverage HRA was previously covered by another HRA and the current individual coverage HRA makes available amounts that were not used to reimburse medical care expenses under the prior HRA (transferred amounts), the transferred amounts are disregarded for purposes of determining whether the HRA is offered on the same terms, provided that if the HRA makes available transferred amounts, it does so on the same terms for all participants in the class of employees.

(iii) *Permitted variation.* An HRA does not fail to be provided on the same terms solely because the maximum dollar amount made available to participants in a class of employees to reimburse medical care expenses for any plan year increases in accordance with paragraph (c)(3)(iii)(A) or (B) of this section.

(A) *Variation due to number of dependents.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available to those participants to reimburse medical care expenses for any plan year increases as the number of the participant's dependents who are covered under the HRA increases, so long as the same maximum dollar amount attributable to the increase in family size is made available to all participants in that class of employees with the same number of dependents covered by the HRA.

(B) *Variation due to age.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available under the terms of the HRA to those participants to reimburse medical care expenses for any plan year increases as the age of the participant increases, so long as the requirements in paragraphs (c)(3)(iii)(B)(1) and (2) of this section are satisfied. For the purpose of this paragraph (c)(3)(iii)(B), the plan sponsor may determine the age of the participant using any reasonable method for a plan year, so long as the plan sponsor determines each participant's age for the purpose of this paragraph (c)(3)(iii)(B) using the same method for all participants in the class of employees for the plan year and the method is determined prior to the plan year.

(1) The same maximum dollar amount attributable to the increase in age is made available to all participants who are the same age.

(2) The maximum dollar amount made available to the oldest participant(s) is not more than three times the maximum dollar amount made available to the youngest participant(s).

(iv) *Former employees.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers the HRA to some, but not all, former employees within a class of employees. However, if a plan sponsor offers the HRA to one or more former employees within a class of employees, the HRA must be offered to the former employee(s) on the same terms as to all other employees within the class, except as provided in paragraph (c)(3)(ii) of this section. For purposes of this section, a former employee is an employee who is no longer performing services for the employer.

(v) *New employees or new dependents.* For a participant whose coverage under the HRA becomes effective later than the first day of the plan year, the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees whose coverage became effective as of the first day of the plan year, or is pro-rated consistent with the portion of the plan year in which the participant is covered by the HRA. Similarly, if the HRA provides for variation in the maximum amount made

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available to participants in a class of employees based on the number of a participant's dependents covered by the HRA, and the number of a participant's dependents covered by the HRA changes during a plan year (either increasing or decreasing), the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees who had the same number of dependents covered by the HRA on the first day of the plan year or is pro-rated for the remainder of the plan year after the change in the number of the participant's dependents covered by the HRA consistent with the portion of the plan year in which that number of dependents are covered by the HRA. The method the HRA uses to determine amounts made available for participants whose coverage under the HRA is effective later than the first day of the plan year or who have changes in the number of dependents covered by the HRA during a plan year must be the same for all participants in the class of employees and the method must be determined prior to the beginning of the plan year.

(vi) *HSA-compatible HRAs.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers participants in a class of employees a choice between an HSA-compatible individual coverage HRA and an individual coverage HRA that is not HSA compatible, provided both types of HRAs are offered to all participants in the class of employees on the same terms. For the purpose of this paragraph (c)(3)(vi), an HSA-compatible individual coverage HRA is an individual coverage HRA that is limited in accordance with applicable guidance under section 223 of the Code such that an individual covered by such an HRA is not disqualified from being an eligible individual under section 223 of the Code.

(vii) *Examples.* The following examples illustrate the provisions of this paragraph (c)(3), without taking into account the provisions of paragraph (d) of this section. In each example, the HRA is an individual coverage HRA that has a calendar year plan year and may reimburse any medical care expenses, including premiums for individual health insurance coverage (except as provided in paragraph (c)(3)(vii)(E) of this section (*Example 5*)). Further, in each example, assume the HRA is offered on the same terms, except as otherwise specified in the example and that no participants or dependents are Medicare beneficiaries.

(A) *Example 1: Carryover amounts permitted—(1) Facts.* For 2020 and again for 2021, Plan Sponsor A offers all employees \$7,000 each in an HRA, and the HRA provides that amounts that are unused at the end of a plan year may be carried over to the next plan year, with no restrictions on the use of the carryover amounts compared to the use of newly available amounts. At the end of 2020, some employees have used all of the funds in their HRAs, while other employees have balances remaining that range from \$500 to \$1,750 that are carried over to 2021 for those employees.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(A) (*Example 1*) for 2020 because Plan Sponsor A offers all employees the same amount, \$7,000, in an HRA for that year. The same terms requirement is also satisfied for 2021 because Plan Sponsor A again offers all employees the same amount for that year, and the carryover amounts that some employees have are disregarded in applying the same terms requirement because the amount of the carryover for each employee (that employee's balance) and each employee's access to the carryover amounts is based on the same terms.

(B) *Example 2: Employees hired after the first day of the plan year—(1) Facts.* For 2020, Plan Sponsor B offers all employees employed on January 1, 2020, \$7,000 each in an HRA for the plan year. Employees hired after January 1, 2020, are eligible to enroll in the HRA with an effective date of the first day of the month following their date of hire, as long as they have enrolled in individual health insurance coverage effective on or before that date, and the amount offered to these employees is pro-rated based on the number of months remaining in the plan year, including the month which includes their coverage effective date.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(B) (*Example 2*) for 2020 because Plan Sponsor B offers all employees employed on the first day of the plan year the same amount, \$7,000, in an HRA for that plan year and all employees hired after January 1, 2020, a pro-rata amount based on the portion of the plan year during which they are enrolled in the HRA.

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