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Evaluating the Administration's Health Reimbursement Arrangement Proposal

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Introduction

On October 29, 2018, the Departments of Labor, the Treasury, and Health and Human Services jointly published a proposed rule that would loosen the rules governing Health Reimbursement Arrangements (HRAs) and other account-based health benefits that employers offer to their employees (Departments 2018).[1] The most important provision of the proposal is to allow employers to use pre-tax dollars to subsidize their employees' purchase of health insurance in the individual market.

This new option would likely be particularly appealing to large employers with sicker workforces.[2] These employers' cost of offering a traditional health plan reflects their workers' above-average health care needs, so subsidizing community-rated individual market coverage could allow them to offer similar coverage at lower cost. Similarly, large employers of all varieties would have an incentive to shift just their sicker workers into the individual market; the departments do propose safeguards that would limit this type of worker-level shifting, but likely not eliminate it.

While these shifts would generate savings that would be shared between employers and their workers, the influx of sicker workers into the individual market would increase premiums, thereby increasing subsidy costs for the federal government and premiums for unsubsidized enrollees. These changes in employer coverage arrangements would also create winners and losers within firms to the extent that firms do not make offsetting changes to their compensation structures, with younger and higher-income workers generally benefiting at the expense of older and lower-income workers. The proliferation of HRAs could also make it hard for consumers to understand their options and comply with the various sets of rules, while imposing new administrative burdens on the Marketplaces.

In our view, the negative effects of allowing firms to subsidize the purchase of individual market coverage, particularly the increase in individual market premiums and the attendant fiscal costs, are likely to outweigh the benefits to employers and their workers. Furthermore, there is reason to doubt that the departments' proposal is legally permissible. We therefore recommend that the departments

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[1] The proposed rule also applies to reimbursement arrangements authorized under IRS Revenue Ruling 61-146 (IRS 1961), which are similar to HRAs. For convenience, this paper uses "HRAs" to encompass both types of arrangements. In addition, on November 19, 2018, the Treasury Department and the IRS released guidance (IRS 2018) addressing the interaction between the proposed regulations and other provisions such as the employer mandate. This guidance is also addressed in this paper.

[2] Throughout, we use the term "large employer" to refer to employers eligible to purchase coverage through the large group market. In most states, the large group market serves employers with more than 50 employees, while smaller employers are served by the small group market. A minority of states set that threshold at 100 employees, rather than 50 employees. The large and small group markets are subject to significantly different rules; notably, the small group market is community-rated, while the large group market is not. Having 50 employees is also generally the cut-off for being subject to the ACA's employer shared responsibility provision, though there are small differences in how the line is drawn for the two purposes.

not finalize this proposal. We also recommend that the departments decline to finalize their proposal to create a separate type of HRA that could be used to purchase short-term, limited-duration coverage. This proposal could allow employers to shift costs from their healthier workers onto their sicker workers and raises its own legal concerns.

If the departments nevertheless move ahead, it is imperative that they retain and strengthen the features of the proposed rule that limit employers' ability to selectively move their sicker workers into the individual market. Failure to retain those provisions could greatly magnify the negative effects of the proposed rule. The departments should also strengthen requirements that employers offering HRAs inform their workers about how that offer affects their eligibility for the premium tax credit.

The remainder of this analysis discusses these points in greater detail. The first section provides background on the rules governing HRAs, and the second section summarizes the departments' proposed rule. The third section examines the effects of the proposal to allow HRAs to be used to purchase individual market coverage, while the fourth section examines the departments' excepted benefits HRA proposal. The fifth section discusses compliance and administrative challenges created by the rule as a whole, and the sixth section examines legal concerns the proposals raise. We close by providing our overall assessment and making recommendations for the final rule.

Background on HRAs

Under long-standing tax law, employer-provided health benefits are generally excluded from income for federal and state tax purposes. Most employers offer health benefits to their workers by setting up a traditional health plan that pays medical claims. However, some employers prefer to offer an account-based benefit that employees can use to pay their own health-related expenses like premiums, copays, and direct payments for medical services. For example, since 2002, the IRS has recognized HRAs as a tax-preferred account-based health benefit. Like other types of employer-provided health benefits, HRAs are a considered group health plan under federal health law.

The Affordable Care Act (ACA) placed a number of requirements on all group health plans. The new rules include requirements that plans cover preventive services without cost-sharing and that plans refrain from imposing annual or lifetime dollar limits on core health benefits; this set of ACA requirements is commonly referred to as the "market reforms." Account-based arrangements like HRAs are typically not able to meet these standards: such arrangements inherently include an annual dollar limit on the amount reimbursed, and even if HRA dollars can be used to pay for preventive services, the "coverage" is limited to the value of the account. Thus, HRAs and other similar arrangements are generally prohibited under the ACA.

However, beginning in 2010, the departments issued guidance and regulations creating limited exceptions to this prohibition. Under those rules, an HRA could be deemed to comply with ACA requirements if it were "integrated"—that is, provided together—with certain health plans that met those requirements. Initially, HRAs could be integrated only with traditional health plans offered by the employer (Departments 2010). This rule recognized that two group health plans provided together are functionally equivalent to a single group health plan that satisfies the ACA requirements. Later guidance permitted the employer to offer an HRA that could be used to pay for expenses in Tricare or Medicare, but only as long as the employer continued to offer traditional coverage that satisfied the market reforms (IRS 2015).[3] Integration was not permitted with individual market coverage, largely for the policy and legal reasons discussed in the remainder of this analysis.

Congress created a limited exception to this general policy in 2016 as part of the 21st Century Cures Act. Congress created a new account-based health benefit similar to an HRA called a Qualified Small Employer Health Reimbursement Arrangement, or QSEHRA. QSEHRAs allow employers with fewer than 50 full-time employees to provide tax-preferred subsidies to employees to purchase individual market coverage. Larger employers are not eligible to create QSEHRAs.

Overview of the Administration's Proposed Policy Changes

In their proposed rule, the departments propose creating two new kinds of HRAs not permitted under current policy:

- **Individual-market-integrated HRA:** The departments propose permitting HRAs that can be integrated with individual market coverage, but only if certain conditions are met. Specifically, a firm can offer an HRA that can be integrated with individual market coverage if it offers such an HRA to *all* similarly situated workers, if those workers are *not* offered a traditional health plan, and if the firm verifies that only employees who actually enroll in individual market coverage receive the HRA dollars. This provision is likely to have the most significant effects in practice.
- **Excepted benefit HRA:** The departments also propose a second type of HRA that will be considered an "excepted benefit." Excepted benefits are exempt from the ACA requirements discussed above, so these HRAs do not need to be "integrated" with other coverage. Excepted benefit HRAs are capped at $1,800 and can be used for only a limited set of purposes, *not* including purchase of individual market coverage or traditional group coverage (except COBRA coverage). Notably, however, they can be used to pay premiums for short-term plans.

[3] The departments took one additional step to address an unusual fact pattern. In a 2015 rule (Departments, 2015), they created a special type of HRA for very small employers that also wanted to offer an HRA benefit to individuals enrolled in Medicare. Very small employers (with fewer than 20 employers) are the only group that is permitted to decline to offer coverage to individuals eligible for Medicare. Thus, the departments created a conforming type of HRA that those employers could use for their Medicare-eligible workers.

> Further, in contrast to individual-market-integrated HRAs, which can be offered only to employees that are *not* offered a traditional health plan, excepted benefit HRAs can be offered only to employees that *are* offered a traditional health plan (regardless of whether or not they enroll in that plan).

The proposed rule also makes conforming changes to other ACA rules. Of note, it specifies the circumstances under which an individual-market-integrated HRA is considered an "affordable" offer of employer coverage that renders an individual ineligible for the premium tax credit. Under the proposal, an individual-market-integrated HRA would be considered an affordable offer of coverage if it allowed an individual to purchase the lowest-cost individual market silver plan for less than a specific percent of their household income (9.86% in 2019). In addition, it allows individuals newly offered an individual-market-integrated HRA a special enrollment period to purchase individual market coverage.

Finally, the proposed rule promises future guidance about how the proposed regulations interact with other provisions, including the employer shared responsibility provision (also known as the employer mandate) and compensation-based non-discrimination rules. On November 19, the Treasury Department and the IRS took a preliminary step on the additional guidance, releasing a Notice describing the approaches they intend to take (IRS 2018).

Effects of the Individual-Market-Integrated HRA Proposal

We first consider the effects of the individual-market-integrated HRA proposal, which would likely have the farthest-reaching effects. Many large employers with sicker workforces would find it attractive to set up individual-market-integrated HRAs in order to access community-rated individual market premiums. These shifts would generally benefit the firms involved but will likely increase individual market premiums and federal costs. This provision would also create winners and losers within firms to the extent that firms do not make offsetting changes to their compensation structures, with younger and higher-income workers generally gaining at the expense of older and lower-income workers. This section analyzes these effects in detail, and a later section discusses compliance and administrative challenges that the combination of the individual-market-integrated HRA and excepted benefit HRA proposals may create for consumers and state-based Marketplaces.

Overall Effects on Employer Coverage Arrangements and the Individual Market

The effects of this proposal depend crucially on how many and what types of employers are likely to find it attractive to subsidize the purchase of individual market coverage. This depends, in turn, on why employers might find subsidizing the purchase of individual market coverage via an HRA more attractive than the coverage options they would have in the absence of the departments' proposal.

The departments and other proponents of allowing employers to subsidize the purchase of individual market coverage commonly identify three potential advantages this approach might have to employers (Departments 2018; Barkett 2018), each of which are discussed below. We are skeptical, however, that any of these considerations would actually play a particularly large role in employer decision making in practice:

- **Lower administrative burden:** Some argue that subsidizing the purchase of individual market coverage may be administratively simpler for employers than offering a traditional health plan. However, these savings seem likely to be small in practice, if they exist at all. While employers would no longer need to select a health plan to offer, they would need to create a new apparatus to verify employees' eligibility for reimbursement and disburse those amounts. And employers would continue to need to make a range of challenging benefit design decisions, like how much to contribute to the HRA for different types of workers and which workers should be eligible to participate. Moreover, offering health benefits via the individual market creates new administrative burdens for workers, who must now select and enroll in a suitable plan. Workers are likely to force employers to take some account of those costs in practice.
- **Greater employee choice:** Another advantage sometimes ascribed to this way of sponsoring health benefits is that it allows employers to offer enrollees a choice among different types of plans and choose one that meets their needs. Offering greater choice may be valuable to employees, and it is true that the individual market offers a choice of multiple insurers and a large number of plans in most of the country (Fehr, Cox, and Levitt 2018). However, employers already can and do offer multiple traditional health plan options to their employees either directly or via so-called private exchanges, so the ability to offer the choice of multiple options is not an advantage of individual-market-integrated HRAs in particular. Moreover, it is notable that the share of employers providing coverage through private exchanges remains relatively small (Accenture 2016), which suggests that the ability to offer employees choice may not have much value in practice.
- **Ability to offer health benefits on a "defined contribution" basis:** A final suggested advantage is that offering an individual-market-integrated HRA would allow employers to take a "defined contribution" approach to offering health benefits in which they specify a fixed dollar amount they will contribute and allow enrollees to choose how to use that fixed contribution. But firms that offer multiple traditional health plan options, either on their own or via a private exchange, can already take this approach, so whatever the merits of this benefit design, it is not a reason to set up an individual-market-integrated HRA in particular.

Rather, the main attraction of offering an individual-market-integrated HRA would likely be that individual market premiums are community-rated, meaning that they do not vary based on health status. Today, large employers' only options to provide coverage are to self-insure or to purchase experience-rated coverage from an insurer; under either of these options, large employers with sicker enrolled populations pay more to obtain coverage and bear higher costs to cover their sicker workers than their healthy ones. For this reason, large employers could realize large benefits from offloading sicker workers into the individual market via an HRA. (Small employers would have no incentive to undertake this type of shifting since small group market premiums are community-rated.) This shifting could happen either at the individual level, with a firm's sicker workers moving to the individual market while healthier workers remain in a traditional health plan, or at the firm level, with firms with sicker-than-average workforces moving all their employees to the individual market.

The departments make clear that they are aware of the risk that expanded use of HRAs could cause an influx of sicker workers into the individual market, particularly if firms are able to encourage only sicker workers to enroll in individual market coverage. The departments' proposal includes two types of safeguards that aim to prevent this type of shifting:

- **Preventing employers from offering individual market HRAs selectively to sicker workers:** The most direct way in which employers might steer only their sicker workers into individual market coverage would be by offering individual-market-integrated HRAs solely to those workers. To prevent firms from doing so, the rule requires individual-market-integrated HRAs be offered to entire classes of workers (rather than to specific workers). However, the rule allows employers to delineate classes based on any combination of a relatively broad set of worker characteristics: (1) full-time employment; (2) part-time employment; (3) seasonal employment; (4) membership in a collective bargaining unit; (5) not having satisfied a waiting period for coverage eligibility; (6) not having attained age 25; (7) being a non-resident alien; and (8) rating area of employment. In addition, firms with common ownership would be treated as separate firms in applying these rules; this is in contrast to the common practice of requiring firms with common ownership to be treated as a single "controlled group" for purposes of provisions related to firm size and segmentation, given the ease with which firms can spin off wholly owned subsidiaries.[4]
- **Preventing workers from choosing between individual market and other coverage:** Another way employers might steer sicker workers into the individual market would be to offer workers a choice between individual market coverage and a traditional health plan that is designed to be unattractive to sicker workers. To prevent this behavior, the

[4] For example, controlled-group aggregation rules apply with respect to the compensation-based nondiscrimination rules under Code section 105(h), the retiree benefit rules under Code section 401 and subsequent sections, the ACA's employer shared responsibility provision under Code section 4890H, the health insurer fee under ACA section 9010, the small employer health insurance tax credit under Code section 45R, and the pharmaceutical manufacturer fee under ACA section 9008.

proposed rule permits employers to offer an individual-market-integrated HRA only to employees who are not offered a traditional health plan.

The departments also bar other arrangements that might result in sicker workers opting for individual market coverage and healthier workers opting for other coverage. Most importantly, the proposed rule bars funds from an individual-market-integrated HRA from being used to purchase short-term plans, an option that may appeal to many healthier workers and be completely unavailable to sicker workers. The departments also note that allowing an individual-market-integrated HRA to be used to purchase short-term plans would raise legal concerns, given that short-term plans do not necessarily satisfy the ACA requirements regarding annual and lifetime limits and preventive services. However, the departments solicit comment on relaxing this restriction.

Similarly, the employer must verify individual market enrollment before making dollars available in the HRA, preventing healthier workers from simply using the amounts in the HRA to pay directly for health care services without purchasing individual market coverage.

While these safeguards are important, they are likely insufficient to fully protect the individual market risk pool. First, despite the proposed requirement that an individual-market-integrated HRA be offered to all similarly situated workers, employers have broad flexibility to decide what workers are "similarly situated." In particular, they can use any combination of the permitted characteristics, which would create opportunities for employers to target HRAs to high-cost classes of workers. For example, these rules may allow a mid-size employer with a single high-cost worker or family to direct that worker to the individual market by subdividing its workforce using the allowed characteristics. Further, there is nothing to restrain risk-based targeting in cases where sicker workers are naturally congregated in one geographic area or class. This type of risk is potentially greatest in states where rating areas cover a relatively small geographic area, as it allows the finest-grained sorting of individuals into classes.[5]

Second, the structure of the rule does nothing to prevent firm-level shifting. As discussed above, firms with a sicker-than-average workforce would likely find an individual-market-integrated HRA attractive, because it would allow them to shift the cost of covering their workforce to the community-rated individual market risk pool. By contrast, healthier-than-average firms would prefer traditional coverage priced based on their own risk. Importantly, the risks to the individual market from this type of behavior are greatest in states that today have a relatively robust and low-premium individual market – because the gulf between the community-rated individual market and the experience-rated

[5] Rating areas across the country vary widely in size. In Florida, for example, each county generally constitutes its own rating area – generating some very small rating areas in rural communities. By contrast, in many other states, rating areas encompass entire metropolitan areas, with non-metropolitan parts of the state all grouped together into a single rating area.

premiums of a sicker-than-average firm are greatest, leaving more relatively unhealthy firms in the range where they benefit from shifting.

Allowing HRAs to be used to purchase individual market coverage could have a countervailing benefit for the individual market. Some firms that are not currently providing coverage – leaving workers to seek coverage in the individual market – may be enticed to set up individual-market-integrated HRAs in order to allow those purchases to be made with pre-tax dollars. It is plausible that the sicker workers at these firms are typically purchasing individual market coverage today, while healthier workers are less likely to do so. To the extent offering the HRA increases individual market enrollment among these firms' healthier workers, this could improve the individual market risk pool.

In the economic impact analysis included with the proposed rule, the departments estimate that the individual-market-integrated HRA proposal would increase individual market premiums by "less than 1 percent" in the long run, while reducing the number of uninsured by 800,000 by 2028, at a cost of $6 billion in that year. These estimates are likely too optimistic, for several reasons.

First, the departments simply assume that the safeguards included in the proposed rule will entirely prevent employers from selectively moving their sicker workers into the individual market, which, as discussed, is likely overly optimistic. Second, the departments' analysis does not appear to account for the substantial variation in individual market risk mix across areas, which would cause the departments to understate the degree of firm-level shifting. Third, the departments' analysis may understate the variation in health status across employers' workforces because it does not appear to account for the full set of factors driving that variation, which would also lead the departments to understate the degree of firm-level shifting under the proposed rule. Finally, it is unclear whether the departments have accounted for the possibility that enrolling in coverage via an individual-market-integrated HRA may be more difficult than enrolling in a traditional health plan, which could cause the departments to overstate the coverage gains under the proposed rule.

We also note that the fact that employers have shown little interest in QSEHRAs is not evidence that employers would be similarly uninterested in individual-market-integrated HRAs. First, QSEHRAs are only available to small employers. Small employers already have access to the community-rated small group market, so gaining access to community-rated coverage via the individual market is not particularly valuable. By contrast, individual-market-integrated HRAs would be available to large employers who currently cannot access community-rated coverage any other way. Second, the rules governing interactions between QSEHRAs and the premium tax credit are far less favorable to employers than the rules that apply under traditional health plans and the rules that would apply to individual-market-integrated HRAs.[6] These two factors are likely why CBO and JCT expected QSEHRAs to have negligible deficit impact (CBO 2016).

Distributional Effects Across Different Groups of Employees

The changes in how some employers structure their health benefits spurred by the individual-market-integrated HRA would also create winners and losers among those employers' workers to the extent employers do not make offsetting changes to their compensation structures. In general, older and lower-income workers would be most likely to be left worse off, while younger and higher-income workers would be most likely to benefit.

Redistribution Across Age Groups. Firms that transition from offering a traditional health plan to offering an HRA could shift costs from younger to older workers. Currently, health plans are generally structured so that employees' cost to enroll does not vary by age. Because individual market premiums are generally age-rated, with premiums for older enrollees up to three times the premium for younger enrollees, achieving the same outcome under an individual-market-integrated HRA would require employers to contribute more to the HRA of their older workers than they do for their younger ones. Employers offering account-based benefits like HRAs and Flexible Spending Accounts (FSA)s have traditionally been barred from varying their contributions in this way. However, the proposed rule and the supplementary notice promise changes that would allow employers to vary HRA contributions to account for age-based premium variation, but they do not require it.[7]

There are reasons that employers switching from a traditional benefit to an individual-market-integrated HRA may seek to hold their older workers harmless. As noted above, employers generally hold employee contributions to traditional health plans constant across age groups, and this approach implicitly requires employers to contribute more to the coverage of older workers since the cost of covering older workers is generally higher than the cost for younger workers. Employers may have arrived at this structure because it is the optimal strategy for attracting and retaining workers of different ages. In addition, larger employers may wish to ensure that their older workers have

[6] In particular, if coverage through a QSEHRA is deemed "unaffordable" and the employee becomes eligible for the premium tax credit, the employee's premium tax credit is reduced by the amount of the QSEHRA contribution. In contrast, if coverage is deemed unaffordable to an employee under a traditional health plan or an individual-market-integrated HRA, the employee generally receives the full premium tax credit.

[7] The Treasury notice provides a safe harbor under the compensation-based non-discrimination rules for cases where "the maximum dollar amount made available to employees who are members of a particular class of employees increases *in accordance with* the increases in the price of an individual health insurance coverage policy in the relevant individual insurance market based on the ages of the employees who are members of that class of employees" (IRS 2018 (emphasis added)). The guidance does not specify what it means for the HRA amounts to increase "in accordance" with the premium based on age. For example, if the ratio of the HRAs were limited to the ratio of premiums based on age, then this would generally not be sufficient to hold older workers harmless. For purposes of this paper, we assume that the safe harbor will permit HRA amounts be set in the even larger ratios necessary to hold older workers harmless.

"affordable" offers of insurance coverage in order to avoid liability under the employer shared responsibility provisions. Both rationales apply with roughly equal force in the HRA context as in the context of a traditional health plan, which could lead employers to seek to hold employees' cost of enrollment constant by age when transitioning to an HRA.

However, it seems likely that some firms, particularly smaller firms not subject to the employer shared responsibility requirement, will not vary HRA contributions by age sufficiently to insulate older workers from increased premiums. Brokers marketing QSEHRAs tend to emphasize flat contributions, even though QSEHRA contributions also may be varied by age (Take Command Health).

Indeed, there are at least two differences between individual-market-integrated HRAs and traditional health plans that may lead employers to treat older and younger workers differently in the two settings:

- While it is administratively simpler to charge employees a uniform premium to enroll in traditional coverage, this dynamic is flipped with an HRA. Under the HRA, it is simpler to provide a flat HRA contribution than to customize contributions to ensure that older and younger workers pay the same amount for coverage. This factor may be particularly important to the extent employers switching to HRAs are motivated by avoiding the administrative cost of offering a traditional health plan, although vendors selling HRA products could simplify the age smoothing for employers to a significant degree.

- Employee perceptions of fairness, which arguably encourage employers to hold employee contributions constant by age in traditional health plans, may have the opposite effect in the context of an HRA. For a traditional health plan, the employee contribution is highly visible, so holding it constant may seem like the fairest approach. (Similarly, the actual cost of coverage by age is completely opaque to the individual and may not even be computed by the employer.)

  By contrast, HRAs make the employer contribution visible and hide the employee's share, so holding the employer contribution constant may seem fairer to employees in the context of an HRA. Indeed, HRA contributions would need to vary widely by age to hold older workers harmless. Allowing an older worker to purchase coverage for the same amount as a younger worker would generally require the ratio of their HRA amounts to be *larger* than the ratio of their unsubsidized premiums. For example, if a silver plan costs $4,000 for a 21-year-old and $12,000 for a 64-year old, allowing each to purchase the plan for $2,000 would require an HRA of $2,000 for the 21-year-old and $10,000 for the 65-year-old, a ratio of 5:1. Making such large discrepancies salient—even if it merely reproduces what was previously happening under the traditional health plan—may create significant resentment among younger workers.

It is important to note that, even if older workers do end up contributing more to their coverage and younger workers less at firms providing coverage through individual-market-integrated HRAs, those changes could be offset in whole or in part by changes in wages for different classes of workers. Whether and how quickly those changes in wages would occur is uncertain, however. And even if changes in wages could hold the age profile of total compensation constant, changes in the cost of enrolling in coverage by age would still likely reshape the age profile of enrollment.

Redistribution Across Income Groups. Firms that transition from offering no coverage to offering an HRA could make their low-income workers worse off while making their high-income workers better off because of interactions with the premium tax credit (PTC) and cost-sharing reductions (CSRs). Under the proposal, low- and moderate-income workers at firms that elect to provide a sufficiently generous HRA contribution would lose access to these subsidies, even where the HRA contribution is substantially less generous than the subsidies. The benefit of using pre-tax dollars to pay individual market premiums would typically fall short of offsetting this loss, in part because these workers generally have low marginal tax rates and so receive less benefit from compensation being tax-free. Conversely, employees with incomes over 400 percent of the poverty level are already subsidy-ineligible and generally benefit more from being permitted to pay for individual market premiums at least in part with pre-tax dollars.

Thus, to the extent firms that would otherwise not offer coverage begin doing so with an individual-market-integrated HRA, it could benefit higher-income employees at the expense of lower-income employees. Over time, it is likely that wages for different groups of workers at these firms would adjust to offset the loss of the PTC, at least to some extent, or that low-income workers would leave for firms that do not offer coverage in order to retain access to the PTC. But there is nevertheless some risk of adverse distributional impacts, especially in the short term.

Effects of the Excepted Benefit HRA Proposal

The proposed excepted benefit HRAs are generally likely to have smaller effects than the individual-market-integrated HRAs because they cannot be used to purchase individual market coverage and, thus, are unlikely to have significant effects on that market. Like the individual-market-integrated HRA, however, this proposal may have some distributional impacts, specifically shifting costs from younger and healthier workers to older and sicker workers.

Notably, some firms may wish to shift costs from their healthier to their sicker workers to the extent they believe that the benefits of improved recruiting and retention among younger and healthier workers will outweigh the corresponding costs among older and sicker workers. Firms have some options to achieve such a cost shift today, like offering a relatively stingy traditional health plan health benefit designed to appeal to their healthier workers at a low premium and offering a more generous plan designed to appeal to their sicker workers at a higher premium. But the excepted benefit HRA may provide a particularly effective means of doing so because it can be used to provide access to underwritten coverage that is particularly unattractive (and frequently unavailable) to sicker workers.

In particular, under the proposal, the excepted benefits HRA would be offered to workers that are also offered traditional coverage, but employees would not be required to enroll in such coverage in order to receive the HRA. As a result, younger and healthier workers may find it attractive to decline employer sponsored coverage, and instead use HRA funds to obtain a short-term limited -duration product that is underwritten and does not offer full benefits, or to use HRA funds to pay incurred medical expenses directly. This would leave disproportionately older and sicker workers in the traditional employer plan – driving up per capita costs for that coverage. Employers could respond to that change by increasing their per capita contribution, or by shifting those costs to the older and sicker workers that remain in such coverage, although they would be limited to some degree in doing so by the risk of incurring penalties under the ACA's employer mandate.

Compliance and Administrative Challenges

In addition to the policy impacts discussed above of each of the new proposed HRA varieties, the two of them together would create compliance and administrative challenges for consumers and state-based Marketplaces. These challenges stem from how the new HRAs would interact with existing marketplace subsidies. In addition, the new special enrollment period for employees newly offered individual-market-integrated HRAs will pose additional challenges for Marketplaces.

Proliferation of HRA Varieties May Be Confusing for Employees. Creating two new varieties of HRAs on top of those that already exist, each of which affects consumers' eligibility for the premium tax credit in different ways, has the potential to create confusion for employees. If this proposal is finalized, there will be four different types of benefits referred to as HRAs that employees could receive – an HRA integrated with group or other coverage under the pre-2018 rules, an individual-market-integrated HRA, an excepted benefits HRA, and a QSEHRA.

Each HRA flavor affects eligibility for the PTC and other tax benefits in different ways, so it is crucial that employees understand which one they are offered and the attendant rules. Specifically, each variety requires a different calculation to determine whether it is considered an affordable offer of employer coverage, and each has different implications depending on that determination. For example, an individual-market-integrated HRA is considered unaffordable based on integration with the lowest-cost silver plan – a different standard from all the others. If the combination is deemed unaffordable, the employee will need to purchase coverage through the Marketplace to receive PTC. But if the combination is deemed affordable, the employee will generally need to purchase coverage off-Marketplace so she can pay for her share of the premium with pre-tax dollars – again, a rule that applies to none of the other types of HRAs.

Employees offered an individual market-integrated-HRA will receive a notice explaining the relevant rules under the proposal, just as those offered a QSEHRA do today. But those receiving the other varieties of HRAs will not. We expect it will be extremely difficult for individual consumers – and even professional assisters – to correctly identify what type of HRA an individual is offered and how that affects their options. Mistaking one flavor for another or misunderstanding the rules could lead consumers to miss out on subsidies for which they are eligible or receive subsidies for which they are ineligible and may be required to repay.

Employers could mitigate some of this confusion by working with specialized agents and brokers to facilitate individual decisions, and we would expect significant employer-facilitated broker involvement if the proposal is finalized. Nonetheless, some employees might still be left to navigate this environment on their own. And even with professional assistance, there will be circumstances where the employer and employee interest diverge (such as when it is in a worker's interest to decline and HRA and receive PTC, exposing her employer to potential penalties under the employer mandate) so that a broker partnering with the employer may not be well situated to advise the individual. This confusion might be exacerbated by the recent deep cuts (Keith 2018) in Marketplace navigator funding.

Administrative Impact on State-Based Marketplaces. Making APTC eligibility determinations requires the Marketplaces to collect accurate information about employment-related benefits an applicant is offered and then to apply the relevant eligibility rule. To do this, the Marketplace asks a series of detailed questions and embeds the various rules into their eligibility logic. The rules are extensive, complicated, and interconnected – and making even small changes that seem logically discrete requires expensive and time-consuming testing throughout the eligibility system. Incorporating the new HRAs in time for the open enrollment period beginning in the fall of 2019 is likely infeasible.

Similarly, special enrollment period eligibility rules are embedded in the Marketplace architecture; adding an additional eligibility category requires expensive and time-consuming software modifications.

Legal Concerns

Beyond the policy concerns outlined above, we believe that the proposed regulations raise significant legal concerns. We address concerns related to the individual-market-integrated HRA and excepted benefit HRA in turn.

Individual-Market-Integrated HRA

We are concerned that deeming an individual-market-integrated HRA to satisfy the market reforms may exceed the departments authority under the statute. As discussed earlier, the ACA applies the market reforms to all types of group health plans (other than excepted benefits), and HRAs standing alone clearly violate the market reforms because they inherently have annual limits and don't provide the required coverage of preventive services.

The departments created the concept of integration through rulemaking to authorize HRAs in a narrow set of circumstances where they are linked to the employer's traditional health plan. In particular, as noted above, the departments concluded that an HRA could be integrated with the employer's own traditional health plan. In that circumstance, the departments determined that the employer's underlying health plan and the HRA could plausibly be considered a single benefit package that together satisfied the market reforms. The traditional plan and the HRA had different features and were formally considered separate group health plans for tax and fiduciary purposes, but from the perspective of the individual employee they were a joint package. Importantly, no one is harmed by allowing the HRA to be integrated with a traditional plan.

In later years, the departments cautiously extended this logic to allow these HRAs to pay for expenses associated with certain analogous benefits, namely, Tricare and Medicare, so long as the employer also offered a traditional health plan with which the HRA could be integrated. Tricare and Medicare provide the same sort of comprehensive coverage as a traditional employer health plan, and they are limited to workers with specific personal circumstances that will generally make the underlying health plan unnecessary. As when an employee is enrolled in an HRA alongside a traditional health plan, no one is harmed when an HRA pays for expenses associated with Tricare and Medicare.

The departments were, however, careful not to extend integration into the individual market. A central goal of the ACA is to create an individual market where healthy and sick individuals without access to employer-sponsored health insurance pool their risk. As noted above, creating a porous boundary between the group and individual markets creates a significant risk of putting upward pressure on individual market premiums. Unlike when HRAs pay for expenses associated with a traditional employer plan or with Tricare and Medicare, integration with the individual market does create potential harm – and that harm goes to one of the core purposes of the ACA. Creating not just winners but also losers greatly weakens the departments' authority to create this additional relief from the statute's general prohibition on HRAs. Thus, the departments had previously concluded that they should not and could not permit HRAs to be integrated with an individual market health plan. Reversing course and permitting individual market integration does not seem to be consistent with the statute.

We also note that unlike most other circumstances where integration is allowed, in the case of the individual market HRA, the employer would no longer be offering a traditional health plan to their workers. This is a major shift: to-date, integration has only been permitted when the employer offers a group health plan that satisfies the market reforms, consistent with the justification that the HRA is considered to satisfy the market reforms because the employer's broader package of coverage satisfies those rules. The individual-market-integrated HRA would be the first time employers would be permitted to have compliance with annual limit and preventive services requirement based solely on the benefits provided by another entity.[8] The ACA does not include any basis for the departments to make this choice.

Further, had Congress intended to allow employers to help employees buy coverage in the individual market, it would have done so directly. Indeed, as noted above, in 2016 Congress created QSEHRAs, which allow certain small employers to offer a benefit that is similar to the individual-market-integrated HRAs. In creating the QSEHRA option, Congress placed careful limits on which employers could use these products and how they had to do so. If the underlying ACA requirements allowed for the individual-market-integrated HRAs, there would have been no reason for Congress to enact separate legislation, and Congress's efforts to limit who could have access to these products would be unnecessary.

In addition, we note that the proposed rule allows integration with grandfathered health plans, even though they need not satisfy the market reforms. It is simply illogical to conclude that an HRA complies with, e.g., the preventive services requirement because it is used to purchase another plan that does *not* comply with the preventive services requirement. The departments explain that this will be a relatively rare circumstance, but that does not provide grounds for their conclusion.

Finally, the departments request comments on whether the final rule should allow an HRA to be integrated with a short-term health insurance. Allowing integration with short-term plans would place even further strain on the concept of integration. First, like grandfathered plans, short-term plans are not themselves subject to the market reforms. Even if a particular short-term plan did cover preventive services and refrain from imposing annual and lifetime limits, the fact that the issuer has voluntarily chosen to design their product in this way does not give enrollees the same protections as if their plan that had a regulatory obligation to comply because there is no enforcement apparatus or private right of action. But even more importantly, allowing a group health plan to be considered "integrated" with a short-term product – which is permitted to discriminate based on health status – would conflict with the core requirement that group health plans may not discriminate based on health status. The departments may not have it both ways: if the HRA and the integrated product are to be considered as a single unit for purposes of assessing compliance with some of the standards that apply to group health plans, then a medically underwritten short-term plan cannot be part of that unit.

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[8] The only other case where integration is allowed in the absence of a compliant plan offered to the employee by the employer is the "special rule" for very small employers that are permitted to make an unusual arrangement for Medicare-eligible employees. And even in that case, the employer is required to provide a compliant plan to their non-Medicare-eligible workers.

Excepted Benefits HRA

We also believe that the creation of a new excepted benefit HRA that can be used to pay premiums for broader insurance benefits may not be permissible under the authority granted to the departments.

Federal law gives the departments authority to define "excepted benefits" that are exempt from many of the substantive requirements applicable to health coverage, including the annual limit and preventive services standards. The proposal designates the excepted benefit HRA as a "limited excepted benefit" – one of the statutory categories. But the departments' ability to designate new kinds of limited excepted benefits is carefully circumscribed in statute; this category is defined as consisting of dental and vision coverage, long-term care benefits, and "such other similar, limited benefits as are specified in regulation." The departments have previously used this grant of authority to define "other similar" benefits to specify that certain health flexible spending arrangements, employee assistance programs, and wrap-around coverage are excepted benefits.

It is difficult to understand how the excepted benefit HRA, as defined in the proposal, can be considered a "limited excepted benefit." Neither dental and vision coverage nor long-term care benefits provide a scope of coverage approaching traditional major medical coverage. By contrast, short-term plans – which excepted benefit HRAs could be used to purchase – are permitted to cover the full range of health care services and can provide benefits similar to traditional insurance (though exactly what benefits they provide and the degree of access for people with pre-existing conditions is not regulated). They are not similar to narrowly-scoped benefits like vision, dental, and long-term care.

Nor do excepted benefit HRAs look like the benefits that have previously been defined as limited excepted benefits by the departments – all of which are insurance-like benefits with very limited scope or account-based benefits that can be used only for very limited purposes. For example, health FSAs are limited to paying out of pocket expenses. Employee Assistance Programs are only considered an excepted benefit if they do not provide "significant benefits in the nature of medical care." The wrap-around benefit is only excepted if it is designed to offer benefits that go beyond individual market coverage, in much the same way that dental and vision benefits supplement a traditional health plan. In all of these cases, there is a clear boundary that distinguishes the excepted benefit from the types of items and services covered in a traditional health plan; short-term plans have none of those inherent limits.

Classifying premium payments as "limited" when the benefit itself is not effectively eliminates the boundary Congress intended to set. Such an approach would allow employers to circumvent the statute and effectively offer these benefits in ways not otherwise permitted.

This argument is buttressed by the fact that federal law expressly treats short-term limited-duration as *not* an excepted benefit. Congress did specify that short-term limited-duration coverage was to be treated differently than other types of insurance – but it did so by saying that the coverage would not be considered part of the individual market, not by adding it as a category of excepted benefits. Allowing premium payments for this type of coverage to become an excepted benefit does not comport with Congress's choice to classify this type of coverage in a different way.

Further, creating a special tax benefit for short-term plans is inconsistent with the structure of the ACA. The ACA expressly disfavors short-term coverage as compared to other kinds of insurance and makes it ineligible for the premium tax credit. As the preamble to the proposed rule notes, this is part of the ACA's general approach of requiring coverage to be adequate and creating a single community-rated risk pool. Thus, the departments' attempt to create a new tax preference for this coverage should be regarded with skepticism.

Overall Assessment and Recommendations for the Final Rule

Based on the policy and legal analysis presented above, we have a number of recommendations for the final rule. We first discuss our recommendations for the individual-market-integrated and excepted benefit HRAs. We close with several cross-cutting recommendations.

Individual-Market-Integrated HRA

The departments' individual-market-integrated HRA proposal would benefit some while imposing costs on others. Large employers with sicker workforces would clearly benefit from the ability to access community-rated premiums in the individual market, and this would often allow those employers to offer coverage to their workers on better terms and could induce some such employers to begin offering coverage. However, as discussed above, these benefits would come at a cost. Notably, individual market premiums would rise, imposing costs for unsubsidized enrollees in the individual market. The federal deficit would also increase due both to higher premium tax credit outlays and, potentially, increased revenue losses attributable to the tax exclusion for employer-provided insurance coverage.

Providing an overall assessment of the policy's effects is challenging both because there is uncertainty about the magnitude of these different effects and because it is not immediately clear how the costs and benefits for different groups should be weighed against each other. Nevertheless, we make our best effort in what follows.

If one relied solely on the departments' regulatory impact analysis, then this proposal appears potentially defensible: the departments predict that the proposal would lead to an increase in insurance coverage of 800,000 by 2028, an increase in the federal deficit of $6 billion in the same year, and only a slight increase in individual market premiums. The implied increase in federal costs per additional person covered is not unreasonably large and is, for example, broadly similar to that associated with policies that increase the generosity of the premium tax credit (Eibner and Liu 2017). Additionally, the HRA policy would improve risk-sharing by relieving employers with very sick workforces of the accompanying health care spending burdens. (On the other hand, as we discussed earlier, this policy could also shift costs from higher-income workers onto lower-income workers in some instances, which we view as cause for concern.)

However, as discussed earlier, we believe that the departments' estimates of the proposal's effects on individual market premiums and the federal budget (and possibly insurance coverage as well) are likely too optimistic. Thus, the overall set of tradeoffs presented by this proposal is likely less attractive, potentially substantially less attractive, than the departments' analysis would suggest.

Moreover, we are inclined to place a particularly heavy weight on the possibility that the proposal could have negative effects on the individual market risk pool. The market currently is in the process of adjusting to a series of relatively significant policy changes, notably the repeal of the individual mandate penalty and the liberalization of rules related to short-term plans. To date, these policy changes have spurred higher premiums, but not significant insurer exists or other disruption. There is a possibility that will change in the years to come, however, if insurers turn out to have underestimated the effect of these changes. In that environment, we view injecting an additional source of downside risk as unwise.

Taken together, these considerations lead us to conclude that the individual-market-integrated HRA proposal would likely do more harm than good. We also note that, as discussed in the last section, there are real questions about whether the departments' proposed approach is consistent with the relevant statutes. In light of these policy and legal concerns, we make the following recommendations:

- **Recommendation #1:** The departments should decline to finalize the proposal to create an individual-market-integrated HRA and should instead maintain the status quo.
- **Recommendation #2:** If the departments nevertheless elect to finalize this proposal, they should retain and strengthen the provisions of the proposed rule that keep employers from shifting only their sicker workers into the individual market. Allowing this type of shifting would greatly magnify the increase in individual market premiums under the proposal, which would in turn substantially increase the proposal's fiscal costs and wipe out much of the potential benefit to large employers with sicker workforces. This is clearly undesirable.

  Specifically, if the departments move forward, we urge them to:

  - Maintain the prohibition on purchasing short-term plans via an individual-market-integrated HRA. As we noted earlier, relaxing this prohibition would also raise significant legal concerns.
  - Maintain the prohibition on offering a traditional health plan alongside an individual-market-integrated HRA and continue to require employers to verify that individuals

enrolled in an individual-market-integrated HRA are actually enrolled in individual market insurance coverage.

- Make it more difficult for employers to selectively offer individual-market-integrated HRAs to subgroups of their workers that have greater health care needs. To this end, the departments should:
  - Not expand the list of factors employers can use when defining the classes of employees to which they offer an individual-market-integrated HRA.
  - Allow employers to combine factors to define classes only in circumstances where the resulting group would be of a sufficient size, such as containing at least 10 percent of the employer's workforce or at least 100 employees.
  - Apply controlled-group aggregation rules when determining when entities with common ownership are considered a single employer to prevent employers from circumventing these rules through reorganization.
  - Modify the regulation to take into account all the relevant facts and circumstances in determining whether the HRA offer was targeted towards sicker workers. That is, rather than treating an offer based on the eight permitted characteristics as permissible in all cases, they should instead specify that use of the eight characteristics would be evidence of a neutral intent, but would not insulate an employer if there was other evidence of targeting.

Excepted Benefit HRA

We believe that the main effect of this proposal would be to give some employers a tool to shift costs away from their healthier workers and toward their sicker workers, a shift we view as clearly undesirable. Additionally, as discussed above, we believe that the departments' proposal to create an excepted benefit HRA is likely not legally permissible. In light of these policy and legal concerns, we make the following recommendations:

- **Recommendation #3:** The departments should not finalize the excepted benefit HRA proposal and should instead maintain the status quo.
- **Recommendation #4:** If the departments do move forward with the excepted benefit HRA proposal, they should not allow the excepted benefit HRA to be used to purchase individual market coverage. Allowing workers a choice between short-term plans and individual market coverage via the excepted benefit HRA would raise essentially the same concerns as allowing that choice in the context of the individual-market-integrated HRA. It would also further

undermine any claim that the benefit was a "limited excepted benefit" – since individual market plans are of course a comprehensive coverage option that contains no limiting features.

Cross-Cutting Recommendations

If the departments move ahead with one or both of the HRA proposals in the proposed rule, that will, as we discussed earlier, create compliance and administrative burdens for consumers and state-based Marketplaces. The only way the departments are likely to be able to fully address these concerns is to decline to create the two new types of HRAs envisioned in the proposed rule. However, the departments may be able to mitigate these concerns to some degree as follows:

- **Recommendation #5:** To help consumers navigate the new environment, we encourage the departments to strengthen the notice requirements and apply them uniformly to not only individual-market-integrated HRAs, but also to excepted benefits HRAs, the HRAs authorized under prior regulations, and all other kinds of employer payment arrangements that could be confused by employees.
- **Recommendation #6:** To allow all actors sufficient time to adjust to the new rules, particularly state-based Marketplaces that will need to make changes to their procedures for assessing enrollee eligibility for subsidies and special enrollment periods, we recommend delaying the effective date of the proposed rule until at least the 2021 calendar year.

Finally, the effects of this proposal are unusually difficult to predict given the inherent difficulties in predicting employers' responses and the extent to which employer responses may vary across geographic areas. Indeed, the departments' own regulatory impact analysis describes the proposal's effects as "highly uncertain." Furthermore, as discussed above, the departments' analysis does not adequately account for several factors that would play an important role in determining the proposal's effects in practice. In light of these uncertainties, we make the following recommendation:

- **Recommendation #7:** The departments should provide additional time for states and other stakeholders to assess the proposal and provide comments. The departments should also improve their own regulatory impact analysis by accounting for: variation in health status across employers driven by factors beyond those currently included in the departments' modeling; variation in individual market risk mix across geographic areas; the likelihood that employers would, under some circumstances, be able to shift sicker subsets of their workforces into the individual market despite the provisions of the proposal intended to prevent such behavior; and the likelihood that individuals enrolling in individual market coverage via an HRA will incur greater hassle costs than those enrolling in a traditional health plan.

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