Integrating Health Savings Accounts with New Health Reimbursement Arrangements

Maximizing Employee Health Care Control and Minimizing Employer Burden

By Brian Blase, Ph.D.

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Overview

For nearly two decades, health savings accounts (HSAs) and the associated tax advantages have helped people save money on their health care expenditures and grow wealth for future health care expenses. HSAs also play a role in producing a better health care system through more cost-conscious consumers and more providers motivated to improve efficiency. While HSAs are extremely valuable, they cannot be used for most health insurance premiums. Fortunately, a new rule from the Trump Administration permits employers to utilize health reimbursement arrangements (HRAs) and use tax-preferred dollars to reimburse employees for premiums for individual-market coverage they purchase. This rule, which took effect on January 1, 2020, has the potential to significantly expand employees' control over their health insurance since most employers that offer health benefits only provide a single choice of health plan. An HSA-compatible individual-coverage HRA will maximize employees' control over their current and future health care needs and will improve overall health policy in the United States.

The Advantage of Health Savings Accounts

HSAs are important tools to help people save money for health expenses as well as to enhance our health system by improving incentives for consumers to receive higher-value services and for providers to deliver higher-value care. HSAs provide two primary benefits to account holders. First, HSAs allow people to use tax-preferred dollars on current health care consumption. Second and arguably more important, HSAs assist people in growing funds for future health care needs, including after retirement. This growth results because HSAs receive a triple tax benefit: People put pre-tax dollars into the HSA;[1] investment earnings grow tax-free and when withdrawals are used to pay for qualified health care expenses, the withdrawal is tax-free.[2]

In order for a person to make HSA contributions, they must have an HSA-qualified health insurance plan and not have other disqualifying coverage.[3] In order to be HSA-qualified, a policy must have a minimum deductible—$1,400 for self-only coverage or $2,800 for family coverage in 2020—which applies to all covered benefits received from an in-network provider (if the plan uses a network).[4] The plan must also contain an annual limit on total out-of-pocket expenses ($6,900 for self-only coverage and $13,800 for a family plan in 2020) for covered benefits, and all out-of-pocket expenses for covered benefits must apply to satisfying the annual limit. Finally, the health plan must not be limited to vision, dental, disability, workers' compensation or other specified types of limited coverage.

People can use HSAs to pay for qualified health care expenses, which are defined in Section 213(d) of the Internal Revenue Code, and include many primary care, behavioral health, dental, and optometric services.[5] People generally cannot use HSA funds to pay premiums for health coverage unless they are receiving federal or state

[1] HSA contributions made via payroll deduction are made before deductions for state and federal taxes, including income and payroll taxes (i.e., "pre-tax"). If individuals fund their own HSAs outside of a payroll deduction, they generally pay the payroll tax. Avoiding the payroll tax has the negative effect of potentially reducing future Social Security benefits.

[2] There are taxes and penalties if people make a withdrawal from their HSA for a reason other than a qualified health care expense.

[3] Section 223 to the Internal Revenue Code, added by Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, permits eligible individuals to establish and contribute to HSAs.

[4] If the plan does not use a network, then the deductible must apply to all covered benefits.

[5] Internal Revenue Service, "Health Savings Accounts and Other Tax-Favored Health Plans," Department of the Treasury, January 30, 2020, https://www.irs.gov/pub/irs-pdf/p969.pdf; Internal Revenue Service, "Medical and Dental Expenses: Including the Health Coverage Tax Credit ," Department of the Treasury, January 21, 2020, https://www.irs.gov/pub/irs-pdf/p502.pdf

unemployment benefits. HSA funds are permitted to pay for COBRA continuation coverage, Medicare, and long-term care insurance (up to annual limits based on one's age).

In 2020, the limits on the amount that could be contributed to an HSA were $3,550 for self-only coverage and $7,100 for family coverage. People aged 55 and older can make an additional $1,000 catch-up contribution, making their respective limits $4,550 and $8,100.

Employers may contribute to workers' HSAs. The contributions are excluded from income and payroll taxes for workers, and employer contributions are deductible as a business expense.[6] According to Paycor, employers at firms with fewer than 500 people make average contributions to a worker's HSA of $750 per single employee and $1,200 for an employee with dependents. At firms with more than 500 people, the average contributions are $500 and $1,000, respectively.[7]

Societal Benefit of HSAs

The vast majority of U.S. health spending is done through third-party payment arrangements. In its report, *Reforming America's Healthcare System Through Choice and Competition*, the Departments of Health and Human Services, Labor, and the Treasury flagged problems with excessive third-party payment for health care since "consumers typically do not have an incentive to shop for value, eliminating one mechanism that could help constrain provider prices. This … has created a market for healthcare goods and services that is inherently inflationary."[8]

> Third-party payment also creates notable separation between producers and consumers, and leaves bureaucracies with the role of allocating resources. … Moreover, excessive third-party payment results in providers serving the interest of payers—government bureaucracies and insurance companies—rather than consumers.

[6] From the final HRA rule, "Code section 106(d) provides that in the case of amounts contributed by an employer to the HSA of an eligible individual, those amounts are treated as employer-provided coverage for medical care expenses under an accident or health plan to the extent the amounts do not exceed the annual limits on contributions to an HSA."

[7] "HSA Employer Contributions: What organizations need to know," Paycor, modified on January 31, 2020, https://www.paycor.com/resource-center/hsa-employer-contributions-what-organizations-need-to-know

[8] "Reforming America's Healthcare System Through Choice and Competition," U.S. Department of Health and Human Services, U.S. Department of the Treasury, U.S. Department of Labor, December 3, 2018, https://www.hhs.gov/about/news/2018/12/03/reforming-americas-healthcare-system-through-choice-and-competition.html

> [I]n most other markets, consumers pay the full price of what they purchase and are therefore likely to carefully consider the value of products relative to alternatives. Active shopping by consumers motivates competition on price and quality among producers. Third-party payment for routine, predictable and shoppable expenses reduces consumers' incentives to obtain maximum value and has contributed to opaque and byzantine prices and bureaucratic complexities. As a result, consumers have less ability and less incentive to carefully shop for healthcare, compare prices and quality, and select the most efficient providers. This, in turn, means that providers have a diminished incentive to innovate and increase their efficiency.[9]

Perhaps most importantly from a societal perspective, HSAs promote a more efficient allocation of health care services. This is because HSAs are owned and controlled by the account owner, funds roll over from year to year, and people can take them from job to job and when they move in and out of the labor force. As a result of these features, HSAs motivate people to be cost-conscious consumers and maximize the value they receive from their health care expenditures. This, in turn, puts pressure on medical providers to lower prices and become more cost efficient.

One study found that the introduction of HSA-qualified plans and HSAs was associated with a 15 percent reduction in total health care spending.[10] A second study found that families that switched from a traditional plan to an HSA-qualified plan spent an average of 21 percent less on health care in the first year after switching, with two-thirds of the savings resulting from fewer episodes of care and one-third from spending less per episode.[11]

Individual Coverage Health Reimbursement Arrangements

HRAs are a type of account-based group health plan funded solely by employer contributions that reimburse employees and their family members for health expenses. Employers set the terms for what the HRA reimburses and can permit contributions to roll over from year to year. HRA contributions provide employers with a way to provide employees a tax-free benefit since they are not subject to federal income or payroll taxes.

[9] Ibid.

[10] Amelia Haviland, Matthew D. Eisenberg, Ateev Mehrotra, Peter J. Huckfeldt, Neeraj Sood, "Do 'Consumer-Directed' Health Plans Bend the Cost Curve Over Time?" NBER Working Paper 21031, Issued March 2015 Revised July 2015, https://www.nber.org/papers/w21031.pdf

[11] Amelia Haviland, Roland McDevitt, M. Susan Marquis, Neeraj Sood, Melinda Beeuwkes Buntin, "Skin in the Game: How Consumer-Directed Plans Affect the Cost and Use of Health Care," RAND Corporation, 2012, https://www.rand.org/pubs/research_briefs/RB9672.html

A 2019 rule issued by the Departments of Health and Human Services (HHS), Labor, and the Treasury created individual coverage HRAs (ICHRAs). This rule permits employers, under certain conditions, to reimburse premiums for individual market coverage chosen by employees and for Medicare coverage for employees age 65 and older.[12] Employees must either be enrolled in individual market plans or Medicare in order to receive reimbursements from the ICHRA.

For off-exchange plans, employers may allow employees to pay residual premiums—the remaining plan premium after the employer's contribution—on a tax-preferred basis by using a salary reduction arrangement under a Section 125 cafeteria plan. Thus, the new rule effectively equalizes federal tax treatment between traditional employer group coverage and employer contributions to employees' purchase of an individual market plan.

Employers make many key decisions about ICHRAs. These include which employees to cover, how much to reimburse, what expenses to reimburse, whether to use waiting periods, when the coverage will start, whether to allow the ICHRA to reimburse family coverage in addition to self-only coverage, and whether to vary reimbursements by providing greater contributions to older workers or workers with larger families.[13] Employers need to provide a notice to employees at least 90 days in advance of the plan year with information about the ICHRA.[14] For firms with at least 50 workers, an ICHRA must be affordable as defined by the Affordable Care Act (ACA) lest the firm face tax penalties under the employer mandate.

[12] Employers cannot discriminate in their offerings of health benefits to employees. As such, they must provide ICHRAs on the same terms to all employees with the exceptions that contributions can be higher for older workers and those with a larger number of dependents. Workers who are age 65 or older are precluded from purchasing coverage in the individual market. Most workers who are Medicare-eligible can use the ICHRA to purchase a Medicare Advantage plan, for cost-sharing for Part A or Part B, or for Medicare supplemental plans, including a prescription drug plan. According to the final HRA rule, there are about 2.5 million people for whom employer coverage is the primary payer and Medicare is secondary. Enrollment in Medicare Part A and B or Part C is required for workers age 65 and older to receive an ICHRA. The final rule clarifies that under an ICHRA, funds can be used to pay for Medicare and Medigap premiums, as well as other medical care expenses. According to the final rule, "Once premiums (and deductibles for medical care expenses) are paid by the individual coverage HRA, there would be few funds available to pay for medical care expenses. Hence, Medicare would effectively become the primary payer in the vast majority of cases."

[13] Employers can provide any amount in the ICHRA, but the amounts must be offered on the same terms to similarly situated employees with two exceptions: Employers can provide up to three times as much for older workers as for younger workers and they can provide greater contributions for workers with more dependents.

[14] The notice needs to include information about the amount made available under the ICHRA, the ability of employees to opt out of the ICHRA, and the implications on the eligibility for the premium tax credit of both an ICHRA offer and enrollment in the individual market using an ICHRA.

The regulatory balance that the Departments faced in constructing this new HRA was maximizing employer flexibility to offer the ICHRA with guardrails against additional adverse selection in the individual market from sick workers being steered there.[15] The regulations permit employers to create classes of employees so that certain employees may be offered the ICHRA while others remain on the firm's traditional group plan.[16] In order to offer ICHRAs to one set of employees and the traditional group plan to another set of employees, the number of employees offered the ICHRA must exceed a certain number.[17] Within each class, employees cannot be offered a choice of an ICHRA and a traditional group plan. Moreover, the ICHRA must be offered on the same terms to all employees within a class, with the exception that greater contributions can be provided for older employees and those with more dependents. Since many employees are resistant to changing current health benefit arrangements, the rule contained a new-hire provision that permits employers to maintain the traditional group plan for existing employees and to offer the ICHRA only to newly hired employees.[18]

The Advantages of the Individual Coverage HRA to Employers and Employees

One of the main advantages received by employers that offer an ICHRA is greater control over the cost of the firms' health benefits. The firm would be able to budget an amount for its employees' health coverage, and it would have greater predictability about annual cost growth. Thus, rather than awaiting a renewal notice from its insurer or third-party administrator (TPA) which may contain higher-than-expected premium charges, the employer would better be able to plan for the future and increase its allocation toward health care by a set amount per year. Offering an ICHRA also allows the employer to offer a health benefit while spending less time on the details and complexities of managing a health plan, freeing the company to focus on its core business.

[15] In the author's capacity as Special Assistant to the President at the White House's National Economic Council from 2017 through 2019, he led the development and policy of the HRA rule.

[16] The classes in the final rule are: full-time workers, part-time workers, salaried workers, hourly workers, seasonal employees, employees subject to a collective bargaining agreement, employees in a waiting period, employees of temporary staffing firms, employees in certain rating areas, employees who are nonresident aliens, and combinations of the classes.

[17] In order to offer a traditional plan to one set of employees and an ICHRA to another set of employees, a minimum class size would apply to the number of individuals offered an ICHRA for certain classes. The minimum number of enrollees in the class offered the ICHRA must be 10 for firms with fewer than 100 workers, 10 percent of workers for a company with between 100 and 200 workers, and at least 20 for firms with 200 or more workers.

[18] With respect to the ICHRA offering, there are no requirements related to the number of new hires.

The ICHRA will lead to more people with employer health benefits, reversing a decline in employer-provided coverage, particularly at smaller firms, that has occurred over the past decade. Even before the coronavirus pandemic, small employers were increasingly not offering health coverage. As the following table demonstrates, the percentage of firms offering coverage significantly declined between 2010 and 2020, particularly at smaller firms. The table also shows that the percentage of workers covered by employer health plans has also markedly declined, with the largest decline at firms with fewer than 50 employees.

Table 1: Employer Offering of Coverage and Employees Enrolled in that Coverage, 2010 & 2020

<table>
<tr><th>Firm size</th><th>Offered – 2010</th><th>Offered – 2020</th><th>Enrolled – 2010</th><th>Enrolled – 2020</th></tr>
<tr><td>3-9</td><td>59%</td><td>48%</td><td rowspan="2">44%</td><td rowspan="2">34%</td></tr>
<tr><td>10-24</td><td>76%</td><td>59%</td></tr>
<tr><td>25-49</td><td>92%</td><td>70%</td><td>59%</td><td>41%</td></tr>
<tr><td>50-199</td><td>95%</td><td>92%</td><td>60%</td><td>58%</td></tr>
</table>

The enrollment figures reported by Kaiser were not separated for firms with fewer than 24 employees.
Source: "2020 Employer Health Benefits Survey," Section 2: Health Benefits Offer Rates, Kaiser Family Foundation, October 7.Figure 2.2, https://www.kff.org/report-section/ehbs-2020-section-2-health-benefits-offer-rates/ "2020 Employer Health Benefits Survey," Section 3: Employee Coverage, Eligibility, and Participation, Kaiser Family Foundation, October 7, 2020, Figure 3.11, https://www.kff.org/report-section/ehbs-2020-section-3-employee-coverage-eligibility-and-participation/

Part of these declines result from the ACA's requirements that increased the cost of health insurance in the small group market. Another reason is the large new subsidies the ACA made available to lower-income Americans. Both the Medicaid expansion and large premium tax credits for lower-income enrollees purchasing an ACA exchange plan—the amount of which is extremely generous for households below 200 percent of the federal poverty level (FPL)—provide an incentive for employers with predominantly lower-wage workers to drop health benefits. These firms can raise worker wages while workers obtain heavily subsidized coverage. If firms make an offer of affordable coverage, employees as well as their family members, are precluded from utilizing a premium tax credit.[19]

The ICHRA provides employers with another way to attract employees to their firm and will generally enhance employee welfare at firms that offer them. For those with an employer who newly offers employee health coverage because of the ICHRA, the ICHRA allows the employee to use tax-free contributions to finance at least part of their health plan, boosting their after-tax total compensation. For

[19] If an employee accepts the offer of an ICHRA, they are precluded from a premium tax credit even if the offer of the ICHRA was "unaffordable."

employers that currently offer a traditional group plan, the ICHRA allows the firm to better tailor health benefits in a way that makes their employees better off in the aggregate. Subject to certain conditions,[20] the new rule allows firms flexibility to offer the ICHRA to employees who may receive the most benefit from the option, such as those in areas of a state where the individual market is stronger, while maintaining other employees in the traditional group plan. Moreover, since offering ICHRAs is voluntary, firms will only offer it to employees if doing so makes the set of employees offered the ICHRA better off than the alternatives of not offering coverage or offering a traditional group plan.

Most employers that now offer health insurance provide workers with only one plan option, so the HRA rule has the potential to significantly increase workers' choice and control over their health insurance. At firms with fewer than 200 employees that offered health benefits, 75 percent provided only a single type of health plan to their employees in 2020.[21] At firms with more than 200 employees that offered health benefits, 42 percent provided only a single type of health plan.[22] An economic study found that offering multiple plan choices in the group market was as valuable to the median consumer as a 13 percent premium reduction. This demonstrates the tangible benefit that will result from the HRA rule.[23]

According to economic modeling, the Department of the Treasury projects that within about five years, 800,000 employers will offer ICHRAs and more than 11 million people—about one million who would otherwise be uninsured—will receive individual market coverage using an ICHRA.[24] Treasury projects that nearly 90 percent of the companies offering the ICHRA will have fewer than 20 workers.

[20] See footnotes 12, 13, 14, 16, 17, and 18.

[21] "2020 Employer Health Benefits Survey," Section 4: Types of Plans Offered, Kaiser Family Foundation, October 7, 2020, Figure 4.1, https://www.kff.org/report-section/ehbs-2020-section-4-types-of-plans-offered/

[22] Ibid.

[23] Leemore Dafny, Kate Ho, and Mauricio Varela, "Let Them Have Choice: Gains from Shifting Away from Employer-Sponsored Health Insurance and toward an Individual Exchange," *American Economic Journal: Economic Policy* 5, no. 1, (2013): 32-58, https://www.aeaweb.org/articles?id=10.1257/pol.5.1.32

[24] Of the 11 million employees and dependents, the administration projects that about seven million will transition from traditional employer-sponsored insurance (ESI), about three million will move from an individual market plan without an HRA to the ICHRA with individual market coverage, and about one million will gain coverage who would otherwise be uninsured. See: Federal Register, "Health Reimbursement Arrangements and Other Account-Based Group Health Plans," U.S. Department of Health and Human Services, U.S. Department of the Treasury, U.S. Department of Labor, June 20, 2019, https://www.federalregister.gov/documents/2019/06/20/2019-12571/health-reimbursement-arrangements-and-other-account-based-group-health-plans

HSA-Compatible Individual Coverage Health Reimbursement Arrangement

The final HRA rule refers to HSAs 81 times as the Departments responded to several comments asking about the interaction between HRAs and HSAs. In the final rule, the Departments referenced the explanation in Revenue Ruling 2004-45 that a person can be covered by a limited-purpose HRA, a post-deductible HRA, or combinations of these arrangements and remain eligible to make HSA contributions.[25] The final HRA rule also referenced Q&A-1 of IRS Notice 2008-59 that stated a limited-purpose HRA used to reimburse health coverage premiums does not disqualify an otherwise eligible person from contributing to an HSA.[26] Of course, a person cannot make or receive HSA contributions if the HRA is used to obtain non-HSA compatible coverage. According to the final HRA rule:

> This prior guidance applies to all HRAs, including individual coverage HRAs. Therefore, for example, an individual coverage HRA that solely makes available reimbursements of individual health insurance coverage premiums does not disqualify an otherwise eligible individual covered under an HDHP [high-deductible health plan] and no other disqualifying coverage from making contributions to an HSA. However, an individual coverage HRA that is not limited in accordance with the relevant guidance under the Code would not be HSA-compatible (for example, an HRA that can reimburse first dollar cost sharing).[27]

While the ICHRA must be offered on the same terms to all employees, the employer can provide employees with a choice of an HSA-compatible ICHRA and a non-HSA compatible ICHRA. The Departments clarified that employers have flexibility in this regard.

> The Departments recognize that some employees offered an individual coverage HRA may choose individual health insurance coverage that is an HDHP and other employees may choose non-HDHP individual health insurance coverage that is not HSA compatible. While some employers may offer all employees in a class of employees an HSA-compatible individual coverage HRA, some employers may want to offer employees in a class of employees a choice between an HSA-compatible

[25] Internal Revenue Service, "Internal Revenue Bulletin No. 2004-22", Department of the Treasury, June 1, 2004, https://www.irs.gov/pub/irs-irbs/irb04-22.pdf

[26] Internal Revenue Service, "Internal Revenue Bulletin No. 2008-29, Notice 2008-59," Department of the Treasury, July 21, 2008, https://www.irs.gov/pub/irs-drop/n-08-59.pdf

[27] "U.S. Departments of Health and Human Services, Labor, and the Treasury Expand Access to Quality, Affordable Health Coverage Through Health Reimbursement Arrangements," U.S. Department of Health and Human Services Press Office, June 13, 2019, https://www.hhs.gov/about/news/2019/06/13/hhs-labor-treasury-expand-access-quality-affordable-health-coverage.html

> individual coverage HRA and an individual coverage HRA that is not HSA compatible. In response to this comment, the final rules clarify that an employer that offers employees in a class of employees a choice between an HSA-compatible individual coverage HRA and an individual coverage HRA that is not HSA compatible does not fail to satisfy the same terms requirement provided both types of individual coverage HRAs are offered to all employees in the class on the same terms. The final rules have been revised to reflect this rule.

If offered a choice between an HSA-compatible ICHRA and a non-HSA compatible ICHRA, the employee opts for either one for the entire plan year or the portion of the plan year the employee is covered by the ICHRA. Employers are permitted to contribute to a worker's HSA if the worker uses the ICHRA to purchase an HSA-qualified plan. Once an individual enrolls in Medicare, they cease to be eligible to make HSA contributions.[28] Since people aged 65 and over must enroll in Medicare in order to receive the ICHRA, employees aged 65 and over would be better off choosing the non-HSA compatible ICHRA.

Best Offering—Premium-Only, Limited ICHRA and Maximum HSA Contribution

To hire the best workforce, employers construct employee compensation to maximize employee well-being. Compensation consists of wages and benefits, with health coverage being the primary benefit. Employers can provide health benefits in the form of premium payments or contributions to HSAs, HRAs, or Health Flexible Spending Accounts (FSAs). Employer contributions to premiums are not subject to federal income or payroll taxes and neither is the employee share of the premium. Employer contributions to HRAs and FSAs are also not subject to federal income or payroll taxes. As stated above, HSA contributions are made with pre-tax dollars and have added tax benefits as the investment grows tax-free and withdrawals for qualified health care expenses are not taxed.

While employers will generally gain both administrative savings and greater budget predictability from offering an ICHRA, a premium-only ICHRA—an ICHRA that can *only* be used to reimburse individual market premiums—would be the least-costly type of ICHRA to administer. A premium-only ICHRA minimizes administrative burdens since every reimbursement from an HRA must be verified as an eligible expense. Some purchases can be automatically verified when people use

[28] IRS Notice 2004-50, 2004-33 IRB 196, Q&A-2, clarifies that eligibility for Medicare does not make an individual ineligible to contribute to an HSA. Rather, eligibility for, and enrollment in, Medicare disqualifies a person from making HSA contributions. See: Internal Revenue Service, "Internal Revenue Bulletin No. 2004-33", Department of the Treasury, August 16, 2004, https://www.irs.gov/pub/irs-irbs/irb04-33.pdf

their HRA card, but sometimes people need to provide an itemized receipt or other supporting documentation to comply with IRS rules for reimbursement.

Under a premium-only ICHRA, there are only two types of required verifications—a one-time proof that the participant has enrolled or will enroll in coverage and a monthly verification that the individual remains enrolled in coverage each time the premiums are reimbursed.

The final HRA rule makes clear that the employer's responsibility for compliance regarding the HRA is much greater if an HSA-compatible ICHRA reimburses for expenses in addition to individual market premiums.

> If a plan sponsor chooses to offer an HSA-compatible individual coverage HRA that reimburses medical care expenses after the minimum deductible under Code section 223(c)(2)(A)(i) is satisfied, it is the employer's responsibility to track medical care expenses incurred during the year and ensure that the individual coverage HRA does not reimburse medical care expenses (other than premiums or expenses allowed as limited purpose) incurred prior to the satisfaction of the minimum deductible.

Most employers likely would hire a third-party administrator (TPA) to handle the compliance verification. The TPA will almost certainly charge less if the only allowable reimbursements from the HRA—and the only need for verification—are for monthly premium payments.

A premium-only ICHRA with an employer-funded HSA will be an extremely attractive financial product to many workers. This arrangement recognizes that HSAs are generally superior to HRAs for workers, since HSAs are owned and controlled by the worker and remain with them over time. In contrast, HRAs are owned and controlled by the employer, and unused HRA amounts are often forfeited by the employee while unused HSA amounts roll over from year-to-year and can convey. Moreover, unused HRA amounts cannot be transferred to an employee's HSA. The main advantages for an HRA are that they can now be used to reimburse individual-market premiums and they can be integrated with more than just HSA-compatible plans.

According to the Kaiser Family Foundation, the average monthly premium available to a 40-year old for the lowest-cost bronze plans in 2020 equaled $331.[29] This

[29] "Average Marketplace Premiums by Metal Tier, 2018-2020," Kaiser Family Foundation, accessed on September 27, 2020, https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

is nearly a $4,000 annual premium. For employers that are able to provide an average employee health benefit of $6,000 for a 40-year old employee, an ideal offering would be a $4,000 ICHRA coupled with a $2,000 contribution to the employee's HSA (roughly $330 a month in the ICHRA and $170 a month into the worker's HSA). In states where the premium for the lowest-cost bronze plan is above the national average, employers may wish to provide somewhat more in the ICHRA and somewhat less in the HSA. In states where the premium for the lowest-cost bronze plan is below the national average, employers may wish to provide somewhat less in the ICHRA and somewhat more in the HSA.

Such a benefit offering has several advantages for employees. First, employees would generally be able to purchase an ACA plan for little, if any, additional premium payment. Of note, the employer would likely need to vary the ICHRA contribution by age to ensure that older workers can purchase zero- or low-cost premium plans. If employees wish to purchase a more expensive plan, they can of course do so by adding their own funds. If they purchase an off-exchange plan, they can use a salary reduction arrangement under a Section 125 cafeteria plan to exclude their premium share from federal taxation.

For employees who choose an HSA-compatible product in the individual market, the employer would provide a monthly contribution to their HSAs. This would allow employees a way to spend tax-free dollars on current medical needs and increase wealth for future medical expenses. Such a financing structure is superior to having the residual employer contribution—the amount the employer puts in the ICHRA minus the premium payments—in an HRA as the unused HRA amounts revert to the employer's control and are often forfeited by the employee. Knowing this, many employees would engage in wasteful spending at the end of the year with money remaining in their HRA or purchase a plan with more expensive benefits than they may need. These actions obviously do not constrain health care costs.

A premium-only ICHRA, along with a fully or partially funded HSA, is also optimal to improve our overall health sector by orienting incentives around maximizing value in two principal ways. First, the ICHRA approach allows employees the ability to obtain coverage that more closely matches their different preferences for coverage—around premiums, cost-sharing, and provider networks—rather than having their employer limit their selection and provide just one plan for all employees. To the extent that employees choose less expensive plans and become more cost-conscious shoppers of health insurance, employers could eventually rebalance their contributions, by cutting back the HRA amounts made available and increasing their HSA contributions. Second, every dollar of employer contribution provided to an HSA incentivizes employees to be cost conscious and seek the best value for their spending—the type of behavior necessary for a more efficient health sector.

ICHRAs must be offered to employees on the same terms, with the noted exceptions that larger contributions can be provided based on the employees' ages as well as the number of dependents covered by the plan. Therefore, an employer could offer employees an average of $350 in a monthly ICHRA—potentially varying it to be $175

for the youngest employees and $525 for the oldest employees—and a choice between an HSA-compatible ICHRA and a non-HSA compatible ICHRA. If employees choose the HSA-compatible ICHRA, the employer could provide funding each month—$150 in order to equate to an average monthly health benefit of $500—into the worker's HSA. In this scenario, the total monthly employer-provided and tax-advantaged benefit would equal $325 for younger workers and $675 for older workers. An additional benefit of this structure is that employees would be encouraged to choose the HSA-compatible ICHRA. If employees do not choose the HSA-compatible plan, they forgo the employer's contribution to the HSA and they lose the ability to gain the favorable tax benefit that HSAs provide for their own contributions.

ICHRA Affordability (for firms with at least 50 full-time workers)

Employers with fewer than 50 full-time equivalent employees (FTEs) do not have to worry about penalties under the employer shared responsibility provisions, i.e., the employer mandate. However, employers with at least 50 FTEs will likely want to ensure that their coverage offer satisfies the employer mandate, meaning that it is both affordable and complies with minimum value requirements.

According to the final Treasury and IRS premium tax credit rule, issued in conjunction with the final HRA rule, an ICHRA would be considered affordable if the premium for the lowest-cost silver plan in the individual's rating area through the exchange, less the self-only amount of the HRA, does not exceed the required contribution percentage of the employee's household income. The required contribution percentage was 9.5 percent in 2014 and is adjusted each year; the required percentage for 2021 is 9.83 percent.[30] According to the regulations, an HRA that is affordable would be deemed to provide minimum value. If an ICHRA offer is unaffordable, the employee can opt out of the ICHRA and obtain a premium tax credit to purchase an ACA plan on the exchange. The employer would then be subject to the employer mandate penalty if the firm has more than 50 FTEs.

On September 27, 2019, the Treasury and the IRS issued a proposed rule regarding how the employer mandate applies to ICHRAs, along with a series of safe harbors to ease employers' ability to comply with the employer mandate.[31] Depending on

[30] As an example, if the lowest cost silver plan equals $400 and the ICHRA contribution is $300, then the employees' share of the premium for the lowest cost silver plan is $100. The average monthly income that person would need for the ICHRA to be affordable in 2021 in this scenario is ($400-$300)/0.0983 = $1,018.

[31] Internal Revenue Service, "Application of the Employer Shared Responsibility Provisions and Certain Nondiscrimination Rules to Health Reimbursement Arrangements and Other Account-Based Group Health Plans Integrated with Individual Health Insurance Coverage or Medicare," Department of the Treasury, September 30, 2019, https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-20034.pdf

how the safe harbors are finalized, the guidance in this paper may need to be slightly updated for the steps employers must take, along with the extra flexibilities that they have, to provide affordable ICHRAs.

To best ensure affordability of the ICHRA, employers will likely need to provide a greater ICHRA contribution to older workers. The table below shows the lowest-cost bronze and silver plans available on average, along with the employer ICHRA offer needed to make coverage affordable to workers with household income of $30,000 and $50,000 for a 25-year-old worker, a 40-year-old worker, and a 60-year-old worker. This table shows that ICHRA affordability is more challenging for older workers. If it is a firm where older workers earn relatively high income, then this problem will be eliminated or minimized. If employers need to make larger ICHRA offerings to older workers to ensure affordability, they may be able to offer lower HSA contributions to those workers.

Table 2: ACA Plans and ICHRA Affordability

	Lowest-cost Bronze	Lowest-cost Silver	Affordable ICHRA ($30,000 income)	Affordable ICHRA ($50,000 income)
25-year-old	$259	$346	$100	Any amount
40-year-old	$331	$442	$196	$32
60-year-old	$701	$937	$691	$527

Source: Kaiser Family Foundation subsidy calculator

The Opportunity to Use the Excepted Benefit HRA to Purchase HSA-Compatible Short-Term Limited-Duration Insurance

In a September 2019 paper published by the Galen Institute, the second new HRA created by the final HRA rule—the excepted benefit HRA (EBHRA)—was examined.[32]

> Employers can offer the EBHRA only to workers who also receive an offer of a traditional group plan. The main benefit of the EBHRA will accrue to workers who obtain a low value from the employer's traditional group plan. For example, 27 percent of workers at firms with fewer than

[32] Brian Blase, "Health Reform Progress: Beyond Repeal and Replace," Galen Institute, September 2019, https://galen.org/assets/Health-Reform-Progress-Brian_Blase.pdf

> 200 workers turn down the offer of employer coverage. Moreover, the Kaiser Family Foundation estimates that 3.8 million of the estimated 27.4 million who were uninsured in 2017 refused an offer of ESI. Workers can use the excepted benefit HRA, which is capped at $1,800 in 2020 and adjusted for inflation afterward, toward the purchase of STLDI [short-term, limited-duration insurance] as well as other coverage, such as dental or vision plans.[33]

STLDI plans are generally much more affordable than individual market coverage because they are not subject to the ACA rules, although they are subject to state regulation and oversight. Employees that use the EBHRA to purchase a STDLI plan are permitted to make HSA contributions so long as the plan meets the requirements for an HSA-qualified plan, and this was confirmed by the Department of the Treasury and IRS in the 2019 HRA rule.[34] After restating the guidance for HSA-qualified plans and that people can remain eligible to make HSA contributions even if they are covered by a limited-purpose HRA, a post-deductible HRA, or combinations of these arrangements, the final HRA rule explicitly states that people can make HSA contributions if they have an STLDI plan that meets the requirements of an HSA-qualified plan.

This prior guidance applies to all HRAs, including excepted benefit HRAs. Therefore, for example, an individual covered by an excepted benefit HRA that is available to pay premiums for STLDI is an eligible individual for purposes of making contributions to an HSA, assuming the HRA is used to purchase STLDI that qualifies as an HDHP (and so, for example, the STLDI does not pay benefits prior to satisfying the minimum required deductible), and the individual has no disqualifying coverage.

Conclusion

Regardless of the outcome of the November elections, ICHRAs are likely here to stay. They have bipartisan support and represent a rare major Trump administration health care policy that has not been subject to legal challenge. There is also

[33] Ibid.

[34] In a paper released by the Health Benefits Institute, HSA expert Roy Ramthun and this author discussed the opportunity for HSA-qualified short-term plans and how the plans needed to be structured to meet the legal criteria. See: Brian Blasé and Roy Ramthun, "Health Savings Accounts and Short Term Plans: A Perfect Match," Health Benefits Institute, May 2020, https://static1.squarespace.com/static/5d9b7bc3e3b66f7f77957469/t/5ed671e1a038472d4854fb99/1591112177933/HSAs+and+STLDs+IA.pdf

significant potential to improving federal health policy by building on ICHRAs. For Democrats, the HRA rule can be viewed as expanding the ACA, where tax-free employer contributions are leveraged by employees to boost coverage. For Republicans, a long-standing policy aim has been moving from defined benefit health arrangements to defined contribution arrangements where employees have greater choice and control over their coverage. Both parties would like health insurance to be more portable to reduce job lock and give families greater flexibility and security.

ICHRAs face several initial challenges. First, most employers and many benefits experts do not yet understand the opportunity. Second, brokers and agents may be resistant to providing information about ICHRAs because a commission schedule has not been developed yet that allows them to earn as much money as if they enroll an employer group in a traditional insurance plan. Perhaps most importantly, the individual market is not an attractive place for employees to receive coverage in many parts of the country, as choices are limited, and premiums and deductibles are high.

These limitations are likely to be temporary, however. Organizations have emerged with the aim of assisting employers in offering ICHRAs and helping employees enroll in coverage using the ICHRA. The broker and agent compensation issue should be remedied as these organizations develop expertise in helping employers establish ICHRAs and minimize associated administrative costs. And, it is certainly possible that the next Congress could enact a variety of reforms aimed at increasing choice in the individual market and expanding plan affordability. These reforms could include risk mitigation programs that would use general tax revenue to finance the cost of medical treatment for people with expensive medical claims and allow employer contributions to combine with government subsidies for lower-income enrollees.

Given that ICHRAs likely will endure, employers and benefit experts should be exploring the issues involved in offering them. This paper discusses how premium-only ICHRAs are compatible with HSAs. Premium-only, HSA-compatible ICHRAs offer employers a way to minimize their administrative costs in offering a health plan and maximize employee choice and control over the financing for their health insurance and care. The ICHRA allows workers to choose the individual market plan that works best for them, and the HSA, partially or fully funded by the employer, can best help individuals finance health care expenditures and grow assets for future medical expenses.

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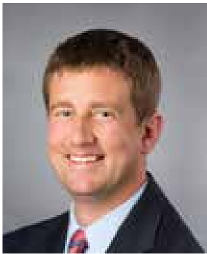

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