

Issue Brief

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Ideas to Expand and Promote the Use of Health Reimbursement Arrangements

Alternatives to “Medicare for All” and Single-Payer

NTU has long opposed proposals to create a single-payer health care system in the U.S., like “Medicare for All.” We have argued that such proposals would limit the choices available to consumers, undermine innovative products and services offered in the current market, lead to shortages for patients, and significantly raise costs for taxpayers.

However, with Americans [reporting health care costs as a top concern](#) - even for people covered through [their employer](#) - it’s not enough for policymakers opposed to single-payer to simply voice their opposition to “Medicare for All.” Advocates for a robust, competitive, and market-based health care system need to offer alternatives that expand consumer choice and access to affordable care.

Key Facts:



Health Reimbursement Arrangements (HRAs) are a unique way for employers to expand health offerings to their workforce.



Millions could benefit if Congress codifies new types of HRAs into law, such as individual coverage HRAs and excepted benefit HRAs.



Lawmakers can also work to make HRAs interact better with HSAs, which would increase the portability of health care for American families.

NTU believes that health reimbursement arrangements (HRAs) are one existing tool that offer small and mid-sized employers more options for providing health insurance to their employees. In this Issue Brief, we'll explain the current state of HRAs in the health insurance marketplace, consider the laws and policies that prevent increased utilization of HRAs by employers, and offer several ideas to expand access to and promote the use of HRAs.

What are HRAs?

Though only one letter separates the acronyms for HRAs and a similar tax-advantaged health option, health savings accounts (HSAs), the two should not be confused. Unlike HSAs, to which both employees and employers can contribute, only employers can contribute to and make disbursements from an HRA. The HRA then reimburses employees for certain qualified medical expenses. Even though HRA payments are a benefit to the employee and their family, these payments are tax-advantaged because they are excluded from the employee's income and employment taxes.

Most HRAs have no limit on how much employers can reimburse employees for qualified expenses (one kind of HRA does; more on that below). Employers are allowed to set a maximum dollar amount they will reimburse per year, though. Like HSAs, the amounts left over in an HRA at the end of the year can roll over to the next year. Unlike HSAs, though, any unspent balance in an HRA can return to the employer when an employee leaves the company. In this sense, HRAs are less portable for the employee and their family than an HSA that's paired with a high-deductible health plan (HDHP).

There are currently four kinds of HRAs: 1) traditional HRAs, which cannot be offered by an employer as a stand-alone health coverage option and must be paired ("integrated") with a traditional group health plan; 2) qualified small employer HRAs (QSEHRAs), which have to be offered as a stand-alone health coverage option by employers with less than 50 employees; 3) individual coverage HRAs (ICHRAs), created by the Trump administration to allow employers to reimburse employees for the cost of premiums for plans purchased on the individual market; and 4) excepted benefit HRAs (EBHRAs), created by the Trump administration as an alternative for employees who are offered but do not accept an offer to purchase a traditional group health plan through their employer.

What Are the Current Limitations on HRA Use?

One limitation on HRAs stems from the complexity bred by having four different kinds of HRAs, only one of which is codified in law. QSEHRAs were created by Congress through the [21st Century Cures Act](#) (H.R. 4), which became law in December 2016. Traditional HRAs actually do not exist in the U.S. Code, but [according to the Congressional Research Service](#) are "governed by IRC Section 105, which allows health plan benefits used for medical care to be exempt from employees' income taxes, and IRC Section 106, which applies the same tax advantage to employer contributions to health plans." As mentioned, ICHRAs and EBHRAs are creations of the Trump administration, through a [regulation](#) issued in June 2019 by the IRS, Department of Labor, and Department of Health and Human Services.

Not only can health arrangements created by regulation (instead of by law) be more confusing for employers and employees, but they are also more susceptible to repeal or reform by future administrations. Employers who are aware of this dynamic, or confused about the complex rules governing HRAs, would not be blamed for hesitating to start arrangements that could one day become political footballs.

While HRA payments apply to a wide range of medical expenses, they cannot be used for a patient's purchase of over-the-counter (OTC) drugs and, until very recently, could not be used by patients to purchase health insurance plans on the individual market.

Although there are no limits on what employers can contribute to traditional HRAs or ICHRAs, there are explicit limits on what they can contribute to QSEHRAs and EBHRAs. In 2019, small employers can only reimburse up to [\\$5,150 for individual coverage and \\$10,450 for family coverage](#). Employers offering an EBHRA can reimburse only up to [\\$1,800 a year](#) for excepted coverage (like vision, dental, or short-term limited-duration insurance (STLDI) plans).

Finally, and as previously mentioned, HRAs are considerably less portable than an employee-owned HSA. While employers can offer to let employees keep their unused HRA funds, they are not required to do so. There are also existing legal limits as to when, how, and how much an employee can roll HRA funds into an employee-owned account like an HSA.

Who Uses HRAs?

According to a Kaiser Family Foundation's [annual Employer Health Benefits Survey](#), in 2018 seven percent of employers offered an HRA. This is up from two percent in 2006. Ten percent of workers were covered by a high-deductible health plan (HDHP) with an HRA, also up from two percent in 2006.

The Trump administration [estimates](#) that their ICHRA and EBHRA options will lead 800,000 employers to offer new HRAs to more than 11 million employees. Additionally, 800,000 people will gain access to coverage when they would have otherwise been uninsured.

Data suggest that small and mid-sized employers, in particular, could take advantage of the ICHRA and EBHRA options. According to [PeopleKeep](#), a company that helps employers offer QSEHRAs, 93 percent of small nonprofits using QSEHRAs “would recommend it to other nonprofits.” Small nonprofits are taking advantage of QSEHRAs, according to PeopleKeep, because they cannot afford to group health insurance but have “the ability to set fixed allowance amounts” with QSEHRAs.

The average employee contribution to premiums is lower for workers with an HDHP and HRA (\$1,142 per year of single coverage) than it is for workers in employer plans without a savings options (\$1,232 per year; Kaiser defines savings options as HRAs or HSAs). The trade-off, unsurprisingly, is that employees in HDHPs with an HRA or HSA option typically have a higher deductible than employees in plans without a savings options. The difference is about \$1,196, but that difference is reduced to just \$422 per year after accounting for employers' contributions to an HRA or HSA.

Four Ideas for Expanding and Promoting the Use of HRAs

The way HRAs are designed and restricted by law have limited their adoption and application by employers and employees. Fortunately, there are several ideas - some proposed by lawmakers and others that have yet to be proposed in legislation - that would accomplish one or more of several goals:

- Increasing employer confidence in offering HRAs to their employees
- Expanding the types of health-related expenses that are qualified for reimbursement from an HRA
- Improving on the portability of HRA funds, by making it easier for employers to roll unspent HRA funds into employee-owned health accounts

Below, we'll review four ideas for expanding access to and promoting the use of HRAs. Each idea accomplishes one or more of the goals outlined above.

1. Codifying ICHRAs, EBHRAs, and Traditional HRAs Into Law

Congress could offer visibility, certainty, and clarity to employers on the design and benefits of ICHRAs, EBHRAs, and traditional HRAs by codifying them into law, like they did (on a bipartisan basis) for QSEHRAs. Though QSEHRAs made up just one provision of a much larger bill, it is worth noting the legislation [passed](#) 392-26 in the House and 94-5 in the Senate.

Legislation codifying these three types of HRAs into law could also incorporate some of the recommendations below, if part of a larger reform effort.

2. Raising the QSEHRA Limits on Payments and Reimbursements

As noted above, small employers can only reimburse up to [\\$5,150 for individual coverage and \\$10,450 for family coverage](#) under a QSEHRA. This falls almost \$600 short of the [average benchmark premiums](#) for a person purchasing insurance in the individual market in 2019, according to data from the Kaiser Family Foundation. While some small employers may not be able to cover reimbursements to this extent, or choose not to, it makes little sense to limit an employer who wants to offer more generous coverage through an HRA.

3. Allowing HRAs to Reimburse for Over-the-Counter (OTC) Medications

This idea is popular among members of Congress, with no fewer than four bills proposing to allow HRA funds to be used for over-the-counter (OTC) medications. The bills are:

- [S. 12](#), the Health Savings Act of 2019, introduced by Sen. Marco Rubio (R-FL) and cosponsored by Sen. Lisa Murkowski (R-AK)
- [S. 1089](#), the Restoring Access to Medication Act of 2019, introduced by Sen. Pat Roberts (R-KS) and cosponsored by Sens. Johnny Isakson (R-GA), Angus King (I-ME), and Joe Manchin (D-WV)
- [H.R. 1922](#), the Restoring Access to Medication Act of 2019, introduced by Rep. Ron Kind (D-WI) and cosponsored by seven Democrats and three Republicans
- [S. 930](#), the Allowing Greater Access to Safe and Effective Contraception Act, sponsored by Sen. Joni Ernst (R-IA) and cosponsored by Sen. Cory Gardner (R-CO)

Including all sponsors and cosponsors, nine Republicans, nine Democrats, and one independent have put their names on legislation that would allow HRA funds to reimburse for OTC medications. This is low-hanging fruit for members of Congress.

4. Allowing Employees to Roll Unspent HRA Funds Into an HSA At the End of a Year or Following a Job Transition

This proposal stems from a bill introduced by Sen. Ben Sasse (R-NE), the Qualified Health Savings Account Distribution Act ([S. 2440](#)). It would enable employers to roll unspent HRA funds into an employee-owned HSA account, making these funds more portable and accessible for that employee if they leave a job later on. Rollovers would be limited to \$2,650 for individual coverage and \$5,300 for family coverage. As Sasse's office [explains it](#):

“Senator Sasse’s Qualified Health Savings Account Distribution Act would allow unspent

money from an employer-based savings arrangement to be rolled into a separate health savings account (HSA), ensuring that funds are not forfeited at the end of the year or following a job transition. Funds should follow individuals. Workers should not lose money they've saved based on restrictive federal rules.”

Bipartisan legislation from the 115th Congress ([H.R. 6305](#) and [H.R. 6199](#)) would accomplish some of the same aims.

Conclusion

As progressive policymakers accelerate their push for Medicare for All and single-payer health care, conservatives and free-market advocates must offer alternatives that would lower cost and expand choice for employers and their employees. NTU believes that expanding and accelerating the use of health reimbursement arrangements (HRAs) would give employers, particularly small and mid-sized employers, a convenient and affordable option for providing health coverage to their employees. HRAs are not a silver-bullet solution to concerns about rising health care costs. However, they present a tax-free way for employers to reimburse their employees' health care costs. Individual coverage HRAs (ICHRAs) and excepted benefit HRAs (EBHRAs), in particular, are promising expansions of the HRA model that could offer even more flexible options to employers. Members of Congress from both sides of the aisle should consider all four ideas above, and hold votes on either existing HRA legislation or future legislation that incorporates them in some fashion.

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