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Trump Administration Health Reimbursement Arrangements Put ACA Subsidies at Risk for Low-Income Workers

Peter Newell
Director, Health Insurance Project, United Hospital Fund

The Trump administration is running out of time to deliver on the cornerstone of its health coverage agenda—the repeal of the Affordable Care Act (ACA) and its replacement with a "beautiful plan."[1] The executive order[2] issued in September 2020 is a largely symbolic document rather than a comprehensive replacement plan, although it also simply restates three bite-sized initiatives that were first set out in a January 2017 executive order[3] and which haven't made much headway in New York. The first initiative, loosening rules on association health plans, was challenged in the courts by a coalition of state attorneys general led by New York, with a decision still pending.[4] A second regulation authorizing "bare-bones" short-term limited-duration insurance policies that lack ACA consumer protections was blocked by New York's insurance regulator.[5] The third of these initiatives, **individual coverage health reimbursement arrangements** (ICHRAs, pronounced "ick-ruhs"), authorizes employers to subsidize individual coverage workers buy on their own. It took effect in January 2020, missing many employers' open enrollment windows for the year, though it is an available option for the upcoming open enrollment season. While the ICHRA proposal may be the best of a bad lot in terms of the Trump administration's coverage initiatives, this brief examines the rule's significant risks for New York consumers, particularly lower-income enrollees.

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Background

One close observer of the employer-sponsored insurance market notes the "tortured history" of health reimbursement arrangements (HRAs) and traces their origin to 2001, when employers began offering the plans, usually in conjunction with high-deductible health plans, under existing and unclear Internal Revenue Service guidance in place at the time.[6] A year later, the IRS blessed the arrangements with new guidance (rather than a statutory change to the IRS Code), including authorizing the HRAs to be used by workers to purchase individual coverage directly from insurers. Employers didn't make the provisions widely available, however, and the Obama administration banned their use in 2013,[7] seeking to protect the stability of the individual market as the ACA was about to take effect. Congress enacted legislation tacked on to the 21st Century Cures Act[8] in 2016 authorizing qualified small employer health reimbursement arrangements, (QSEHRAs), available to employers with 50 or fewer workers, with the amounts eligible to be allocated capped at $5,250 annually ($437 per month) and $10,600 annually, for 2020. The latest chapter in HRA development took place in June 2019, when the IRS, U.S. Department of Treasury, Centers for Medicare & Medicaid Services, and U.S. Department of Labor's Employee Benefit Security Administration (together referred to as "the federal agencies" in the rest of this report), issued a final rule[9] authorizing ICHRAs and a related arrangement, excepted benefit health reimbursement arrangements (EBHRAs), effective January 1, 2020.

How Do ICHRAs Work?

ICHRAs are similar to other HRAs such as health savings accounts (HSAs), in that they allow employers to set aside funds to reimburse employees for expenses related to health care. In the case of ICHRAs, however, no account is actually established; instead, employer groups allocate funds for each employee, and then employees submit claims to employers (or administrators) for reimbursement, with the reimbursement amounts not taxed as income for the workers. In contrast to QSEHRAs, ICHRAs do not limit the amount that employers may set aside, and businesses of all sizes are eligible to participate. Within general IRS guidance on what constitutes eligible medical expenses,[10] employers establishing an ICHRA have broad discretion over the amount of reimbursement; whether to provide allowances for both individuals and families; different allowances based on workers' ages;[11] what expenses can be reimbursed, such as individual market premiums or cost sharing or both; and whether to roll over unspent amounts from one year to the next. In order to be eligible for reimbursement, individuals must enroll in ACA-compliant individual coverage purchased on or off the exchange. EBHRAs, however, can be used for reimbursement of dental and vision coverage, or short-term limited-duration insurance (except in New York).[12]

Are ICHRAs the Answer to Declining Employer-Sponsored Coverage and ACA Gaps?

ICHRAs have some appeal as a way to help workers access health coverage when it's not available on the job. Of 8.7 million New Yorkers aged 19 to 64 actively participating in the workforce, more than 634,000 lack either public or private coverage.[13] Reflecting higher and higher prices, offer rates by smaller employers have declined dramatically. For employers with 50 or fewer workers, offer rates declined from 54% in 2000, to 34% in 2019; all told, some 1.6 million workers in New York are employed at private sector firms of this size.[14] As premiums for employer-sponsored insurance (ESI) continue to rise, ICHRAs might be an attractive option for employers who want to attract and retain valued employees but can't afford to pay the full freight for a comprehensive group plan. ICHRAs can help employers avoid another pitfall as well: the tax-advantaged ICHRA reimbursements don't count as income for an employee, unlike well-intentioned salary increases for workers without group coverage that might reduce or eliminate their eligibility for advance premium tax credits (APTCs) through the marketplace. ICHRAs can also provide some support for part-time or gig economy workers ineligible for ESI. Individuals paying Part A, B, and D Medicare premiums are also eligible for ICHRA reimbursement, which could ease the affordability burden on older New Yorkers as well. Finally, ICHRA funds from an employer could offset ACA cost-sharing requirements for workers with APTCs, or smooth out the "cliffs" faced by individuals earning over 400% FPL, who are ineligible for ACA subsidies.

So What's Not to Like About ICHRAs?

Despite the surface appeal of ICHRAs, they have some drawbacks as well. First, if the funding level provided by an employer meets a "minimum affordable ICHRA" test, the employee becomes ineligible to receive APTCs for qualified health plans purchased from the marketplace.[15] Second, employers can offer both ICRHAs and traditional ESI to workers in 11 different classes,[16] such as hourly vs. salaried employees, or workers at different locations. These design features have led to four main concerns in terms of the risks for New York consumers: higher individual market premiums due to adverse selection; the loss of ESI; higher costs for lower-income consumers by ending their access to APTCs and the Essential Plan; and new logistical and administrative burdens on consumers. Details on each of these concerns follow.

Higher Individual Market Premiums

One of the most frequent criticisms of the administration's draft rule was how it was expected to harm the individual market risk pool. The American Academy of Actuaries[17] and other groups warned that adverse selection could arise in several situations, leading to an increase in individual market premiums. For example, since premiums for larger employers are based on the age, sex, and overall claims experience of workers, some employers might shift sicker (or female or older) workers into ICHRA arrangements while maintaining ESI for younger, healthier workers. In addition, older, sicker workers are more likely to purchase coverage with ICHRAs than younger, healthier workers, particularly in the absence of a penalty for not purchasing coverage, which could also put upward pressure on premiums. The final rule seeks to address the employer shift problem by setting minimum numbers of workers within a class that must participate in order for an ICHRA to be established,[18] along with other safeguards. The federal agencies estimate a 1% increase in individual market premiums, but one recent analysis[19] warns of the risk of higher premium increases, despite the changes.

Loss of ESI

For employers offering comprehensive ESI now, there are compelling reasons to switch to an ICHRA, instead of dropping coverage entirely. They are a way to reduce health benefit costs but still provide some support for workers. Promoters of ICHRAs also describe other benefits for employers, such as "getting out of the business of managing your employees' health risk," and reducing costs by replacing a defined benefit plan (ESI) with a defined *contribution* plan—the same argument that has led many employers to ditch pensions for IRAs. The availability of ICHRAs could put comprehensive retiree health plans at risk as well.[20] Under a pending federal rule,[21] providing affordable ICHRAs would also insulate employers from penalties under the ACA's employer shared responsibility provision, which is still on the books.[22] The federal agencies concede that some workers will lose comprehensive group coverage; the question is how many. Some insurance professionals interviewed believe that differences between group and individual coverage—such as narrower networks—will dissuade employers from switching to ICHRAs, out of fear of blowback from valued employees. The federal agencies estimate a loss of ESI for 7 million workers nationally in 2029;[23] if New York State's share of that loss is proportional to its overall share of ESI nationally, about 441,000 New York workers would lose comprehensive coverage through their jobs. [24]

The federal agencies acknowledge the expected ESI decline, though they add an observation that seems tone deaf in this COVID-challenged economy: "In the event that coverage costs for particular employees substantially increase, those employees are expected to seek employment at firms that continue to offer traditional group health plan coverage."[25]

Higher Costs for Lower-Income Consumers

The biggest risk associated with ICHRA offers by New York employers is the potential loss of Essential Plan (EP) coverage for New Yorkers earning less than 200% of the federal poverty level, marketplace premium subsidies, and other benefits under the ACA. Under the final rule, employees can "opt out" of receiving the ICHRA only if the lowest-cost silver tier individual plan in the area, less the value of the ICHRA, exceeds 9.78% of their household income. Those employees with marketplace coverage and APTCs whose ICHRA meets this "minimum affordable ICHRA" standard lose

TABLE 1. 2020 ACA PREMIUM/INCOME CAPS VS. MINIMUM AFFORDABLE ICHRA

Income	ACA Premium Cap ($ or % of Income)	NYSOH Enrollment	Minimum Affordable ICHRA
< 200% FPL	0$ to $20	790,000	9.78%
200% to 250% FPL	6.49% to 8.29%	68,000	9.78%
250% to 300% FPL	8.29% to 9.78%	45,000	9.78%
300% to 400% FPL	9.78%	48,000	9.78%
> 400% FPL	No cap	114,000	9.78%

Sources: Applicable premium caps from *Explaining Health Care Reform: Questions about Health Insurance Subsidies*. January 16, 2020. Henry J. Kaiser Family Foundation. https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/; NYSOH Enrollment in column 3 from NYSOH 2019 Open Enrollment Report. May 2019. https://info.nystateofhealth.ny.gov/2019openenrollmentreport; Minimum Affordable ICHRA in column 4 based on applicable percentage in ICHRA Final Rule.

their APTCs. The federal agencies estimate that take-up of ICHRAs by employers will lead to a reduction in premium tax credits of $6.2 billion annually by 2029,[26] and it's easy to see why: the reduction in tax credits is baked into the design of the minimum affordable ICHRA rule. It effectively overrides ACA statutory caps on premiums for enrollees eligible for APTCs.

ACA premium tax credits are based on capping the income an eligible individual pays for premiums, beginning at just over the limit for Medicaid eligibility at 3.09% of income, and topping off at 9.78% of income, when subsidies end. As shown in Table 1, costs for most families losing APTCs for ICHRAs will increase because the minimum affordable ICHRA caps are higher than the ACA caps. The formula might be more disruptive for New York, because the EP provides free or $20 per month coverage for eligible individuals earning 200% FPL or less. While these individuals could use their ICHRA for the purchase of an individual plan without APTCs, an actuarily equivalent platinum plan is priced at $900 per month in New York County, $822 in Albany County, and $721 in Erie County. The next most vulnerable group falls into the 200 to 250% FPL category, where the spread between the premium cap and minimum affordable ICHRA is still significant; cost-sharing reductions provided for this group of enrollees would also be forfeited, leading to higher out-of-pocket costs. Individuals in the 300 to 400% category are least at risk. It's also important to note that the ICHRA rule replicates the ACA "family glitch" problem,[27] so if an individual is offered an affordable ICHRA, any dependents on a family policy lose coverage or APTCs as well.

In order to illustrate how ICHRA offers could play out in New York, Table 2 shows current individual premiums and APTCs in three New York counties at a range of hypothetical incomes, and estimating how the premiums of individuals with those incomes would change with a minimum affordable ICHRA.

In Erie County (Buffalo area), a comparatively lower-cost county, costs would increase for individuals deemed ineligible for APTCs

TABLE 2. ACA PREMIUM TAX CREDITS VS. ICHRAS AT DIFFERENT INCOME LEVELS: HYPOTHETICAL SCENARIOS IN THREE NY COUNTIES

2a: Erie County (Lowest-Cost Silver Plan: $489)

Income	APTCs	Premium	Minimum ICHRA	New Premium	Change
$24,000	N/A	$20	$293	$196	$176
$25,000	$363	$117	$285	$207	$90
$30,000	$300	$180	$244	$245	$65
$31,000	$286	$193	$236	$236	$43
$40,000	$173	$308	$163	$326	$18
$48,000	$107	$373	$98	$391	$18
$50,000	N/A	$489	$81	$408	($81)
$60,000	N/A	$489	N/A	$489	$0

2b: Tompkins County (Lowest-Cost Silver Plan: $659)

Income	APTCs	Premium	Minimum ICHRA	New Premium	Change
$24,000	N/A	$20	$463	$186	$166
$25,000	$538	$121	$455	$204	$83
$30,000	$475	$184	$414	$245	$61
$31,000	$460	$198	$406	$253	$55
$40,000	$347	$312	$333	$326	$14
$48,000	$281	$377	$268	$391	$14
$50,000	N/A	$659	$251	$408	($251)
$60,000	N/A	$659	$170	$489	($170)

2c: Queens County (Lowest-Cost Silver Plan: $619)

Income	APTCs	Premium	Minimum ICHRA	New Premium	Change
$24,000	N/A	$20	$423	$196	$176
$25,000	$484	$136	$415	$204	$68
$30,000	$420	$199	$374	$245	$46
$31,000	$407	$213	$366	$253	$40
$40,000	$293	$326	$293	$326	$0
$48,000	$277	$392	$228	$391	($1)
$50,000	N/A	$619	$211	$408	($211)
$60,000	N/A	$619	$130	$489	($130)

Incomes were selected to show impacts of minimum affordable ICHRAs at varying levels of ACA eligibility, starting with the upper limit of EP eligibility ($24,000) and finishing with incomes above the level required for ACA premium tax credits ($50,000 and $60,000); APTCs and premiums are derived from entering incomes into NYSOH's Search for Plans tool; minimum ICHRA based on formula *annual income/12 subtracted from monthly premium for lowest-cost silver plan in the county = minimum affordable ICHRA*; new premium is the monthly lowest-cost silver plan in a county less the applicable ICHRA allowance; change is difference between the ACA-subsidized premium and the new ICHRA premium, with negative amounts representing savings for consumers and positive amounts representing losses.

because of an affordable ICHRA offer. Importantly, a $293 monthly ICHRA would also end Essential Plan eligibility for enrollees at the higher end of the EP eligibility scale. About 30,000 Erie County residents were enrolled in the EP or a qualified health plan in 2019,[28] and the same lowest-cost silver plan applies in six other neighboring counties. (The slightly more expensive lowest-cost silver plan of $485 per month in effect in Monroe [Rochester area] and five other counties suggests that residents there with marketplace coverage would also be at higher risk of forfeiting ACA help if employers offered ICHRAs.) At the same time, for those ineligible for APTCs in Erie County, ICHRAs would provide limited value, since an unsubsidized premium is "affordable" at the $60,000 income level in low-cost Erie under the ICHRA rule.

In upstate rural Tompkins County, a considerably higher-cost region, ICHRAs would have different effects. EP enrollees would perhaps be less exposed, because a minimum affordable ICHRA would need to reach $463, about 45% higher than in Erie County, to trigger the loss of coverage. Employers would need to make significant investments in ICHRAs in Tompkins County to reach the minimum affordable standard, but workers with incomes above the APTC cutoff would receive significant benefits.

In Queens County, with ACA premiums higher than Erie but lower than Tompkins, lower-income workers with APTCs would fare better without ICHRAs. And a higher-priced minimum affordable ICHRA would probably expose EP enrollees to a slightly lower risk of losing coverage but would not eliminate it. Workers ineligible for APTCs could gain ICHRA reimbursements that would lower their premium costs.

Clearly, regional health care costs will greatly affect the impact of ICHRAs on employees, but the amount that employers allocate for ICHRAs will be a critical factor. Annual costs of employer-sponsored coverage may be a ceiling, since employers who can afford ESI would be likely to provide it. One federal survey[29] found the 2019 average cost of individual coverage for private sector employees in New York to be $650 per month, and $1,906 per month for families.

There are no federal data on allowance levels for ICHRAs nationally, but a survey by one benefit consultant in the ICHRA market estimated that the average QSEHRA allocation in 2019 was $3,360 for individuals ($280 per month) and $6,168 for families ($514 per month).[30] The same company found a much higher allowance when it surveyed clients with ICHRAs after the rule was in effect for 90 days: $5,971 for individuals ($498 per month) and $12,892 for families ($1,074 per month).[31] It may be that these allowances reflect decisions by employers to replace ESI with ICHRAs, but allowances at these levels would create coverage issues for many New Yorkers eligible for the EP or APTCs. If employers establish allowances that exceed the minimum affordable ICHRA level, it would take some of the sting out of losing APTCs, but at the same time cause more individuals to lose ATPCs. A broad range of compensation for workers at a place of business also could put employers in a difficult position: figuring out how to structure an allocation that helps higher-paid workers ineligible for ACA assistance but doesn't harm lower-paid ones eligible for the EP or APTCs. One ICHRA consultant advises under 50-employee businesses to consider purposefully designing ICHRA plans that don't meet the affordability standard.[32]

Increased Burden on Consumers

Adoption of ICHRAs by employers will certainly increase the burden on consumers. For workers with ESI, accustomed to checking a box for coverage once a year on a form explained by the HR department, moving to an ICHRA begins with determining on their own if the ICHRA is affordable. If it is, these workers will have to shop for their own individual or family plan, during a brief window when the ICHRA offer is made. Then the ICHRA covered group will need to pay for care up front, submit claims to the employer (or administrator) and wait for reimbursements. Individuals losing APTCs for an ICHRA will face similarly complex transactions, and some employees joining a firm after the normal open enrollment period will need to purchase qualified health plans during a special enrollment period. Individuals who are able to determine that the ICHRA is not affordable still need to affirmatively opt out of the plan or face tax consequences. Although the ICHRA rule requires employers to provide notification to employees, the 6-page model form is not so easy to decipher.[33] To its credit, New York State of Health created a minimum ICHRA affordability tool on its website.[34] And while it cautions that it cannot provide tax advice, NYSOH provided training to assistors before the rule took effect, created a special ICHRA unit, and advised its assistors to counsel consumers to work with them on ICHRA-related issues before making coverage decisions.[35]

Conclusion

Based on interviews with health plan officials, insurance producers, business leaders, and regulators, ICHRAs have yet to make a real splash in New York. One plan official described ICHRAs as a “niche market” that employers might use for seasonal or part-time workers. One broker believed that start-ups might find ICHRAs useful in a transition period, providing some benefits for workers until the company grows enough to provide ESI. Another wild card is the impact of the COVID-19 pandemic on employer’s benefit decisions, at a time when many individuals have lost their ESI, businesses are still hurting from the effects of the shutdown, and Congress is still deadlocked on another round of stimulus funding. One business leader noted that employers may be reluctant to try out a new benefit arrangement now, given the challenges of the past year.

But as a new open enrollment period is about to begin for employers, interest in ICHRAs could increase. Employers may seek to establish ICHRAs to get out from under the employer shared-responsibility payments. Certainly, the federal agencies (and vendors) continue to beat the drum about ICHRAs, pushing out written materials regularly[36] and holding monthly promotional webinars;[37] they estimate that about 11.4 million workers will be enrolled in individual coverage with ICHRAs by 2029,[38] about the same number of Americans as are currently enrolled in Marketplace coverage. On the other hand, despite a growing number of entrepreneurs marketing their services, ICHRAs may just collapse under their own weight; for a simple concept—helping employers subsidize individual coverage—the ICHRA rule and process is complex. It touches on complicated

ERISA issues, COBRA, IRS Section 125 cafeteria plans, Medicare and the Medicare Secondary Payer rules, the ACA employer mandate and other parts of the ACA, and health savings accounts. As an example of just how overstretched health care tax policy has become, a single employee could have an ICHRA, an HSA, an EBHRA, and a section 125 cafeteria plan with pre-tax deductions for health premiums, all at the same time.

Voters will certainly have a say in November on what role ICHRAs, adopted solely through rule, will play in the health care system, and the U.S. Supreme Court is scheduled to hear oral arguments on a lawsuit seeking to invalidate the entire ACA on November 10, 2020. Most court watchers agree that the sad passing of Justice Ruth Bader Ginsburg, coupled with the expected confirmation of nominee Amy Coney Barrett, puts the ACA in greater jeopardy. Judge Barrett has written that "Chief Justice Roberts pushed the Affordable Care Act beyond its plausible meaning to save the statute."[39]

Whatever the outcomes on these broader legal and political stages, ICHRAs could be vastly improved for New Yorkers with three changes—made through the regulatory authority of the federal agencies, or, if necessary, through a statutory change enacted by Congress:

- First, grant Essential Plan enrollees an automatic right to opt out of ICHRAs without an affordability test.

- Second, allow individuals to receive both ICHRAs and APTCs if they are eligible for both. After all, other tax-preferred health provisions are not restricted based on income, and large amounts of federal and state revenue flow to upper-income owners of HSAs, HRAs and, most famously, through the tax exclusion of employer contributions to health insurance.[40]

- And third, to discourage the wholesale replacement of ESI with ICHRAs, limit the option to small employers (like QSEHRAs)—or condition large employers' exemption from the employer responsibility provisions on providing as much as a typical employer would contribute to a comprehensive group plan, rather than the current minimum affordable ICHRA standard.

These three simple changes would establish ICHRAs as a tool that helps address shortcomings in the ESI market and the ACA—rather than undermining them.

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