Insight

# Sizing Up the Final HRA Rule

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## EXECUTIVE SUMMARY


- Before the Affordable Care Act (ACA), Health Reimbursement Arrangements (HRAs) allowed employees to use tax-preferred dollars to purchase individual market insurance or *a la carte* health care services; the ACA outlawed most uses of HRAs.
- The Trump Administration has finalized a rule that will allow employers, beginning in January 2020, to offer their employees individual-coverage HRAs that employees could then use to purchase individual market health insurance with an HRA; the rule contains stipulations intended to prevent employers from moving less healthy employees onto the individual market.
- An analysis of the rule by the Treasury Department indicates the rule could boost individual market enrollment, helping to further stabilize the market, while decreasing the number of people without insurance.


## HRAS BEFORE THIS RULE

Last week, the Trump Administration finalized a rule that will expand the use of Health Reimbursement Arrangements (HRAs). [1] The rule rolls back Obama Administration-era regulations that curtailed HRAs when implementing the Affordable Care Act (ACA).

Before the ACA, HRAs served as a vehicle that allowed employees to purchase a non-group insurance plan of their choice or *a la carte* health care services. Employees could then submit receipts to their employer, who would then reimburse them for those expenditures with pre-tax dollars. This arrangement was appealing to employers—especially small employers—as they could provide employees the means to purchase health insurance without assuming the risk of providing insurance.

Several requirements in the ACA—most notably the essential health benefits and the prohibition on annual and lifetime limits on health insurance—severely curtailed this option. HRAs were considered a form of group plan under the ACA, meaning that any employer offering a stand-alone HRA would violate the ACA and expose itself to crippling penalties. HRAs have a limit on spending, which was considered an annual limit even when the HRA was enough to purchase individual market insurance. The ACA all but eliminated this form of HRA, though the 21st Century Cures Act created an exception for a qualified small employer health reimbursement arrangements (QSEHRA).[2] Firms with 50 or fewer employees use QSEHRAs for premiums of ACA-compliant qualified health plans (QHP). Currently, roughly 10 percent of group plans couple an HRA with some sort of high-deductible health plan.[3]

## WHAT THE FINALIZED RULE WILL DO

The final rule expands HRAs by removing previous rules that barred the use of HRAs for purchasing individual market insurance. The rule stipulates that the newly created "individual coverage HRAs" must be used to purchase individual market insurance for the HRA to be legal. Under the rule, the HRA must be used to buy insurance in the individual health insurance market; an individual coverage HRA could not be used to purchase, for example, a short-term limited duration insurance (STLDI) plan.

The rule predicts that, in the absence of restrictions, employers would seek to place their unhealthy employees into HRAs so that they could take on less risk in their traditional group plans. Such a scenario would increase adverse selection in the individual market and increase premiums. The rule seeks to prevent this outcome by placing restrictions on how employers decide who receives an HRA versus traditional group insurance. Employers can only discriminate based on different "classes" of employees that are defined in the rule. The classes are as follows:

- Full time;
- Part time;
- Seasonal;
- Employees covered by a collective bargaining agreement;
- Employees that have not satisfied a waiting period for coverage;
- Employees who have not attained age 25 prior to the beginning of the plan year;
- Foreign employees who work abroad;
- Employees whose primary site of employment is in the same rating area;
- Salaried employees;
- Non-salaried employees; and
- Employees of an entity that hired the employees for temporary placement at an unrelated entity.

Beyond deciding who receives an HRA, employers will be unable to change the generosity of the HRA within a class based on health. Within a class, employers will only be able to alter the generosity of an HRA based on age and household size, parameters which coincide with the ACA's community rating guidelines for insurers.

Next, the rule will give those eligible for premium tax credits in the individual market the ability to opt out of their HRA and into the tax credit. It stipulates that employers must notify their employees if their HRA affects their ability to claim the ACA's premium tax credit, cost-sharing reductions, or both.

Finally, the rule will create "excepted benefit" HRA so that employers can reimburse employees for various qualified medical expenses. These are HRAs that could be offered on top of an employee's traditional group coverage, Medicare, TRICARE, or individual health insurance coverage. The rule sets out four main stipulations for an HRA to qualify as an excepted-benefit HRA:

- Other group-plan coverage must be made available to the employee;
- Employers could not offer more than $1,800 in 2020, an amount that will grow by inflation (CPI-U) for subsequent years;
- The HRA will not render a person ineligible for premium tax credits;
- The HRA could not be used for premiums for individual health insurance, group health insurance, or Medicare parts B or D, although it could be used for STLDI or COBRA premiums; and

Excepted-benefit HRAs must have uniform availability—employers can't discriminate based on health status—and the proposed rule requests comment on what additional standards are needed to prevent health discrimination for excepted-benefit HRAs.

## WHY IT MATTERS

HRAs were an unnecessary casualty of the ACA. This rule should give employers, who were forced into all-or-nothing decisions regarding their employees' health care, some flexibility and relief. The binary decision the ACA forced on employers likely reduced insurance coverage among employers who could not afford full insurance, so it stands to reason that increased flexibility will increase coverage. The rule comes with some Treasury Department analysis to back this claim up. The table below gives an overview of Treasury's findings.

### Table 1 – Estimated Effects from Treasury Study[4]

| **Calendar Year** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** | **2029** |
|---|---|---|---|---|---|---|---|---|---|---|
| **Change in Coverage (Millions)** | | | | | | | | | | |
| Individual health insurance coverage with HRA | 1.1 | 2.7 | 5.3 | 8.1 | 10.9 | 11.0 | 11.2 | 11.4 | 11.4 | 11.4 |
| Traditional group health plan | -0.6 | -1.7 | -3.3 | -5.0 | -6.7 | -6.8 | -6.8 | -6.8 | -6.9 | -6.9 |
| Individual health insurance coverage without HRA | -0.4 | -0.9 | -1.8 | -2.7 | -3.6 | -3.6 | -3.7 | -3.8 | -3.8 | -3.8 |
| Uninsured | -0.1 | -0.2 | -0.3 | -0.5 | -0.6 | -0.7 | -0.7 | -0.7 | -0.7 | -0.8 |
| | | | | | | | | | | |
| **Fiscal Year** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** | **2029** |
| **Change in Revenue (Billions)** | | | | | | | | | | |
| Premium Tax Credit Reduction | 0.3 | 0.8 | 1.8 | 3.0 | 4.4 | 4.7 | 5.4 | 5.7 | 6.0 | 6.2 |
| Other Income and Payroll Tax Deductions | 0.5 | 1.7 | 3.8 | 6.4 | 9.4 | 10.9 | 12.6 | 13.9 | 14.7 | 15.5 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Net Revenue Reduction | 0.2 | 1.0 | 1.9 | 3.4 | 5.0 | 6.2 | 7.2 | 8.3 | 8.8 | 9.3 |
| Medicare Part A | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 |
| Medicare Part B | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 |
| Medicare Part D | 0.0 | 0.0 | 0.1 | 0.2 | 0.2 | 0.2 | 0.3 | 0.3 | 0.3 | 0.3 |
| Total Cost | 0.2 | 1.0 | 2.0 | 3.6 | 5.2 | 6.4 | 7.5 | 8.5 | 9.1 | 9.6 |

A few figures from the table stick out. The number of uninsured is expected to decrease and federal revenues are expected to decrease on net. Most significantly, however, individual market insurance coverage is expected to increase by over 10 million by the year 2024. This jump would double the number of people in the individual market and would likely have a significant effect on premiums by stabilizing the individual market. Further, while the Treasury estimates that employees entering the individual market with HRAs will have slightly higher health care expenses on average than those currently in the individual market, this inflow of less healthy individuals will lead to only a 1 percent increase in premiums. Overall, these numbers indicate the Treasury is confident that there will be an increase in individual market enrollment, and that the effect of that increased enrollment on the individual market's risk pool will likely be small.

Overall, the administration's proposed rule on HRAs will give employers and employees more health care options, which could lead to potential increases in the number of insured individuals. It does so while taking steps to limit the individual market's exposure to increased health care costs that employees with pre-existing conditions might bring.

[1] https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-12571.pdf

[2] https://www.congress.gov/bill/114th-congress/house-bill/6

[3] http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018

[4] The original table can be found on page 276 of the final rule.

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