

Individual Coverage HRA Model Attestations

Instructions for Individual Coverage HRAs

The Departments of the Treasury, Labor, and Health and Human Services (the Departments) have issued final regulations allowing plan sponsors to offer individual coverage health reimbursement arrangements (HRAs), subject to certain requirements.¹ Among other requirements, individual coverage HRAs must implement, and comply with, reasonable procedures to satisfy two substantiation requirements:

- **The annual coverage substantiation requirement:** The HRA must substantiate that participants and each dependent covered by the HRA are, or will be, enrolled in individual health insurance coverage or Medicare Part A and B or Medicare Part C for the plan year (or for the portion of the plan year the individual is covered by the HRA, if applicable).
- **The ongoing substantiation requirement:** The HRA may not reimburse a medical care expense unless, prior to the reimbursement, the participant substantiates that the individual on whose behalf the reimbursement is requested is (or was) enrolled in individual health insurance coverage or Medicare Part A and B or Medicare Part C for the month during which the medical care expense was incurred.

Each of these substantiation requirements may be satisfied by a participant attestation, among other permissible methods. Other methods include providing a third party document or, for the ongoing substantiation requirement, direct payment of insurance premiums, which the Departments expect will be a method some HRAs prefer.² The Departments have developed the attached model attestations for HRAs that choose to use attestation to satisfy either the annual coverage substantiation requirement or the ongoing substantiation requirement.

To use the model attestations properly, the HRA must fill in the additional information specific to the HRA, such as contact information, which is indicated by *italicized* prompts in brackets. The Departments consider the use of the model attestations to constitute reasonable procedures that satisfy the annual coverage substantiation requirement and the ongoing substantiation requirement, as applicable. Use of the model attestations is not required, and the models may be combined with other documents, such as the form the HRA otherwise uses to confirm that expenses sought to be reimbursed under an HRA are for medical care. The model attestations also may be modified to reflect the terms of the particular HRA, for example, to remove the attestations that relate to family members, if the HRA does not cover family members.

NOTE: Individual coverage HRAs should *not* include this instructions page with the individual coverage HRA attestation forms provided to participants.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1361. This information collection is associated with the substantiation requirements for individual coverage HRAs. The time required to complete this information collection is estimated to be minimal per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. This information collection is required to obtain or retain a benefit (45 CFR 146.123(c)(5)). If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850 or adam.pellillo@cms.hhs.gov, Attention: Information Collections Clearance Officer.

¹ See 26 CFR 54.9802-4, 29 CFR 2590.702-2, and 45 CFR 146.123.

² See the final regulations (26 CFR 54.9802-4(c)(5), 29 CFR 2590.702-2(c)(5) and 45 CFR 146.123(c)(5)) for additional information.

Individual Coverage HRA Model Attestation: Annual Coverage Substantiation Requirement

Instructions: You have been offered an individual coverage health reimbursement arrangement (HRA) to help you pay for medical care expenses. To enroll in this individual coverage HRA, you must be enrolled in individual health insurance coverage, Medicare Part A (Hospital Insurance) and B (Medical Insurance), or Medicare Part C (Medicare Advantage). You should have received a notice that describes the individual coverage HRA that you are being offered. If you have not, or if you have questions about the individual coverage HRA, contact [add contact information].

If you plan to enroll in the individual coverage HRA, you must complete this form to confirm that you will have individual health insurance coverage, Medicare Part A and B, or Medicare Part C while you are covered by the HRA. If your family members will also be covered by the individual coverage HRA, you need to fill out the applicable section of this form on their behalf.

You must sign and date the form. Your family members do not need to sign or date the form. Please return the completed form to [add instructions for returning the form]. You must return the form by [add deadline for returning the form].

I attest to the following:

I, _____, am covered (or will be covered) by the following health
(insert name)
coverage: _____.
(insert name of insurance company or indicate "Medicare")

This health coverage began (or will begin) on _____.
(insert date coverage began or will begin)

Instructions: Complete the following if you plan to enroll a family member in the individual coverage HRA. If more than one family member will be covered by the individual coverage HRA, fill out a form for each family member. [This section may also be copied to allow a participant to list all family members on a single form.]

The following family member, _____, is covered (or will be covered) by
(insert name)
the following health coverage: _____.
(insert name of insurance company or indicate "Medicare")

This health coverage began (or will begin) on _____.
(insert date coverage began or will begin)

I hereby affirm that the above information is true and accurate.

Signed: _____

Date: _____

Individual Coverage HRA Model Attestation: Ongoing Substantiation Requirement

Instructions: To receive reimbursement for medical care expenses under your individual coverage health reimbursement arrangement (HRA), you must complete this form for each request for reimbursement.

The individual coverage HRA will reimburse you for a medical care expense incurred during a month only if you have (or had) individual health insurance coverage, Medicare Part A (Hospital Insurance) and B (Medical Insurance), or Medicare Part C (Medicare Advantage) during that month. Similarly, the individual coverage HRA will reimburse you for a medical care expense your family member incurred during a month only if the family member has (or had) individual health insurance coverage, Medicare Part A and B, or Medicare Part C during that month. In this form, you are attesting that you (or your family member) meet this requirement. *[If this form is not combined with the form used to seek reimbursement of medical care expenses, add a statement that the reimbursement form is separate.]*

You must sign and date this form. Your family member does not need to sign or date the form. Please return the completed form to *[add instructions for returning the form, including any applicable deadline]*.

Complete the following if you're requesting reimbursement of your medical care expense from the individual coverage HRA.

I attest to the following:

I, _____, am requesting reimbursement for a medical care
(insert name)
expense incurred during _____, and for that month I am (or was) covered under
(insert month, year)
the following health coverage: _____.
(insert name of insurance company or indicate "Medicare")

Instructions: Complete the following if you're requesting reimbursement of a family member's medical care expense from the individual coverage HRA.

I, _____, am requesting reimbursement for a medical care expense
(insert name)
incurred by _____, during _____, and
(insert name of family member) (insert month, year)
for that month this family member is (or was) covered under the following health coverage:

(insert name of insurance company or indicate "Medicare")

I hereby affirm that the above information is true and accurate.

Signed: _____

Date: _____