AMWINS BENEFITS | Small to Mid-Market

Individual Coverage Health Reimbursement Arrangement (ICHRA) Compliance Guide

Updated October 2025

A Practical Guide to Understanding ICHRA Compliance!

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HRA Overview

Prior to 2002, medical reimbursement plans using carryover accounts were of limited popularity, partly because of uncertainty about their tax treatment. In 2002, IRS guidance established a safe harbor allowing unused amounts to carry over from year-to-year without becoming subject to federal tax and essentially created the vehicle we now know as a health reimbursement arrangement (HRA). Since then, HRAs have become much more common. There is no specific Code section governing HRAs, but the IRS has confirmed their tax-favored treatment under the general principles of Code §§105 and 106.

In its most basic form, an HRA is an employer-funded arrangement that reimburses employees for certain medical care expenses incurred by employees and their spouses and dependents up to an amount defined by the plan. HRAs are set up as notional (i.e., unfunded) accounts. This means that there is never any money actually held in a specific employer or employee account; rather, the employer reimburses eligible expenses from its general assets. Important HRA rules include the following:

- An HRA must be paid for solely by the employer and may not be provided through a salary reduction election or under a §125 cafeteria plan.
- Following the passage of healthcare reform in 2010, most HRAs must be integrated with other health coverage (i.e., made available solely to those actually enrolled in other health coverage) unless the HRA reimburses only excepted benefits such as dental or vision. In addition, most HRAs are not permitted to reimburse individual health insurance premiums.
- An HRA can be designed so that unused reimbursement in one plan year can be carried over into subsequent plan years.
- HRA claims must be substantiated based on IRS rules before they can be reimbursed.

In 2016, Congress passed the 21st Century Cures Act, which created qualified small employer HRAs (QSEHRAs). QSEHRAs share some basic design features with other HRAs, but they allow reimbursement of health coverage premiums, including individual health plans and Medicare, and are available only to small employers (<50 FTEs) who do not offer other group health plan coverage to employees.

Then in 2019, agency regulations were issued establishing two additional types of HRAs: excepted benefit HRAs (EBHRAs) and individual coverage HRAs (ICHRAs). An EBHRA is available to reimburse §213(d) qualifying medical expenses other than insurance premiums. EBHRA funding is limited to approximately $2,000 per year and it can only be offered to employees who are also eligible for the employer's traditional group health plan. An ICHRA can provide reimbursement for all §213(d) qualifying medical expenses, including insurance premiums, and the annual funding is unlimited. However, the employees cannot be given a choice between a traditional group health plan and an ICHRA, and the ICHRA can only provide reimbursement to those who attest to having individual health coverage or Medicare.

ICHRA Strategy Considerations

ICHRA adoption has been slow but seems to be gaining traction. For employers, an ICHRA has the potential to: (i) cut down on the burden to select the right plan design(s); (ii) lessen the compliance and administrative responsibilities; and (iii) provide a predictable budget. If handled correctly, it can also be viewed as attractive to employees, especially in areas where the individual health plans have adequate networks in place at attractive prices. The ICHRA allows employees to choose their plan and to keep it beyond employment. A transition to an ICHRA is most successful for employers who invest in extra education, communication, assistance for employees choosing individual plans, and seamless reimbursement of coverage premiums.

Below are several potential situations that may cause an employer to give an ICHRA serious consideration.

Employers Having Trouble Meeting Participation Requirements

Many employers, especially those with a significant number of low-wage workers, struggle to meet minimum participation requirements imposed by a health insurance carrier. An employer can offer to fund an ICHRA at any level, and since employees use the money to help purchase their own individual health plans, employee participation rates do not matter.

Employers with High Turnover or Many Variable Hour Employees

Employers with a very fluid workforce have a more difficult time administering benefits under a traditional group health plan. An ICHRA offer could ease some of that administrative burden for this type of employer.

Employers Who Want to Offer Something to Part-Time Employees

Very few employers offer group health plan coverage to part-time employees. An employer could offer an ICHRA to part-time employees with a relatively small employer contribution that may still be an attractive benefit.

Applicable Large Employers Offering Only Minimum Essential Coverage (MEC)

Some large employers have opted to offer a limited coverage “skinny” MEC plan solely for the purpose of avoiding the §4980H(a) penalty. An employer could make an ICHRA offer to the same employee population with an employer contribution that is less than the typical cost of a MEC plan and can also provide more flexibility with respect to employee reimbursement (not limited primarily to preventive coverage).

Employers with High Health Plan Rates Due to Claims Experience

Since individual health plans are community rated, employee claims experience will have no direct impact on individual insurance costs. Employers with worse than average claims experience could see a decrease in total health care spend by moving at least a portion of the population to an ICHRA.

Employers with a Workforce that is Diverse or Geographically Spread Out

Employers that have a workforce that is diverse or is spread across the country may struggle to put group health plan coverage in place to meet various cost and coverage needs. This is especially true as more employers are allowing remote work. An ICHRA could provide a similar level of employer contribution while allowing employees to choose coverage that better matches their specific needs.

Employers with a Significant Number of Medicare-Eligible Employees in a Permitted Class

Although the ICHRA cannot be offered to just Medicare-eligible employees, if an employer has a significant number of employees who are Medicare eligible, the ICHRA may be a more attractive option for an allowed class of employees.

ICHRA – General Requirements

An ICHRA must meet several requirements.

- Participants must be enrolled in individual health coverage or Medicare and must provide annual and ongoing substantiation of enrollment in individual health coverage or Medicare;
- Eligibility and reimbursement levels must comply with rules for specified “classes” of employees;
- Employees offered the ICHRA cannot also be offered a traditional group medical plan;
- Participants must be able to opt out of and waive any future reimbursements; and
- A notice must be provided upon initial eligibility and annually thereafter.

Each of these requirements is discussed in further detail below.

Enrollment in Individual Health Coverage or Medicare

The ICHRA is required to be “integrated” with individual health coverage or Medicare. This means that all individuals (including spouses and dependents) must be enrolled in individual health coverage or Medicare and provide proof of that coverage to receive tax-favored reimbursement from the ICHRA.

- Individual health coverage includes coverage purchased through a public Marketplace or purchased from an insurance carrier or private exchange outside the Marketplace. It includes student health insurance, catastrophic coverage, grand-mothered coverage, and grandfathered coverage, but does NOT include short-term, limited-duration insurance; coverage that consists

solely of excepted benefits; TRICARE; or coverage purchased through a healthcare sharing ministry.

- Medicare coverage must be Medicare Part A and B or Part C.

Example 1:

An ICHRA is offered to an employee and his spouse. The employee is enrolled in Medicare, and the spouse is enrolled in individual health coverage through a public Marketplace. The employee may submit qualifying medical expenses for himself or his spouse for reimbursement by the ICHRA because the employee and spouse are enrolled in individual health coverage or Medicare.

Example 2:

An ICHRA is offered to an employee, his spouse, and his two children. The employee is enrolled in Medicare; the spouse and children are enrolled in a group health plan through the spouse's employer. The employee could submit qualifying medical expenses for himself for reimbursement by the ICHRA, but not expenses incurred by the spouse or children who are not enrolled in individual health coverage or Medicare.

Substantiation of Individual Health Coverage or Medicare

Before allowing enrollment in the ICHRA or providing reimbursement for premiums or other qualifying medical expenses, the plan (or the employer) must obtain substantiation of enrollment in individual health coverage or Medicare from any employees, spouses, or dependents requesting enrollment or reimbursement. Some may already be enrolled in individual health coverage or Medicare, but some may need to obtain individual health coverage. The typical annual open enrollment for individual coverage runs from approximately November 1 through December 15. In addition, a special enrollment period will be available for 60 days for those individuals participating in a non-calendar year ICHRA or becoming eligible for an ICHRA outside the annual open enrollment window.

There is an annual substantiation requirement that applies prior to enrollment in the ICHRA and an ongoing substantiation requirement that applies each time reimbursement is requested. In other words, participants must confirm enrollment in individual health coverage or Medicare annually and each time reimbursement is requested.

Annual Substantiation	***Ongoing Substantiation***
Prior to initial enrollment in the ICHRA, or prior to enrollment via open enrollment, the plan must verify that employees, spouses, and dependents enrolling in the ICHRA are, or will be, enrolled in individual health coverage or Medicare during the plan year. This verification must occur no later than the first day of ICHRA enrollment or coverage*	Prior to any reimbursement from the ICHRA, the individual requesting reimbursement must provide verification that the individual was enrolled in individual health coverage or Medicare for the month during which the expense(s) were incurred.

**There is an exception for when a new dependent's coverage is added retroactively (e.g., due to the birth of a child) so long as verification is provided prior to any medical expenses being reimbursed.*

Plans have flexibility in determining what type of substantiation will be accepted to prove enrollment in individual health coverage or Medicare. The following is a list of acceptable methods for annual or ongoing substantiation of individual health coverage or Medicare (not meant to be exhaustive):

- A document from a third party (likely the insurance carrier) such as an insurance card, a completed application with plan selection, or an explanation of benefits.
- A list bill from an insurance carrier showing all covered individuals.
- Electronic substantiation – e.g., debit card technology.
- Direct payment of insurance premiums.
- An attestation stating that the individual(s) are, or will be, enrolled in individual health coverage or Medicare, the date coverage began or will begin, and the name of the provider of the coverage.

Although the plan could require third party verification, collecting an attestation of enrollment or coverage from participants is adequate. The agencies have provided a model attestation form that may be used for both annual and ongoing substantiation.

Substantiation of Qualifying Medical Expenses

If ICHRA reimbursement is permitted for qualifying medical expenses other than premiums, appropriate third-party verification of such expenses should be provided along with certification that the expense has not otherwise been reimbursed and that the individual will not seek reimbursement for the expense from any other plan. This matches the requirements for reimbursement for other types of HRAs. Ongoing substantiation of continued enrollment in individual health coverage or Medicare can be satisfied by collecting a written attestation from the participant on the same form used for requesting reimbursement.

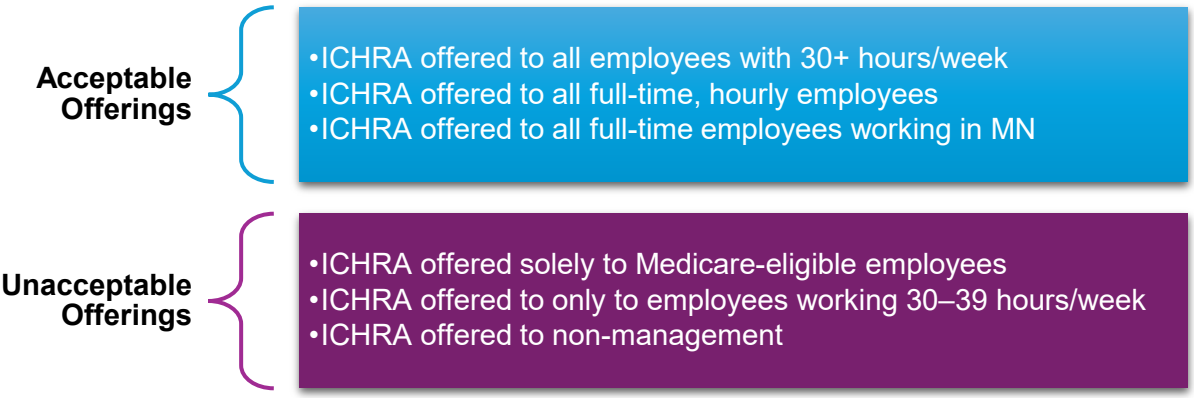
Eligibility and Reimbursement by Class

If the ICHRA is not offered to all employees, it must be offered to all employees within a specified class, and generally on the same terms. Only the classes (or combination of classes) found in the table below may be used.

Permitted Classes
Full-time employees (as defined under §105(h) or §4980H
Part-time employees (as defined under §105(h) or §4980H)
Seasonal employees (as defined under §105(h) or §4980H)
Salaried workers
Non-salaried workers (e.g., hourly workers)

Employees working in the same geographic location (insurance rating area, state, or multi-state region)
Employees covered by a collective bargaining agreement
Employees who have not satisfied a waiting period
Non-resident aliens with no U.S.-based income
Temporary employees of staffing firms (common law employees of the staffing firm)

Any group of employees formed by combining two or more of these classes is permitted, and classes can be defined separately for each entity within a controlled group or affiliated service group.



Although the general rule is that the ICHRA must be offered on the same terms to all employees within a specified class, the dollar amount can vary based on age (up to 3x more for older employees than for younger employees) or by the number of dependents eligible for reimbursement. Individual health coverage premiums vary by age, so it may make sense for employers to make a larger amount of reimbursement available to older employees. In addition, the employer may be willing to make a larger amount available to those employees who choose to enroll their spouses and dependents.

Keep in mind, non-employees (e.g., independent contractors, owners, board members, directors) cannot participate in employer-sponsored benefits on the same tax-favored basis as employees, and therefore they generally cannot participate in an ICHRA.

ICHRAs and Traditional Group Medical Plans

Those employees offered an ICHRA cannot also be offered a traditional group medical plan by the same employer. Said differently, employees cannot be given a choice between a traditional group medical plan and an ICHRA.

If an employer offers a traditional group medical plan to some employees and an ICHRA to other employees (within the permitted classes), the offering must meet minimum class size rules if an employer uses any of the following classes for determining who is eligible for the ICHRA:

- full-time;
- part-time;
- salaried;
- non-salaried; or
- geographic location (if the location is smaller than a state).

The minimum class size rules require a minimum number of employees to be eligible for the ICHRA. See the minimum class requirements in the table below.

Employer Size	Minimum Class Size (# Eligible)
<100 employees	10 employees
100–200 employees	10% of total employees
>200 employees	20 employees

Opt-Outs & Waiver of Reimbursement

The ICHRA is minimum essential coverage (MEC). Any individual who enrolls in an ICHRA is then ineligible for a premium tax credit (PTC) when purchasing individual health insurance through a public Marketplace. This is true no matter what amount of reimbursement is available via the ICHRA. Therefore, eligible participants must be able to opt out of ICHRA coverage and to waive any future reimbursements to preserve PTC eligibility when applicable.

Notice Requirements

Employees who are eligible to participate in an ICHRA must be provided with a notice at least 90 days before the beginning of each plan year, or for those who become eligible later, no later than the employee's effective date of coverage. The notice is meant to help individuals understand the coverage available via the ICHRA and how the ICHRA may impact eligibility for a PTC toward coverage through a public Marketplace. NOTE: When the ICHRA is newly established, the notice can be provided no later than the date on which the ICHRA is first effective.

A model notice is available provided by the agencies. The model notice provides basic information about how the ICHRA affects eligibility for a PTC toward public Marketplace coverage. It also provides general information about how to obtain individual health coverage and enrollment time frames. The notice should be tailored to indicate who is eligible for the ICHRA, the maximum dollar amounts available, substantiation requirements for participation, and what expenses qualify for reimbursement.

ICHRA Funding & Reimbursement

Employers have broad flexibility to set eligible expenses and annual limits for reimbursement, but only employer dollars are involved. Employees cannot contribute to an ICHRA, and it cannot be run through a cafeteria plan.

Employer Funding Limits

There is no annual maximum or minimum limit on ICHRA reimbursement, so employers can determine how much they are willing to spend annually and set the reimbursement levels accordingly. Although there is no minimum limit, applicable large employers (ALEs) may want to make enough available via the ICHRA each month to ensure the offer of coverage is affordable under §4980H(b). On the other hand, small employers who are not subject to §4980H may want to make an unaffordable offer of coverage to preserve PTC eligibility for employees, spouses, and their dependents.

If participants do not incur enough eligible expenses to use up the maximum amount of reimbursement available for the year, the employer could keep the money; or the employer could design the ICHRA to allow a certain level of carryover from one year to the next, or to allow a spenddown upon a loss of eligibility for the ICHRA.

Eligible Expenses

Although most ICHRAs will provide premium reimbursement (for individual health coverage or Medicare), employers can choose how eligible expenses are defined. The ICHRA may be available to reimburse premiums, §213(d) qualifying medical expenses other than premiums, or a combination of the two. It is also possible to limit which qualifying medical expenses are eligible for reimbursement (e.g., solely prescription drug coverage), but reimbursement cannot be limited only to expenses not covered by Medicare (Medicare Secondary Payer (MSP) rules). For the ICHRA to be compatible with an HSA, eligible expenses must be limited to premiums and excepted benefits.

If the ICHRA reimburses individual health coverage and Medicare premiums, participants could be required to pay monthly premiums and then submit them for reimbursement. Alternatively, a debit card could be made available, or the ICHRA could be set up to pay the carrier directly. Many employees will owe something for their monthly individual health coverage or Medicare premium(s) even if the ICHRA is available for reimbursement of premiums because the amount the employer makes available via the ICHRA to reimburse premiums may not cover the full monthly cost. Some employers may choose to facilitate payment of the monthly premiums via a combination of ICHRA reimbursement and payroll deductions. If the individual health coverage is purchased outside the Marketplace, the employer may permit pre-tax payroll deductions through its cafeteria plan; however, if the individual health coverage is purchased through a public Marketplace, it would be necessary to collect payroll deductions after-tax.

If the ICHRA will reimburse qualifying medical expenses other than premiums, participants must be required to submit proper third-party substantiation before being reimbursed (or, alternatively, follow debit card procedures already approved for other types of HRAs and health FSAs).

Employer Mandate (§4980H) & ACA Employer Reporting

Applicable large employers (ALEs) – employers with 50 or more full-time equivalents (FTEs) – are required to offer coverage to full-time employees and their dependents to avoid potential penalties under §4980H. The ICHRA can be designed to meet these requirements and therefore is an option not only for small employers, but for ALEs as well.

§4980H(a) – Minimum Essential Coverage (MEC)

To meet §4980H(a) requirements, MEC must be offered to at least 95% (or all but 5, if greater) of full-time employees and their dependent children. An ICHRA is an offer of MEC for purposes of satisfying §4980H(a) requirements. There is no minimum amount an employer must make available via the ICHRA for it to be an offer of MEC to full-time employees and their dependents. So, for example, an employer could make $10/month available to full-time employees and their dependents via the ICHRA and meet §4980H(a) offer of coverage requirements.

§4980H(b) – Affordability and Minimum Value

To avoid employer liability under §4980H(b), an ALE must offer coverage that provides minimum value (60% or better actuarial value) and is affordable. An ICHRA that is "affordable" will automatically be considered a minimum value offer of coverage for purposes of §4980H(b) so long as the ICHRA is available to reimburse individual health coverage and Medicare premiums (not just qualifying medical expenses other than premiums).

For an offer of coverage to be affordable, the employee contribution cannot exceed a set percentage (9.02% in 2025, 9.96% in 2026) of an employee's household income or one of the affordability safe harbors. The affordability of an ICHRA is tied to the lowest cost silver plan available on the public Marketplace.



If the employee contribution for the ICHRA is affordable based on any of the three affordability safe harbors (i.e., FPL, rate of pay, or Form W-2), the ICHRA will be affordable for purposes of satisfying §4980H(b) requirements.

Individual health coverage premiums vary by an individual's location and age. This makes it more challenging to determine affordability for all full-time employees. To help address this challenge, IRS rules provide the following guidance:

- ***Rates by Age*** – Affordability can be based on the employee's age on the first day of the plan year, or when the employee is first eligible for the ICHRA, to avoid having to make adjustments in accordance with age changes during the plan year.
- ***Location Safe Harbor*** – Instead of using the lowest cost silver Marketplace plan available where the employee resides, an employer can use the cost of the plan at the employee's primary site of employment. An employee's primary site of employment is the location at which the employer reasonably expects the employee to perform services, which may be the employee's residence if the employee does not have a particular assigned office space or a worksite to which to report.
- ***Look-Back Month Safe Harbor*** – An employer with a calendar year plan may use the monthly premium for the lowest cost silver Marketplace plan for January of the prior calendar year. An employer with a non-calendar year plan may use the monthly premium for the lowest cost silver Marketplace plan for January of the current calendar year.
- ***Non-Tobacco Rates*** – As with group health plans, affordability is based on plan premiums applicable to non-tobacco users.

EXAMPLE: Employee earns $18.00/hour and will have Box 1 wages of $40,000 in 2025.

- FPL safe harbor: Employee monthly contribution ≤ $113.20/mo.
- Rate of pay safe harbor: Employee monthly contribution ≤ $233.06/mo. ($18 x 130 x 9.96%)
- Form W-2 safe harbor: Employee monthly contribution ≤ $332.00/mo. ($40,000 x 9.96% / 12)

To assist with calculating affordability review the ACA Affordability Considerations as well as the Affordability Calculator found under Forms and Benefits on the website.

Employer Reporting

An ICHRA is a self-funded group health plan that requires coverage reporting by the employer exactly as it is required for a self-funded traditional group medical plan. Although the federal individual mandate is no longer in effect, employers offering self-funded medical coverage are still required to report who is covered under the self-funded plan in Part III of Form 1095-C (for ALEs) or on Form 1095-B (for small employers). In addition, some employers may have to report coverage to state governments in states that have put individual mandates in place (e.g., California, Massachusetts, New Jersey, Rhode Island, and DC).

Separately, ALEs are required to report offer of coverage information for full-time employees, including an offer of an ICHRA. ALEs who offered an ICHRA to full-time employees will need to report details about the ICHRA offering in Part II of the employee's Form 1095-C. Specifically, the ALE must report the employee's age, use Codes 1L – 1S to indicate the type of offer on Line 14, list the employee contribution on Line 15, and provide zip code information on Line 17.

Premium Tax Credit (PTC) Eligibility

An individual who purchases coverage via a public Marketplace may qualify for a PTC to help pay the monthly premiums if:

- The individual is not enrolled in other MEC;
- The individual is not eligible for employer-sponsored coverage that provides minimum value and is affordable; AND
- The individual has household income of 100–400% of the federal poverty line (FPL).

ICHRA – Not affordable

If an employee is offered an ICHRA that is not affordable, the employee may choose between the ICHRA and a PTC toward coverage through a public Marketplace. It is not possible to take advantage of both. The employee loses eligibility for the PTC upon enrolling in the ICHRA because the ICHRA is MEC. For example, if an employer makes $100 available monthly via an ICHRA, the employee for whom the offer is unaffordable should consider whether the PTC available via the public Marketplace, if any, is more or less than $100/month. If it is less, enrolling in the ICHRA may be the better choice; but if it is more, the employee is probably better off waiving the ICHRA.

If spouses and dependents are eligible for the ICHRA, the same rules apply for them.

ICHRA – Affordable

If an employee is offered an ICHRA that is affordable, the employee is not eligible for a PTC for coverage through a public Marketplace even if the employee waives the ICHRA coverage. In addition, if the ICHRA is affordable for the employee, spouses and dependents who are eligible for the ICHRA are also disqualified for any PTC.

Miscellaneous Compliance Considerations

ERISA

The ICHRA is a group health plan subject to ERISA plan documentation requirements (e.g., SPD and SBC) and Form 5500 filings, depending upon the size of the plan.

There is a safe harbor for individual health coverage and Medicare integrated with the ICHRA so long as certain requirements are met. To avoid having the integrated individual health plans be subject to ERISA, the employer must refrain from selecting or endorsing any particular insurance carrier or coverage options, cannot receive any financial incentive, and must notify participants annually that the individual health insurance is not subject to ERISA. Most importantly, individuals must be permitted to enroll in any qualifying individual health coverage.

Although coverage purchased via a private exchange could also be integrated with an ICHRA, platforms providing only a subset of individual health coverage options will need to be carefully designed to meet ERISA safe harbor requirements (even if individuals still have the option of finding

other individual health coverage on their own). Ideally, a platform would be designed to either: (i) provide access to all individual health coverage options; or (ii) provide resources for how to access individual health coverage options not made available via such platform.

COBRA

An ICHRA is a group health plan subject to federal COBRA continuation requirements (for employers with 20 or more employees). An individual who loses eligibility for an ICHRA due to a qualifying event (e.g., termination of employment, reduction in hours, a dependent aging out, divorce) must be offered COBRA for the ICHRA; however, losing ICHRA coverage due to failure to maintain individual coverage is not a qualifying event.

An individual who is offered COBRA for the ICHRA may be required to pay a monthly premium of up to 102%, but there is very limited guidance as to how to set the COBRA premium. If the ICHRA is available solely to reimburse premiums and the funding is generally exhausted/used each month, it may be reasonable to charge 102% of the monthly amount made available to the individual prior to the qualifying event. However, if the funding exceeds what is generally used by participants, it may not be as simple as basing it on whatever balance remains for the plan year.

COBRA must be offered for the ICHRA, but it won't often be attractive to elect COBRA and pay the corresponding COBRA premium to maintain access to the ICHRA reimbursement. We recommend adjusting the COBRA election letter or providing a cover letter to the COBRA election notice, explaining how the ICHRA works via COBRA. Qualified beneficiaries need to understand that they are independently responsible for continuing their individual coverage or Medicare directly with the carrier and that electing COBRA (and paying the associated premium) simply provides ongoing access to the ICHRA reimbursement, which won't often make a lot of sense.

HSA-Eligibility

An ICHRA that reimburses only individual health coverage premiums or excepted benefits will not prevent eligibility to contribute to an HSA. However, if the ICHRA is also available to reimburse other qualifying medical expenses (e.g., cost-sharing under the individual medical plan) prior to meeting the HDHP minimum deductible, individuals enrolled in the ICHRA will not be eligible to contribute to an HSA.

Employers are permitted to offer two ICHRA options and still meet the "same terms" rule within a class of employees. The employer could offer the following within a particular class – (i) an ICHRA limited solely to reimbursement of premiums for those who are otherwise eligible to contribute to an HSA; and (ii) an ICHRA more broadly available to reimburse any §213(d) qualifying medical expenses for those who are not eligible to contribute to an HSA (e.g., those who are entitled to Medicare or who choose a non-HDHP for individual health coverage).

PCORI Fees

Health reimbursement arrangements (HRAs), including ICHRAs, are self-funded plans subject to the PCORI fee, which are reported and paid annually in the second quarter using Form 720, Line 133 (133(c) and (d). The fee is due by July 31 of the year following the year in which the plan ends (e.g., for a plan year that ended 12/31/2024, the fee would be due by 7/31/2025). The fee is approximately $3 per covered life. For HRAs, including ICHRAs, there is a special counting rule that permits the plan to pay the fee only with respect to each HRA participant/employee as covered lives; the employer is not required to count dependents or beneficiaries.

Benefit Nondiscrimination

Benefit nondiscrimination rules restrict the ability to favor highly compensated individuals on a tax-favored basis. If plans are found to be discriminatory, highly compensated individuals may be taxed on some or all benefits received under the plan.

§105(h) Nondiscrimination Rules – Self-Funded Group Health Plans

ICHRAs are subject to §105(h) nondiscrimination rules for self-funded group health plans. Although an ICHRA may differentiate amounts available by age on a 3:1 ratio without violating §105(h) rules, and may also differentiate contributions based on family size, an offer of ICHRA coverage could still be discriminatory under §105(h) if, for example, a disproportionate number of older, highly compensated individuals take advantage of the maximum ICHRA reimbursement available (which might be more for older employees). In addition, employers who choose to offer an ICHRA to some employees while maintaining a self-funded traditional group medical plan for another class of employees should be aware that this choice could result in the traditional group medical plan being discriminatory if the remaining employees eligible for or participating in the traditional group medical plan consist of too many highly compensated individuals.

§125 Nondiscrimination Rules – Cafeteria Plan Benefits

An HRA, including an ICHRA, cannot be part of an employer's cafeteria plan because it can be funded only by the employer (and not employees). However, if the ICHRA negatively impacts the number of non-highly compensated employees participating in the cafeteria plan because they are no longer eligible to participate in the employer's traditional group medical plan, or if employees are permitted to pay for individual health coverage purchased outside the public Marketplace pre-tax through the employer's cafeteria plan, discrimination issues may arise under §125 nondiscrimination rules.

Medicare Secondary Payer (MSP)

MSP rules determine coordination of benefits between an employer's group health plan and Medicare. When the employer's group health plan is the primary payer, the employer is generally required to offer Medicare-eligible employees (and their spouses) the same benefits at the same cost as those offered to younger eligible employees, and the employer is prohibited from incenting Medicare-eligible individuals to waive the employer's group health plan in favor of Medicare coverage.

Employers are permitted to offer an ICHRA to those eligible for or enrolled in Medicare, and they may also allow reimbursement of Medicare premiums without violating the MSP rules, so long as the ICHRA is not designed to reimburse only expenses not covered by Medicare.

The ICHRA is considered a group health plan and therefore generally is the primary payer to Medicare.

Age Discrimination in Employment Act (ADEA)

When determining how much the employer will make available for reimbursement via the ICHRA, employers must also consider ADEA rules, which restrict an employer's ability to discriminate against older employees. An opinion letter issued by the EEOC addressed two scenarios and clarified they are permitted under ADEA rules:

(i) an ICHRA offering where the employer makes the same monthly dollar amount available to all ICHRA participants; and

(ii) an ICHRA offering where the employer increases the monthly dollar amount by employee age (with older employees receiving more).

The first scenario is okay because the employer is making the same amount available to all participants regardless of age. The second scenario is okay as well, whether the amount made available by the employer reflects a percentage of the individual's health insurance premium or simply increases with an employee's age, because older employees receive a larger monthly amount.

Additional Resources

IRS ICHRA Information

CMS HRA Information

EEOC Opinion Letter on ICHRAs Under the ADEA