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SUMMARY

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# Health Reimbursement Arrangements (HRAs): Overview and Related History

A health reimbursement arrangement (HRA) is a tax-advantaged arrangement that reimburses individuals for qualified health care costs. With some exceptions, qualified health care costs generally include amounts that individuals paid out-of-pocket for the following:

- the diagnosis, cure, mitigation, treatment, or prevention of disease and the treatments affecting any part of the body
- health insurance premiums
- qualified long-term-care services
- menstrual care products

The Internal Revenue Service (IRS) first acknowledged HRAs in 2002 guidance as a health benefit that employers could offer their employees and former employees (including retirees). Under these initial rules, employees and former employees could use employer-contributed HRA funds to help cover the costs of health insurance and/or unreimbursed medical care up to a specified limit. Since then, legislative and regulatory activity regarding HRAs (and private health insurance more generally) have resulted in new types of HRAs and modified the ways employers may offer this benefit.

As an employer-provided benefit, an individual's eligibility to receive HRA contributions is tied primarily to whether the individual works for an employer that offers such a benefit. If an employer offers such a benefit to its employees, the employer contributes money to an employee's HRA and then reimburses the individual for any qualified medical expenses he or she incurs, so long as there is a balance. Employer contributions to an HRA are excluded from an employee's gross income and wages (hence are not subject to income or payroll taxes), and distributions from such arrangements for qualified medical expenses are tax-free. Only employers can contribute to HRAs.

There are five kinds of HRAs:

- **group health plan HRAs**, which are available to employees of an employer offering this benefit who are enrolled in a group health plan (e.g., employer-sponsored insurance)
- **qualified small employer HRAs (QSEHRAs)**, which are available to employees of a small employer providing this benefit who are enrolled in minimum essential coverage (e.g., employer-sponsored insurance, individual coverage, Medicare, Medicaid)
- **individual coverage HRAs (ICHRAs)**, which are available to employees of an employer offering this benefit who are enrolled in individual coverage (e.g., coverage not provided through an employer that individuals directly purchase for themselves and their families)
- **excepted benefit HRAs**, which are more limited than other HRAs, with the smallest HRA contribution limit and the most restrictions on the types of premiums that can be reimbursed from the HRA
- **retiree-only HRAs**, which are available only to retirees of employers offering this benefit

As HRAs, these arrangements have many similar features; however, there are some distinctions among these HRAs. For example, an individual's eligibility for an HRA is tied primarily to whether the individual works for an employer that offers an HRA as a benefit; however, depending on the kind of HRA, the individual also may need to be covered by a particular type of insurance to be eligible for reimbursement from the HRA.

This report briefly summarizes each kind of HRA, highlighting key aspects regarding eligibility and insurance coverage requirements, contributions, distributions, and the treatment of unused balances for each arrangement. It also provides a side-by-side comparison table of the different kinds of HRAs (**Table 2**). The report concludes with an **Appendix** that describes the history of HRAs and contextualizes certain HRA rules.

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# Introduction

Health reimbursement arrangements (HRAs) are one type of tax-advantaged arrangement that individuals can use to cover the cost of qualified health care costs, including medical expenses not otherwise reimbursed by health insurance coverage and, in some cases, health insurance premiums.[1]

The Internal Revenue Service (IRS) first acknowledged HRAs in guidance issued in 2002 as a health benefit that employers could offer their employees and former employees (including retirees). Under these initial rules, employees and former employees could use employer-contributed HRA funds to help cover the costs of health insurance and/or unreimbursed medical care up to a specified limit. Since then, legislative and regulatory activity regarding HRAs (and private health insurance more generally) has resulted in new types of HRAs and modified the ways employers may offer this benefit to their employees.

Since HRAs are an employer-established health benefit, an individual's eligibility to receive HRA contributions is tied primarily to whether the individual works for an employer that offers an HRA.[2] If an employer offers such benefit to its employees, the employer contributes money to the employee's HRA and then reimburses the individual for any qualified medical expenses he or she incurs, so long as there is a balance.[3]

Employer contributions to an HRA are excluded from an employee's gross income and wages (hence are not subject to income or payroll taxes).[4] Distributions from such arrangements for qualified medical expenses are tax-free.

This report discusses five kinds of health reimbursement arrangements (HRAs), listed below in the order they are discussed in the report:

[1] Health savings accounts (HSAs) and flexible spending arrangements (FSAs) are two other types of tax-advantaged accounts or arrangements that can be used to pay for unreimbursed medical expenses. Health reimbursement arrangements (HRAs) are similar to FSAs in that eligibility for both arrangements is tied to whether an individual's employer offers the account as a benefit, though HRAs are distinct from FSAs in that HRAs can be funded only by employers. Employees usually fund FSAs, and employers may make additional contributions. In contrast, HSAs are distinct from HRAs in that HSAs are not necessarily provided through employers (although employers can incorporate HSAs as part of a benefits package). Relatedly, HSA funds belong to the individual and stay with the individual if he or she leaves the employer, which generally is not the case for HRAs. When an individual with an HRA leaves his or her employer, the HRA funds stay with the employer unless the employer provides otherwise or the individual accesses the HRA under applicable Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA; P.L. 99-272) continuation coverage requirements. Also in contrast to HRAs, HSA funds may be invested. For an overview and further comparisons between HSAs, FSAs, and HRAs, see CRS Report R46782, *A Comparison of Tax-Advantaged Accounts for Health Care Expenses*.

[2] Self-employed individuals are not eligible for HRAs. Internal Revenue Service (IRS), "Health Reimbursement Arrangements," Notice 2002-45, at https://www.irs.gov/pub/irs-drop/n-02-45.pdf (hereinafter, IRS Notice 2002-45).

[3] Employers need not actually contribute to HRAs until employees seek reimbursement from the HRAs; the arrangements may be simply notional. To facilitate easy reading, this report often uses the term *contribution* also to refer to amounts that employers make available to employees for reimbursement under the terms of the arrangement. The HRA amount made available to individuals also is often referred to as the reimbursement limit. U.S. Government Accountability Office (GAO), *Consumer Directed Health Plans: Health Status, Spending, and Utilization of Enrollees in Plans Based on Health Reimbursement Arrangements*, GAO-10-616, July 2010, p. 7, at https://www.gao.gov/assets/gao-10-616.pdf.

[4] HRA contributions are exempt from Social Security, Medicare, and federal unemployment employment taxes, with limited exceptions. See treatment of accident and health benefits in IRS, *Publication 15-B: Employer's Tax Guide to Fringe Benefits*, January 31, 2022, at https://www.irs.gov/pub/irs-pdf/p15b.pdf.

- group health plan HRAs
- qualified small employer HRAs (QSEHRAs)
- individual coverage HRAs (ICHRAs)
- excepted benefit HRAs
- retiree-only HRAs

As HRAs, these arrangements have many similar features. For example, all HRAs can be funded only with employer contributions and such amounts are not included as employee wage income. In addition, all reimbursements are tax-free if they are used for the qualifying medical expenses of the employee or the employee's spouse, dependents, and children under the age of 27.[5]

However, there are some distinctions between each kind of HRA. For example, depending on the kind of HRA, an individual may need to be covered by a particular type of insurance to be eligible for reimbursement from the HRA.

This report briefly summarizes each kind of HRA, highlighting key aspects regarding eligibility, contributions, distributions, and the treatment of unused balances. The first three HRAs discussed generally require account holders to be enrolled in a particular type of health insurance policy. These three HRAs are chronologically ordered by the date of establishment. The next two HRAs discussed address different circumstances that do not require account holders to be enrolled in a particular type of health insurance policy.

The report also provides a side-by-side comparison table of the different kinds of HRAs (**Table 2**). Additionally, because understanding the development of HRAs helps to highlight differences among the types of HRAs, it concludes with an **Appendix** that describes the legislative and regulatory history of HRAs and contextualizes certain HRA rules.

# Group Health Plan HRAs

In general, group health plan HRAs require employees to be enrolled in a group health plan (e.g., employer-sponsored insurance) to receive contributions to and reimbursement from their HRAs. This type of HRA was not established in statute but was first acknowledged by the Internal Revenue Service (IRS) in 2002.[6] As one of the earliest designated types of HRAs, group health plan HRAs initially were referred to simply as *HRAs*, a naming convention that remains in colloquial use. (This report uses the term *group health plan HRAs* to prevent confusion when discussing HRAs generally.)

[5] In this context, the term *dependent* includes all dependents that the HRA holder claims on his or her tax return and any person the HRA holder could have claimed as a dependent on his or her tax return, except that (1) the person filed a joint return, (2) the person had a gross income of $4,400 or more (for tax year 2022), or (3) the HRA holder could have been claimed as a dependent on someone else's return. IRS, *Health Savings Accounts and Other Tax-Favored Health Plans*, IRS Publication 969, February 11, 2021, p. 18, at https://www.irs.gov/pub/irs-pdf/p969.pdf (hereinafter, IRS Publication 969). Gross income amount for 2022 was published in IRS, "26 CFR 601.602: Tax Forms and Instructions," IRS Revenue Procedure 2021-45, at https://www.irs.gov/pub/irs-drop/rp-21-45.pdf (hereinafter, IRS Revenue Procedure 2021-45).

[6] IRS Notice 2002-45; IRS Revenue Ruling 2002-41.

## Eligibility and Qualifying Insurance

Group health plan HRAs generally are available to current and former employees whose employers offer this benefit. As implied by the name, employees must be enrolled in a group health plan (e.g., employer-sponsored insurance) to be eligible for a group health plan HRA.[7]

If an employer offers a group health plan HRA to its employees, the employer also must offer employer-sponsored coverage. Employers often offer group health plan HRAs alongside high-deductible health plans (HDHPs), though employers are not required to do so.[8] Eligibility for a group health plan HRA is not tied to HDHPs specifically; the group health plan in which an individual must be enrolled to be eligible for this type of HRA does not need to satisfy any cost-sharing requirements (e.g., to have a high enough deductible).

In addition, an individual is not required to be enrolled in his or her own employer's coverage to be eligible for a group health plan HRA. For example, if permitted by the individual's employer, an employee could receive group health plan HRA contributions from his or her employer if the individual were simultaneously enrolled in employer-sponsored coverage offered by his or her spouse's employer.[9]

## Contributions

There is no federal limit on the amount employers may contribute to an employee's group health plan HRA. When setting up the benefit, employers must establish a maximum HRA amount that would be made available to individuals, sometimes referred to by the IRS as a reimbursement limit.[10] The employer also would specify the reimbursement limit period. For example, an employer may specify that the reimbursement limit applies for a calendar year.

## Qualifying Medical Expenses

Group health plan HRAs must be used for unreimbursed payments of qualifying medical expenses, including items within the definition of *medical care* under *Internal Revenue Code* (IRC) Section 213(d) and menstrual care products.[11] Although health insurance premiums generally are included as a qualifying medical expense under IRC Section 213(d), group health plan HRAs cannot reimburse individual coverage premiums.[12] Employers offering group health plan HRAs may further restrict the types of medical and health services eligible for reimbursement.

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[7] More specifically, employees must be enrolled in a group health plan that satisfies certain federal private health insurance requirements to be eligible for the group health plan HRA. For a description of the federal requirements that the group health plan must satisfy, see **Appendix**.

[8] Gary Claxton et al., *2021 Employer Health Benefits Survey*, Kaiser Family Foundation, November 10, 2021, p. 124, at https://files.kff.org/attachment/Report-Employer-Health-Benefits-2021-Annual-Survey.pdf.

[9] Department of Labor (DOL), Employee Benefits Security Administration (EBSA), *FAQs About Affordable Care Act Implementation Part 37*, January 12, 2017, at https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-37.pdf (hereinafter, DOL, EBSA, *FAQs*).

[10] IRS Notice 2002-45.

[11] As used in this report, *unreimbursed payments* refers to payments made directly by an individual for medical care that do not get reimbursed (e.g., by the individual's insurance plan). See "Qualifying Medical Expenses Under IRC Section 213(d)" text box in this report.

[12] IRS, Q&A 2 in "Further Guidance on the Application of the Group Health Plan Market Reform Provisions of the Affordable Care Act to Employer-Provided Health Coverage and on Certain Other Affordable Care Act Provisions," IRS Notice 2015-87, at https://www.irs.gov/pub/irs-drop/n-15-87.pdf (hereinafter, IRS Notice 2015-87).

### Qualifying Medical Expenses Under IRC Section 213(d)

All types of health reimbursement arrangements (HRAs) allow tax-advantaged reimbursements for qualified medical expenses. The definition of *qualified medical expenses* for HRAs is based on the definition of *medical care* that is used for the medical and dental expenses itemized deduction; this definition is at *Internal Revenue Code* (IRC) Section 213(d). Put simply, items that would qualify for the medical and dental expenses itemized deduction generally could be considered HRA-qualifying medical expenses, though certain HRA-specific rules may prevent portions of the IRC Section 213(d) definition from being considered a qualified medical expense for a particular HRA type.

The definition of medical care at IRC Section 213(d) does not provide an exhaustive list of all items that are considered medical care; rather, it broadly defines the term *medical care* to include amounts paid for "the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body." It also includes certain transportation and lodging expenditures, amounts paid for health insurance and qualified long-term-care costs, and limited amounts of long-term-care insurance premiums. As interpreted by the Internal Revenue Service (IRS) and courts, costs for ambulances, body scans, and chiropractors would fall within the definition of medical care, whereas, in general, personal-use expenses (e.g., toothpaste) and general health expenses (e.g., weight-loss programs) would not.

The IRS-issued Publication 502 provides more detailed information about what generally is and is not considered medical care under the medical and dental expenses itemized deduction. As such, Publication 502 also indicates which items generally are considered qualifying medical expenses for HRA purposes, though it does not incorporate any HRA rules. Furthermore, even though Publication 502 indicates that over-the-counter medicines are not considered medical care for the medical and dental expenses itemized deduction, such medicines are considered HRA-qualifying medical expenses.

**Sources:** IRC §213; IRS, "Medical and Dental Expenses," Publication 502, January 11, 2022, at https://www.irs.gov/pub/irs-pdf/p502.pdf; and IRS, *Health Savings Accounts and Other Tax-Favored Health Plans*, IRS Publication 969, February 11, 2021, p. 18, at https://www.irs.gov/pub/irs-pdf/p969.pdf.

**Note:** Although IRS Publication 502 includes a list of items that are considered medical care, the list does not include all possible medical expenses.

Group health plan HRA funds can be used only for qualifying medical expenses incurred by the employee (current and former), the employee's spouse and dependents (including those of deceased employees), and the employee's children younger than 27 years of age at the end of the year.[13] To use a group health plan HRA to pay for the medical expenses of an employee or an employee's spouse, dependents, and children younger than 27 years of age, these individuals also must be enrolled in a group health plan.[14]

## Treatment of Unused Balances

Unused group health plan HRA balances may be carried forward to increase the HRA holder's reimbursement limit in subsequent periods, though employers may limit the aggregate carryovers.[15]

Employers may, but are not required to, set up group health plan HRAs in such a way that employees who cease to be covered under a group health plan retain access to their remaining

[13] See footnote 5.

[14] The employee, the employee's spouse, and the employee's dependents need not all be enrolled in the same group health plan. For example, the employee may be enrolled in the group health plan offered by his or her employer and the employee's spouse and dependents may be enrolled in a group health plan offered by the spouse's employer. IRS Notice 2015-87 and DOL, EBSA, *FAQs*.

[15] IRS Notice 2002-45 and IRS, Department of the Treasury, EBSA, DOL, Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services, "Health Reimbursement Arrangements and Other Account-Based Group Health Plans," 84 *Federal Register* 28888, July 20, 2019 (hereinafter, 84 *Federal Register* 28888).

HRA balances that were credited to the employee when he or she was enrolled in a group health plan.[16]

If an employee separates from his or her employer, the employee either forfeits his or her group health plan HRA balances or must be allowed to permanently opt out and waive future reimbursement from the HRA.[17] Former employees may retain access to their group health plan HRAs if they do not opt out of the HRA and the employer has structured the benefit to be available to former employees. Former employees also may be able to access the group health plan HRA under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA; P.L. 99-272) continuation coverage requirements.[18]

# Qualified Small Employer HRAs

QSEHRAs are a type of HRA that only certain small employers can provide. Employers providing this benefit can provide only a QSEHRA as a health benefit; they cannot also offer health insurance coverage. Employees receiving this benefit must enroll in minimum essential coverage and may do so by using QSEHRA funds to help cover premium costs. Employees can then use any remaining QSEHRA balances to cover other qualified medical expenses, if the employees remain enrolled in appropriate coverage.

Congress established QSEHRAs in the 21st Century Cures Act (P.L. 114-255) in 2016.[19]

## Eligibility and Qualifying Insurance

QSEHRAs generally are provided to *all* current employees of small employers that provide this benefit.[20] Employers are generally considered *small*—and hence eligible to provide QSEHRAs—if they have fewer than 50 full-time-equivalent employees and do not offer health insurance to any of their employees.[21]

To receive the tax benefits associated with QSEHRAs, employees must be enrolled in *minimum essential coverage*.[22] Most types of comprehensive coverage are considered minimum essential

[16] IRS, Q&A 5 in "Application of Market Reform and Other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain Other Employer Healthcare Arrangements," IRS Notice 2013-54, at https://www.irs.gov/pub/irs-drop/n-13-54.pdf (hereinafter, IRS Notice 2013-54).

[17] The opt-out feature is because the benefits provided by the HRA generally would preclude an individual from being able to claim a premium tax credit. IRS Notice 2013-54, Q&A 4.

[18] For more information on COBRA continuation coverage, see CRS Report R40142, *Health Insurance Continuation Coverage Under COBRA*.

[19] Section 18001 of P.L. 114-255.

[20] Unlike other health benefits, employees cannot waive qualified small employer HRA (QSEHRA) participation. Employers must provide a QSEHRA to all eligible employees, though the terms of the QSEHRA may exclude certain types of employees. Specifically, employees with less than 90 days of service, employees younger than the age of 25, part-time or seasonal employees, employees covered by a collective bargaining unit where accident and health benefits were the subject of good-faith bargaining, and nonresident alien employees with no earned income from sources within the United States. 26 U.S.C. §105(h)(3)(B), as referenced by 26 U.S.C. §9831(d)(3)(A). IRS, "Qualified Small Employer Health Reimbursement Arrangements," IRS Notice 2017-67, at https://www.irs.gov/pub/irs-drop/n-17-67.pdf (hereinafter, IRS Notice 2017-67).

[21] More specifically, employers not subject to the employer shared responsibility provisions are considered small employers for QSEHRA purposes. 26 U.S.C. §9831(d)(3)(B). For more information on the employer shared responsibility provisions, see CRS Report R45455, *The Affordable Care Act's (ACA's) Employer Shared Responsibility Provisions (ESRP)*.

[22] For information on the types of plans in which an individual with a QSEHRA can enroll, see IRS, "Appendix A:

coverage, including public coverage, such as coverage under programs sponsored by the federal government (e.g., Medicaid, Medicare) and private insurance (e.g., a spouse's employer-sponsored insurance, individual insurance). The qualifying insurance does not need to satisfy any arrangement-specific cost-sharing requirements (e.g., have a high enough deductible).

Unlike ICHRAs (discussed below), employees with a QSEHRA who enroll in individual coverage through a Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) individual market exchange still may qualify for a premium tax credit if the QSEHRA is not considered *affordable* (**Table 1**).[23] Affordability is determined using a formula that incorporates the premium of the second-lowest-cost silver plan that is available to the individual on the exchange, the individual's annual household income, and the amount of the QSEHRA contribution.[24] If eligible, the amount of premium tax credit available to an individual would be determined in accordance with the standard premium tax credit formula but would be reduced to account for the amount of the QSEHRA contribution that the individual receives.

## Contributions

QSEHRAs are subject to an annual employer contribution limit. In 2022, reimbursements from a QSEHRA cannot exceed $5,450 per year for self-only coverage or $11,050 per year for coverage that includes family members.[25] These dollar amounts are prorated for part-year employees and part-year QSEHRAs and are indexed for inflation in future years. Employers may choose to provide a QSEHRA with a reimbursement limit below these specified amounts.

Employers must provide the QSEHRA "on the same terms" to *all* employees. Similar to ICHRAs, employers may vary QSEHRA amounts according to employee age and family size.[26]

## Qualifying Medical Expenses

QSEHRAs generally must be used for unreimbursed payments of qualifying medical expenses, a category that includes items within the definition of medical care under IRC Section 213(d) and menstrual care products.[27] Employers offering QSEHRAs may further restrict the types of medical and health services that are eligible for reimbursement by QSEHRA funds.

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Types of Minimum Essential Coverage," in IRS Notice 2017-67.

[23] Premium tax credits are financial assistance that reduces the amount individuals pay for health insurance coverage through an individual market exchange. For more information on the premium tax credit, see CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*.

[24] A QSEHRA is considered *affordable* if the monthly premium amount that the employee pays (after accounting for any monthly QSEHRA amounts) for self-only coverage for the second-lowest-cost silver plan is less than 9.61% of one-twelfth of the employee's household income in 2022. For this exercise, the monthly QSEHRA amount is the annual contribution amount that is available to the employee divided by 12, unless the employer provides different QSEHRA amounts to those with self-only and family coverage; in that case, the monthly QSEHRA amount is the annual self-only QSEHRA amount divided by 12. The percentage is indexed for inflation in future years. The term *silver plan* refers to one of the four categories of health insurance plans offered on the ACA individual market exchange. 26 U.S.C. §36B(c)(4)(C); IRS Notice 2017-67; and IRS, Revenue Procedure 2021-36, at https://www.irs.gov/irb/2021-35_IRB#REV-PROC-2021-36.

[25] IRS Revenue Procedure 2021-45.

[26] Contribution amounts may vary in accordance with the premium variation for an individual market health insurance policy based on age or the number of family members. The individual market health insurance policy that the employer may rely on to determine the amount of permitted variance must be minimum essential coverage and must be available to at least one eligible employee. 26 U.S.C. §9831(d)(2)(C) and IRS Notice 2017-67.

[27] QSEHRA amounts used to reimburse pretax premiums of a health insurance plan provided by the employer of the

QSEHRA funds can be used only for qualifying medical expenses incurred by the employee, the employee's spouse and dependents (including those of deceased employees), and the employee's children younger than 27 years of age at the end of the year.[28] To use QSEHRA funds to reimburse the medical expenses of an employee or an employee's spouse, dependents, and children younger than 27 years of age, these individuals also must be enrolled in minimum essential coverage.[29]

### Treatment of Unused Balances

Unused QSEHRA balances may be carried forward in subsequent periods, though employers may limit aggregate carryovers.[30] Carried-over QSEHRA amounts count toward the subsequent year's annual contribution limit.[31]

If an employee ceases to be covered by minimum essential coverage, the QSEHRA cannot reimburse the employee's medical expenses.

If an employee separates from his or her employer, QSEHRA balances are forfeited.

## Individual Coverage HRAs

In general, employers offer ICHRAs to their employees, who then generally use the ICHRA funds to purchase individual market health insurance policies (i.e., non-group policies). For example, an employer could offer this type of HRA to an employee who then receives reimbursement from the HRA to cover his or her premiums for insurance offered on the ACA individual market exchange. The employee could use any remaining balances not used for premiums to cover other qualified medical expenses that he or she incurs while enrolled in individual coverage.

This type of HRA is relatively new. It was established in a final rule issued on June 20, 2019, by the Departments of Health and Human Services (HHS), Labor (DOL), and the Treasury.[32]

### Eligibility and Qualifying Insurance

ICHRAs generally are available to current and former employees whose employers offer this benefit. As implied by the name, to be eligible for an ICHRA, employees must be enrolled in an individual market health insurance policy (i.e., non-group policy) that satisfies certain federal private health insurance requirements.[33] Qualifying insurance includes individual coverage on and off the ACA individual health insurance exchanges, catastrophic plans, transitional plans (or *grandmothered* plans), and fully insured student health insurance coverage.[34] The individual

employee's spouse are taxable. IRS Notice 2017-67.

[28] See footnote 5.

[29] The employee, the employee's spouse, and the employee's dependents need not all be enrolled in the same health plan. IRS Notice 2017-67.

[30] IRS Notice 2002-45 and 84 *Federal Register* 28888.

[31] IRS Notice 2017-67.

[32] 84 *Federal Register* 28888.

[33] For a discussion of these private health insurance requirements, see **Appendix**.

[34] Transitional plans, or *grandmothered plans*, are individual and small-group market plans that meet certain requirements and are in states that have continuously opted to exempt them, per federal guidance. Transitional plans are exempt from some federal requirements. Individual coverage HRAs (ICHRAs) also may be paired with grandfathered plans. If certain conditions are met, ICHRAs can be paired with Medicare (26 C.F.R. §54.9802-4(e)). For more

market coverage does not need to satisfy any arrangement-specific cost-sharing requirements (e.g., have a high enough deductible).

Unlike QSEHRAs, employees with an ICHRA who enroll in individual coverage through an ACA individual market exchange are ineligible for premium tax credits (**Table 1**).[35] However, employees may opt out of the ICHRA and, in doing so, may become eligible for a premium tax credit if the ICHRA is not considered *affordable*. Affordability is determined based on a formula that takes into account the premium of the lowest-cost silver plan available to the individual, the amount of ICHRA contributions, and the individual's annual income.[36]

**Table 1. Comparison of Premium Tax Credit Eligibility Between Qualified Small Employer HRAs (QSEHRAs) and Individual Coverage HRAs (ICHRAs)**

| | QSEHRAs | ICHRAs |
|---|---|---|
| Premium Tax Credit Eligibility | QSEHRA must be considered unaffordable to be eligible. | ICHRA must be considered unaffordable and individual must opt out of ICHRA to be eligible. |
| Affordability Determination | Made using the second-lowest-cost silver plan on the exchange available to the employee. | Made using the lowest-cost silver plan on the exchange available to the employee. |
| HRA Impact on Premium Tax Credit Amount (if eligible) | QSEHRA monthly amount reduces the premium tax credit amount. For example, someone who is eligible for $500 in premium tax credit and receives $300 a month in QSEHRA contributions would receive $200 in premium tax credit. | Employee must choose between ICHRA amount and premium tax credit. |

**Sources:** Internal Revenue Service (IRS), "Qualified Small Employer Health Reimbursement Arrangements," IRS Notice 2017-67, at https://www.irs.gov/pub/irs-drop/n-17-67.pdf; and IRS, Department of the Treasury, Employee Benefits Security Administration, Department of Labor; Department of Health and Human Services, Centers for Medicare & Medicaid Services, "Health Reimbursement Arrangements and Other Account-Based Group Health Plans," 84 *Federal Register* 28888, July 20, 2019.

**Notes:** QSEHRAs = qualified small employer health reimbursement arrangements; ICHRAs = individual coverage health reimbursement arrangements. Other factors (e.g., income) also affect premium tax credit eligibility. For more information on premium tax credits, see CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*.

Employees offered an ICHRA do not have the option to choose between this benefit and employer-sponsored insurance, because employers are not allowed to offer an employee both an

information on grandfathered plans, transitional plans (*grandmothered* plans), and fully insured student health insurance coverage, see CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*.

[35] Premium tax credits are financial assistance that reduces the amount individuals pay for health insurance coverage through an individual market exchange. For more information on the premium tax credit, see CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*. 84 *Federal Register* 28915.

[36] An ICHRA is considered *affordable* if the monthly premium amount that the employee pays (after accounting for any monthly ICHRA amounts) for self-only coverage for the lowest-cost silver plan is less than 9.61% of one-twelfth of the employee's household income in 2022. For this exercise, the monthly ICHRA amount is the annual HRA contribution amount available to the employee divided by 12, unless the employer provides different ICHRA amounts to those with self-only and family coverage, in which case, the monthly ICHRA amount is the annual self-only ICHRA amount divided by 12. The percentage is indexed for inflation in future years. 26 U.S.C. §36B(c)(4)(C) and IRS Revenue Procedure 2021-36 at https://www.irs.gov/irb/2021-35_IRB#REV-PROC-2021-36.

ICHRA and any of the following: another group health plan, an excepted benefit HRA, or a QSEHRA.[37]

From the employer perspective, employers offering ICHRAs do not need to offer this benefit to *all* of their employees. However, if the employer offers the ICHRA to only a subset of its workforce, the employer must similarly offer the ICHRA to everyone within a specified *class of employees* (e.g., full-time employees, part-time employees).[38] For example, an employer may elect to offer full-time employees employer-sponsored insurance and to offer part-time employees an ICHRA.[39]

## Contributions

There is no federal limit on the amount employers may contribute to an employee's ICHRA, but employers must establish a reimbursement limit when setting up the benefit offering.[40] The employer also would specify the reimbursement limit period. For example, an employer may specify that the reimbursement limit applies for a calendar year.

Employers offering ICHRAs to their employees must offer ICHRAs on the same terms to all employees within a class of employees. *On the same terms* refers to both the amount of ICHRA funding available for reimbursement and the terms and conditions of the benefit.[41] However, employers may vary employee ICHRA amounts according to employee age and family size.[42]

## Qualifying Medical Expenses

ICHRAs generally must be used for unreimbursed payments of qualifying medical expenses, a category that includes items within the definition of medical care under IRC Section 213(d) and menstrual care products. Employers offering ICHRAs may further restrict the types of medical and health services that are eligible for reimbursement by ICHRA funds.

ICHRA funds can be used only for qualifying medical expenses incurred by the employee (current and former), the employee's spouse and dependents (including those of deceased employees), and the employee's children younger than 27 years of age at the end of the year.[43] To use ICHRA funds to pay for the medical expenses of an employee and an employee's spouse,

[37] Because an employer cannot offer a group health plan to an employee if the employer already is offering the employee an ICHRA and because an excepted benefit HRA must be offered alongside a (non-HRA) group health plan, an employee cannot receive an offer of an ICHRA and an excepted benefit HRA. 26 C.F.R. §54.9802-4(c)(2); 84 *Federal Register* 28902; IRS Notice 2017-67.

[38] For a list of allowable classes of employees, see 26 C.F.R. §54.9802-4(d)(2).

[39] In instances where an employer offers a group health plan to at least one class of employees and offers an ICHRA to at least one other class of employees, the employer may be subject to requirements that specify the minimum number of employees that are allowed to be in the class of employees being offered the ICHRA. 26 C.F.R. §54.9802-4(d)(3).

[40] 84 *Federal Register* 28931.

[41] 84 *Federal Register* 28904.

[42] Specifically, an employer may increase the maximum amount contributed to an employee's ICHRA as the employee's age increases. Such discrepancy cannot exceed 3:1 and generally ties to the premium variance allowed in the individual market for a person's age. Additionally, an employer may increase the maximum amount contributed to an employee's HRA as the employee's number of dependents increases. 26 C.F.R. §54.9802-4(c)(3)(iii); 84 *Federal Register* 28905. For age-rating restrictions in the individual market, see 42 U.S.C. §300gg.

[43] See footnote 5.

dependents, and children younger than 27 years of age, these individuals also must be enrolled in an individual health insurance policy.[44]

### Treatment of Unused Balances

ICHRA holders may carry forward unused ICHRA balances to increase his or her HRA limit in subsequent periods, though employers may limit the aggregate carryovers.[45]

If an employee ceases to be covered by individual health insurance coverage, the employee must forfeit the entire balance of his or her HRA.[46]

If an employee separates from his or her employer, the employee must either forfeit his or her ICHRA balances or must be allowed to permanently opt out and waive future reimbursement from the HRA.[47] Former employees may retain access to their ICHRAs if they do not opt out of the HRA and the employer has structured the benefit to be available to former employees. Former employees also may be able to access the ICHRA under COBRA continuation coverage requirements.[48]

## Excepted Benefit HRAs

Excepted benefit HRAs are more limited in scope than other HRAs; excepted benefit HRAs have the lowest annual contribution limit among all HRAs and the most limitations with respect to the types of premiums that the HRA can reimburse. Unlike for the first three HRAs discussed in this report, there is no qualifying insurance associated with excepted benefit HRAs. Individuals may be enrolled in any coverage type (or may be uninsured) and still may receive reimbursement from an excepted benefit HRA. This type of HRA is also relatively new, having been established in the same 2019 final rule that established ICHRAs.[49]

### Eligibility and Qualifying Insurance

Excepted benefit HRAs generally are available to current and former employees whose employers offer this benefit. There is no qualifying insurance associated with excepted benefit HRAs.

Employers offering an excepted benefit HRA to their employees must offer the benefit alongside employer-sponsored insurance, though the employee cannot be required to accept the employer-sponsored insurance in order to receive the excepted benefit HRA.[50]

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[44] The employee, the employee's spouse, and the employee's dependents need not all be enrolled in the same health plan. 84 *Federal Register* 28929.

[45] IRS Notice 2002-45 and 84 *Federal Register* 28888.

[46] 26 C.F.R. §54.9802-4(c)(1)(ii).

[47] The opt-out feature is because the benefits provided by the ICHRA generally would preclude an individual from being able to claim a premium tax credit. 84 *Federal Register* 28913-28915.

[48] For more information on COBRA continuation coverage, see CRS Report R40142, *Health Insurance Continuation Coverage Under COBRA*.

[49] 84 *Federal Register* 28888.

[50] Ibid., pp. 28933-28934.

## Contributions

Contributions to excepted benefit HRAs are capped at $1,800 for 2022 and indexed to inflation for future years, though employers may make less than that amount available for reimbursement.[51]

## Qualifying Medical Expenses

Excepted benefit HRAs generally must be used for unreimbursed payments of qualifying medical expenses, a category that includes items within the definition of medical care under IRC Section 213(d) and menstrual care products. Although health insurance premiums generally are included as a qualifying medical expense under IRC Section 213(d), excepted benefit HRAs cannot reimburse for individual health insurance coverage premiums, group health plan premiums, or Medicare premiums.[52] The only premiums that excepted benefit HRAs can reimburse are those for health care continuation coverage (e.g., COBRA); coverage that consists solely of excepted benefits; and generally short-term, limited-duration insurance.[53] Employers offering excepted benefit HRAs may further restrict the types of medical and health services that are eligible for reimbursement by excepted benefit HRA funds.

Excepted benefit HRA funds can be used only for the qualifying medical expenses incurred by the employee (current and former), the employee's spouse and dependents (including those of deceased employees), and the employee's children younger than 27 years of age at the end of the year.[54]

## Treatment of Unused Balances

Excepted benefit HRA holders may carry forward unused balances in subsequent periods, though employers may limit the aggregate carryovers.[55] Unlike for QSEHRAs, carried-over amounts *do not* count toward the annual limit.

If an employee separates from his or her employer, the individual may retain access to their excepted benefit HRA if the employer has structured the benefit to be available to former employees. Former employees also may be able to access the excepted benefit HRA under COBRA continuation coverage requirements.

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[51] 26 C.F.R. §54.9831-1(c)(3)(viii)(B) and IRS, "26 C.F.R. 601.602: Tax Forms and Instructions," Revenue Procedure 2021-25, at https://www.irs.gov/pub/irs-drop/rp-21-25.pdf.

[52] Excepted benefits cannot reimburse premiums for individual health insurance coverage or group health plans but may reimburse individual health insurance coverage or group health plan premiums that consist solely of excepted benefits. 26 C.F.R. §54.9831-1(c)(3)(viii)(C).

[53] In general, health plans in their provision of excepted benefits are exempt from all federal health insurance requirements. A diverse collection of insurance benefits can be considered excepted benefits, including auto liability insurance, limited-scope dental and vision benefits, benefits for long-term care, specific disease coverage, and supplemental Medicare plans (i.e., Medigap plans). If certain conditions are met, the excepted benefit HRA would be prevented from reimbursing short-term, limited-duration insurance premiums. 26 C.F.R. §54.9831-1(c)(3)(viii)(F).

[54] See footnote 5.

[55] IRS Notice 2002-45 and 84 *Federal Register* 28937.

# Retiree-Only HRAs

As implied by the name, retiree-only HRAs are HRAs that are available only to former employees of employers offering the benefit. There is no qualifying insurance associated with retiree-only HRAs; individuals may be enrolled in any coverage type (or may be uninsured) and still have a retiree-only HRA. Although not explicitly referenced, retiree-only HRAs also stem from the IRS acknowledgment of HRAs in 2002.[56]

## Eligibility and Qualifying Insurance

Retiree-only HRAs generally are available to former employees of an employer that offers this benefit. There is no qualifying insurance associated with retiree-only HRAs.

## Contributions

There is no federal limit on the amount employers may contribute to an individual's retiree-only HRA, but employers must establish a reimbursement limit when setting up the benefit offering.[57] The employer also would specify the reimbursement limit period. For example, an employer may specify that the reimbursement limit applies for a calendar year.

## Qualifying Medical Expenses

Retiree-only HRAs generally must be used for unreimbursed payments of qualifying medical expenses, a category that includes items within the definition of medical care under IRC Section 213(d) and menstrual care products. Employers offering retiree-only HRAs may further restrict the types of medical and health services that are eligible for reimbursement by retiree-only HRA funds.

Retiree-only HRA funds can be used only for the qualifying medical expenses incurred by the former employee, the former employee's spouse and dependents (including those of deceased employees), and the former employee's children younger than 27 years of age at the end of the year.[58]

## Treatment of Unused Balances

Unused retiree-only HRA balances may be carried forward to increase the HRA holder's limit in subsequent periods, though employers may limit the aggregate carryovers.

In some instances where an individual loses access to a retiree-only HRA, individuals may be able to retain access to their retiree-only HRAs through COBRA continuation coverage.[59]

[56] IRS Notice 2002-45; IRS Revenue Ruling 2002-41.

[57] IRS Notice 2002-45.

[58] See footnote 5.

[59] For more information on COBRA continuation coverage, see CRS Report R40142, *Health Insurance Continuation Coverage Under COBRA*.

**Table 2. Comparison of General Rules for Five Types of Health Reimbursement Arrangements (HRAs), 2022**

| | Group Health Plan HRA | Qualified Small Employer HRA (QSEHRA) | Individual Coverage HRA (ICHRA) | Excepted Benefit HRA | Retiree-Only HRA |
|---|---|---|---|---|---|
| | | | **Setting Up an HRA** | | |
| Eligibility | Employees of an employer that offers this benefit. Former employees of an employer that offers this benefit to former employees.<br>Self-employed individuals are not eligible. | Generally, employees of a small employer (typically fewer than 50 full-time or full-time-equivalent workers in the prior year) that offers this benefit.<br>Self-employed individuals and former employees are not eligible. | Employees of an employer that offers this benefit. Former employees of an employer that offers this benefit to former employees.<br>Self-employed individuals are not eligible. | Employees of an employer that offers this benefit. Former employees of an employer that offers this benefit to former employees.<br>Self-employed individuals are not eligible. | Former employees of an employer that offers this benefit to former employees.<br>Self-employed individuals are not eligible. |
| | | | **Contributing to an HRA**[a] | | |
| Source of Contributions | Employer. | Employer. | Employer. | Employer. | Employer. |
| Tax Status of Contributions | Employer contributions are not included as employee wage income. | Employer contributions are not included as employee wage income. | Employer contributions are not included as employee wage income. | Employer contributions are not included as employee wage income. | Employer contributions are not included as employee wage income. |
| Annual Contribution Limits | No statutory or regulatory limit for employer contributions. | $5,450 for self-only coverage and $11,050 for family coverage. Employers may set lower limits. | No statutory or regulatory limit for employer contributions. | Individual limit of $1,800 a year per employer. Employers may set lower limits. | No statutory or regulatory limit for employer contributions. |
| Annual Cost-of-Living Adjustments for Contribution Limits | Not applicable. | Yes; adjustments based on the C-CPI-U.[b] | Not applicable. | Yes; adjustments based on the C-CPI-U.[b] | Not applicable. |

| | Group Health Plan HRA | Qualified Small Employer HRA (QSEHRA) | Individual Coverage HRA (ICHRA) | Excepted Benefit HRA | Retiree-Only HRA |
|---|---|---|---|---|---|
| | | | **Distributions from an HRA** | | |
| When Funds Are Available | Funds are available as they are accrued. | Funds are available as they are accrued. | Funds are available as they are accrued. | Funds are available as they are accrued. | Funds are available as they are accrued. |
| Length of Time Funds Are Available | Employers have discretion and may specify a period of less than one year. | Employers have discretion and may specify a period of less than one year. | Employers have discretion and may specify a period of less than one year. | Employers have discretion and may specify a period of less than one year. | Employers have discretion and may specify a period of less than one year. |
| Tax Status of Reimbursements for Qualifying Medical Expenses | Reimbursements are tax-free. | Reimbursements are tax-free.[c] | Reimbursements are tax-free. | Reimbursements are tax-free. | Reimbursements are tax-free. |

| | Group Health Plan HRA | Qualified Small Employer HRA (QSEHRA) | Individual Coverage HRA (ICHRA) | Excepted Benefit HRA | Retiree-Only HRA |
|---|---|---|---|---|---|
| Qualifying Medical Expenses | Most unreimbursed medical expenses that fit within the definition of medical care listed in IRC §213(d), including health insurance premiums and amounts paid for long-term-care coverage. Menstrual care products and over-the-counter medicines are considered a qualifying medical expense.<br>May not be used on individual market premiums.<br>Employers may impose additional limitations on what is considered a qualifying medical expense. | Unreimbursed medical expenses that fit within the definition of medical care listed in IRC §213(d), including health insurance premiums and amounts paid for long-term-care coverage. Menstrual care products and over-the-counter medicines are considered a qualifying medical expense.<br>Employers may impose additional limitations on what is considered a qualifying medical expense. | Unreimbursed medical expenses that fit within the definition of medical care listed in IRC §213(d), including health insurance premiums and amounts paid for long-term-care coverage. Menstrual care products and over-the-counter medicines are considered a qualifying medical expense.<br>Employers may impose additional limitations on what is considered a qualifying medical expense. | Most unreimbursed medical expenses that fit within the definition of medical care listed in IRC §213(d), including amounts paid for health care continuation coverage (e.g., COBRA); generally, coverage consisting solely of excepted benefits; and, generally, short-term, limited-duration insurance.[d] Menstrual care products and over-the-counter medicines are considered a qualifying medical expense.<br>May not be used on individual market, group health plan, or Medicare premiums (unless premiums are for coverage that consists solely of excepted benefits).<br>Employers may impose additional limitations on what is considered a qualifying medical expense. | Unreimbursed medical expenses that fit within the definition of medical care listed in IRC §213(d), including health insurance premiums and amounts paid for long-term-care coverage. Menstrual care products and over-the-counter medicines are considered a qualifying medical expense.<br>Employers may impose additional limitations on what is considered a qualifying medical expense. |

| | Group Health Plan HRA | Qualified Small Employer HRA (QSEHRA) | Individual Coverage HRA (ICHRA) | Excepted Benefit HRA | Retiree-Only HRA |
|---|---|---|---|---|---|
| Qualifying Medical Expenses Incurred by Which Individuals | Employee (current or former), employee's spouse and dependents (including those of deceased employees), and employee's children under the age of 27. | Current employee, employee's spouse and dependents (including those of deceased employees), and employee's children under the age of 27. | Employee (current or former), employee's spouse and dependents (including those of deceased employees), and employee's children under the age of 27. | Employee (current or former), employee's spouse and dependents (including those of deceased employees), and employee's children under the age of 27. | Former employee, former employee's spouse and dependents (including those of deceased employees), and employee's children under the age of 27. |
| Qualifying Health Insurance Enrollment Necessary for Reimbursement | Employee and others covered by the HRA generally must be enrolled in qualifying health insurance. Employers may set up group health plan HRAs in such a way that an employee who ceases to be covered under a group health plan retains access to HRA balances that were accrued when enrolled in a group health plan. | Employee and others covered by the HRA must be enrolled in qualifying health insurance. | Employee and others covered by the HRA must be enrolled in qualifying health insurance. | Not applicable. | Not applicable. |
| Qualifying Health Insurance | Any non-HRA group health insurance plan that satisfies annual limit and preventive service requirements. | Any health insurance plan that is considered minimum essential coverage.[e] | Any individual market coverage that satisfies annual limit and preventive service requirements. | None. | None. |
| Tax Status of Nonmedical Reimbursements | Nonmedical distributions are not permitted. | Nonmedical distributions are not permitted. | Nonmedical distributions are not permitted. | Nonmedical distributions are not permitted. | Nonmedical distributions are not permitted. |

| | Group Health Plan HRA | Qualified Small Employer HRA (QSEHRA) | Individual Coverage HRA (ICHRA) | Excepted Benefit HRA | Retiree-Only HRA |
|---|---|---|---|---|---|
| | | | **Remaining HRA Balances** | | |
| Carryover of Unused Funds | Unused amounts generally may be carried over indefinitely, although employers may limit the amount that can be carried over. | Unused amounts generally may be carried over indefinitely, although employers may limit the amount that can be carried over. | Unused amounts generally may be carried over indefinitely, although employers may limit the amount that can be carried over. | Unused amounts generally may be carried over indefinitely, although employers may limit the amount that can be carried over. | Unused amounts generally may be carried over indefinitely, although employers may limit the amount that can be carried over. |
| Carryover Amounts Count Toward Annual Statutory or Regulatory Contribution Limit | Not applicable. | Yes. | Not applicable. | No. | Not applicable. |
| Portability of Arrangement | Unless the employer has made the HRA available to former employees, amounts in the arrangement are forfeited when an employee separates from the employer, although extensions for those covered by COBRA sometimes apply. | Any amounts in the arrangement are forfeited when an employee separates from the employer. | Unless the employer has made the HRA available to former employees, amounts in the arrangement are forfeited when an employee separates from the employer, although extensions for those covered by COBRA sometimes apply. | Unless the employer has made the HRA available to former employees, amounts in the arrangement are forfeited when an employee separates from the employer, although extensions for those covered by COBRA sometimes apply. | In instances where an individual loses access to a retiree-only HRA, extensions for those covered by COBRA sometimes apply. |

**Sources:** Congressional Research Service (CRS) analysis of IRC §§105, 106, and 9831(d) and other IRS sources (available upon request to congressional clients).

**Notes:** C-CPI-U = Chained Consumer Price Index for All Urban Consumers; COBRA = Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) continuation coverage; IRC = *Internal Revenue Code*; IRS = Internal Revenue Service.

a. Employers need not actually contribute to HRAs until employees seek reimbursement from the HRAs; the arrangements may be simply notional. To facilitate easy reading, this table uses the term *contribution* to also refer to amounts that employers make available to employees for reimbursement under the terms of the arrangement. The HRA amount made available to individuals also is often referred to as the reimbursement limit. U.S. Government Accountability Office (GAO), *Consumer Directed Health Plans: Health Status, Spending, and Utilization of Enrollees in Plans Based on Health Reimbursement Arrangements*, GAO-10-616, July 2010, p. 7, at https://www.gao.gov/assets/gao-10-616.pdf.

b. For more information on C-CPI-U, see CRS Report R43347, *Budgetary and Distributional Effects of Adopting the Chained CPI*.

c. Reimbursements for pretax premiums for group health plan coverage sponsored by the employer of an eligible employee's spouse must be counted as income.

d. In general, health plans in their provision of excepted benefits are exempt from all federal health insurance requirements. A diverse collection of insurance benefits can be considered excepted benefits, including auto liability insurance, limited-scope dental and vision benefits, benefits for long-term care, specific disease coverage, and supplemental Medicare plans (i.e., Medigap plans).

e. Most types of comprehensive coverage are considered minimum essential coverage, including public coverage, such as coverage under programs sponsored by the federal government (e.g., Medicaid, Medicare) and private insurance (e.g., a spouse's employer-sponsored insurance, individual insurance). For information on the types of plans in which an individual with a QSEHRA can enroll, see IRS, "Appendix A: Types of Minimum Essential Coverage," IRS Notice 2017-67.

# Appendix. A Brief Legislative and Regulatory History of Health Reimbursement Arrangements

Health Reimbursement Arrangements (HRAs) have a unique history that stems, in part, from the treatment of this account-based benefit as employer-sponsored insurance for tax and regulatory purposes. As such, a chronological history of HRAs can help to contextualize some of the different rules that apply to group health plan HRAs, qualified small employer HRAs (QSEHRAs), individual coverage HRAs (ICHRAs), excepted benefit HRAs, and retiree-only HRAs.

## HRAs as Group Health Plans

HRAs were not explicitly established in statute but instead were first acknowledged by the Internal Revenue Service (IRS) in guidance issued in 2002.[60] Per the IRS, HRAs are arrangements that are paid solely by the employer; reimburse employees only for their, their spouse's, and their dependents' medical care expenses (including premiums); provide reimbursements up to a maximum dollar amount; and carry forward unused balances in the arrangement from one year to the next.

Initially, employers typically offered HRAs to their employees in one of two ways: (1) alongside a health insurance plan or (2) standing alone.[61] In offering a stand-alone HRA, employers would not offer health insurance coverage to their employees but instead would offer to contribute to an HRA on the employees' behalf. Employees then could use the funds from the HRA to cover the cost of health insurance coverage, including coverage offered in the individual market. Employees also could use these amounts to cover the cost for medical care directly, which may have been especially relevant to employees who did not purchase insurance.

HRA contributions are not counted in an employee's wage income and hence are not subject to income or payroll taxes. This exclusion is the result of the IRS considering HRAs a *group health plan*, a term that generally refers to employer-sponsored health insurance coverage.[62] In other words, employer HRA contributions are excluded from an employee's income in the same way that employer contributions to employer-sponsored health insurance premiums are excluded from an employee's income.

Being considered a group health plan allows HRAs to have tax-advantaged status but also results in HRAs being subject to other requirements that generally apply to certain private health insurance plans. For health plan regulatory purposes, HRAs are considered a self-insured group health plan and generally are subject to self-insured group health plan requirements.[63] For

[60] Internal Revenue Service (IRS), "Health Reimbursement Arrangements," Notice 2002-45, at https://www.irs.gov/pub/irs-drop/n-02-45.pdf (hereinafter, IRS Notice 2002-45); Revenue Ruling 2002-41.

[61] As initially defined, health reimbursement arrangements (HRAs) were not required to be offered alongside health insurance and there was no requirement that any employee receiving an HRA must be enrolled in any type of health insurance coverage. Relatedly, employers were not precluded from offering HRAs alongside employer-sponsored health insurance coverage. For example, see IRS, "Section 105—Amounts Received Under Accident and Health Plans (Also 106—Contributions by an Employer to Accident and Health Plans, 125—Cafeteria Plans," IRS Revenue Ruling 2002-41, at https://www.irs.gov/pub/irs-drop/rr-02-41.pdf.

[62] Contributions to and appropriate reimbursements from an HRA generally are excluded from an employee's gross income under 26 U.S.C. §§105 and 106.

[63] For a description of self-insured group health plans and an overview of how private health insurance is regulated, see "Regulation of Private Health Insurance: HRAs as Self-Insured Group Health Plans" text box in this report. IRS,

example, HRAs are subject to the same nondiscrimination rules applicable to self-insured group health plans generally.[64] If HRAs do not comply with self-insured group health plan requirements, employers risk being penalized for offering noncompliant self-insured group health plans.[65]

**Regulation of Private Health Insurance: HRAs as Self-Insured Group Health Plans**

Federal regulation of private health insurance plans generally varies based on the segment of the private health insurance market in which the plan is sold (i.e., individual market, fully insured small-group market, fully insured large-group market, and self-insured plans). Some private health insurance requirements apply to all market segment plans, and some apply to a subset of market segment plans.

The individual market (or non-group market) is where individuals and families buying insurance on their own (i.e., not through a plan sponsor) may purchase health plans.

Health plans in the group market are offered through a plan sponsor, typically an employer. For regulatory purposes, the group market is divided into the fully insured small-group market, the fully insured large-group market, and self-insured plans.

For purposes of federal requirements that apply to the group market, states may elect to define *small* groups as groups with 50 or fewer individuals (e.g., employees) or groups with 100 or fewer individuals. The definition for *large* group builds on the small-group definition; a large group is a group with at least 51 individuals or a group with at least 101 individuals, depending which small-group definition is used in a given state.

*Fully insured* group market segments refer to health plans purchased by employers and other plan sponsors from state-licensed issuers. Employers or other plan sponsors that offer *self-insured plans* set aside funds to pay for health benefits directly, and they bear the risk of covering medical expenses generated by the individuals covered under the self-insured plan.

HRAs are considered a self-insured group health plan and are subject to the federal requirements applicable to such plans.

For more information on the regulation of private health insurance plans, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

## HRAs and the Patient Protection and Affordable Care Act: Integration Requirements

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) established various requirements on private health insurance plans, including self-insured group health plans. One such requirement prohibited self-insured group health plans from setting annual limits on how much the plan spends for covered health benefits during a plan year.[66] HRAs are structured in such a way that they generally cannot satisfy the annual limit requirement: HRAs are an account-based benefit, and employers make fixed dollar amounts available through an HRA for

Department of the Treasury, Employee Benefits Security Administration (EBSA), Department of Labor (DOL); Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), "Health Reimbursement Arrangements and Other Account-Based Group Health Plans," 84 *Federal Register* 28893, June 20, 2019 (hereinafter, 84 *Federal Register* 28888).

[64] 26 U.S.C. §105(h); IRS Notice 2002-45.

[65] 26 U.S.C. §4980D.

[66] More specifically, the requirement prohibits self-insured group health plans from setting annual limits on coverage of the essential health benefits (EHB). The requirement to cover the EHB does not apply to self-insured group plans, but such plans must comply with the prohibition on setting annual or lifetime limits with regard to their EHB-equivalent benefits. 42 U.S.C. §300gg-11. For more information on this requirement, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*. This requirement applies to individual coverage, small-group coverage, large-group coverage, and self-insured plans. See "Regulation of Private Health Insurance: HRAs as Self-Insured Group Health Plans" text box in this report.

the plan year (i.e., it is not an open-ended benefit).[67] This naturally limits the extent to which an HRA can reimburse an individual for covered health benefits, which means HRAs generally will fail to satisfy the annual limit requirement.

The ACA also established a requirement that self-insured group health plans generally must provide coverage for certain preventive health services without imposing cost sharing.[68] Similar to the annual limit requirement, HRAs, by design, generally fail this requirement; once an individual receives reimbursement equal to the amount in his or her HRA, the HRA will no longer be able to cover preventive care health services without imposing cost sharing.

In implementing the ACA, the IRS, Department of Labor (DOL), and Department of Health and Human Services (HHS) (the tri-agencies) acknowledged a way in which HRAs can be considered to satisfy the aforementioned requirements: through *integration* with a (non-HRA) group health plan.[69] An HRA is considered *integrated* with a group health plan if the employee receiving the HRA is also enrolled in a (non-HRA) group health plan that *does* satisfy such requirements.[70] Put simply, if an HRA is paired with an employer-sponsored health insurance plan that satisfies the necessary requirements, the collective unit (and each subcomponent of that unit) would be considered to satisfy the requirements. The integration rule applied to HRAs that began on and after January 1, 2014.[71]

The integration rule prevented HRAs from being able to be integrated with individual market coverage (including coverage sold on and off an ACA individual market exchange), even though individual market coverage is subject to the same annual limit and preventive care requirements that apply to self-insured group health plans.[72] The decision to not allow integration with individual market plans was the result of tri-agency concerns that doing so could result in adverse selection in the individual market.[73] Further, in a 2019 rule on HRAs, the three agencies

[67] IRS Notice 2002-45.

[68] This requirement applies to individual coverage, small-group coverage, large-group coverage, and self-insured plans. 42 U.S.C. §300gg-13. See "Regulation of Private Health Insurance: HRAs as Self-Insured Group Health Plans" text box in this report.

[69] Group health plan HRAs also can be integrated with Medicare and TRICARE plans, if certain conditions are met. IRS, "Guidance on the Application of Code §4980D to Certain Types of Health Coverage Reimbursement Arrangements," Notice 2015-17, at https://www.irs.gov/pub/irs-drop/n-15-17.pdf; IRS, Department of the Treasury, EBSA, DOL, and HHS, "Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections," 75 *Federal Register* 37188, June 28, 2010; and IRS, "Application of Market Reform and other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain other Employer Healthcare Arrangements," IRS Notice 2013-54, at https://www.irs.gov/pub/irs-drop/n-13-54.pdf (hereinafter, IRS Notice 2013-54). Certain aspects of this guidance were subsequently included in a final rule issued by the three agencies: IRS, Department of the Treasury, EBSA, DOL, and HHS, "Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections Under the Affordable Care Act," 80 *Federal Register* 72192 (hereinafter, 80 *Federal Register* 72192).

[70] The health insurance coverage with which group health plan HRAs can be *integrated* does not need to satisfy any arrangement-specific cost-sharing requirements (e.g., have a high enough deductible). Furthermore, the integrated group health plan is not required to be the employee's employer-sponsored plan. For example, the employee's HRA may be integrated with a group health plan offered by his or her spouse's employer. IRS Notice 2013-54 and DOL, HHS, and the Department of the Treasury, *FAQs About Affordable Care Act Implementation Part 37*, January 12, 2017, at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-37.pdf.

[71] IRS Notice 2013-54.

[72] DOL, HHS, and the Department of the Treasury, *Affordable Care Act Implementation FAQs—Part 11*, January 24, 2013, at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11; IRS Notice 2013-54; 26 C.F.R. §54.9815-2711(d); and 80 *Federal Register* 72192.

[73] The term *adverse selection* describes "a situation in which an insurer (or an insurance market as a whole) attracts a disproportionate share of unhealthy individuals." American Academy of Actuaries, *Risk Pooling: How Health*

acknowledged that HRAs that could be integrated with individual market coverage also could result in health factor discrimination.[74] In other words, the three agencies were concerned that, if allowed, employers may be incentivized to offer their "healthier" employees employer-sponsored insurance and offer their "sicker" employees an HRA integrated with individual market coverage, which in turn, would reduce the costs of the employer-sponsored insurance offered to the "healthier" employees.[75] If the disproportionately "sicker" employees enrolled in individual market coverage, this could result in an increase in individual market coverage premiums for all individuals purchasing coverage in that state's individual market (holding constant all other factors that might affect premiums). The extent of this increase in individual market premiums would depend on the health status and total number of employees shifted into the individual market in response to this change in employer offer strategies.

These developments effectively prevented employers from being able to offer stand-alone HRAs to their employees, though Congress and the three agencies both have subsequently revisited the issue of stand-alone HRAs.

**Regulation of Private Health Insurance: Retiree-Only Plans**

Fully insured and self-insured group health plans (including HRAs) covering fewer than two current employees are exempt from all federal private health insurance requirements. This exemption was established in the Health Insurance Portability and Accountability Act (P.L. 104-191), which was enacted in 1996.

Considering this regulatory structure, retiree-only HRAs do not need to be integrated with or offered alongside any type of health insurance plan because they are not subject to the private health insurance requirements that result in the need for HRA integration. As a result, retiree-only HRAs can be offered as stand-alone HRAs.

For an overview of group health plans covering fewer than two current employees, see CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*.

*Insurance in the Individual Market Works*, July 2017, at https://www.actuary.org/sites/default/files/files/publications/RiskPoolingFAQ071417.pdf; 84 *Federal Register* 28898.

[74] 84 *Federal Register* 28896.

[75] To understand this effect on premiums, it is important to consider how premiums are determined. Premiums are determined largely based on the estimated amount of medical claims that an insurer will need to cover for the group of individuals being insured. If an employer reduced the estimated claims of the employees enrolled in its employer-sponsored plan by shifting "sicker" employees to an HRA integrated with individual coverage, premiums for the employer-provided plan would go down (holding constant all other factors that might affect premiums). However, if these "sicker" employees used their HRAs to enroll in individual market coverage, individual market coverage premiums would increase (holding constant all other factors that might affect premiums) to account for the additional claims that the individual market insurers would need to cover. The extent of this increase in individual market premiums would depend on the health status and total number of employees shifted into the individual market in response to this change in employer offer strategies. A premium increase in one state's individual market would affect the premiums of all individuals enrolling in coverage in the state's individual market. (Though some individual market enrollees may not feel such effects if they are receiving coverage that is fully subsidized by the premium tax credit. For more information on premium tax credits, see CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*.)

# Recent HRA Developments: QSEHRAs, ICHRAs, and Excepted Benefit HRAs

## Congress Establishes QSEHRAs

In 2016, Congress established a new type of HRA: a qualified small employer health reimbursement arrangement (QSEHRA).[76] This new type of HRA shared many of the rules that applied to HRAs in general; however, it also had some distinct features. The following three features are particularly relevant to this historical narrative:

1. Per statute, QSEHRAs *are not* considered a group health plan for private health insurance requirement purposes.
2. As implied by the name, only certain small employers could provide QSEHRAs.
3. QSEHRAs could be used to pay for individual market coverage.

Because QSEHRAs are not considered a group health plan for private health insurance requirement purposes, these arrangements do not need to be integrated with a (non-HRA) group health plan to satisfy private health insurance requirements. However, separate QSEHRA rules require individuals to be enrolled in *minimum essential coverage* to receive QSEHRA tax benefits.[77] To satisfy the minimum essential coverage requirement, individuals could use their QSEHRA to enroll in individual market coverage.

In creating QSEHRAs, Congress recognized that offering employer-sponsored insurance coverage may not be feasible for some small employers.[78] Thus, QSEHRAs provide small employers with the ability to offer a more limited health benefit to their employees without also having to offer their employees employer-sponsored health insurance coverage. In other words, QSEHRAs provide small employers the ability to offer a type of stand-alone HRA.

## Executive Order 13813

In 2017, then-President Trump issued Executive Order (E.O.) 13813, "Promoting Healthcare Choice and Competition Across the United States." E.O. 13813 directed the three agencies to "consider proposing regulations or revising guidance, to the extent permitted by law and supported by sound policy, to increase the usability of HRAs, to expand employers' ability to offer HRAs to their employees, and to allow HRAs to be used in conjunction with nongroup [i.e., individual market] coverage."[79] In response to this executive order, the three agencies finalized a rule in 2019 that established two new HRAs: the ICHRA and the excepted benefit HRA.

[76] Section 18001 of the 21st Century Cures Act (P.L. 114-255).

[77] Most types of comprehensive coverage are considered minimum essential coverage, including public coverage, such as coverage under programs sponsored by the federal government (e.g., Medicaid, Medicare) and private insurance (e.g., employer-sponsored insurance; non-group, or individual, insurance). 26 U.S.C. §106(g).

[78] See committee report for a bill related to the 21st Century Cures Act (H.R. 5447). U.S. Congress, House Committee on Ways and Means, *Small Business Health Care Relief Act of 2016, To Accompany H.R. 5447*, 114th Cong., 2nd sess., June 21, 2016, H.Rept. 114-634 (Washington: GPO, 2016), p. 9.

[79] 82 *Federal Register* 48385.

### *ICHRAs*

The 2019 tri-agency rule that created ICHRAs effectively removed the prohibition on HRA integration with individual market coverage for *all* employers (i.e., not just small employers, as was the case with QSEHRAs).[80] Since individual market coverage is subject to the same annual limits and preventive services coverage requirements that apply to group health plans, the rule found that HRAs could be integrated with individual market coverage and still satisfy the necessary group health plan requirements.[81]

However, in allowing this integration, the three agencies acknowledged the potential for the aforementioned adverse selection and health factor discrimination. As such, the three agencies created specific rules for ICHRAs that sought to limit the extent to which employers would be able to (either intentionally or unintentionally) steer employees and their dependents with adverse health factors away from the employer's health insurance plan and into the individual market.[82]

One such ICHRA-specific rule prevents employers offering ICHRAs from being able to offer employees a choice between an ICHRA and an employer-sponsored insurance plan. Employers offering ICHRAs do not need to offer this benefit to all of their employees, but if an employer offers an ICHRA to only a subset of its workforce, the employer must offer this benefit similarly to everyone within the specified class of employees (e.g., full-time employees, part-time employees). For example, an employer may elect to offer full-time employees a (non-HRA) group health plan and part-time employees an ICHRA, but the employer cannot offer either group both benefit options.

Another ICHRA-specific rule requires employers to offer ICHRAs on the same terms to every employee within a class of employees being offered an ICHRA. *On the same terms* refers to both the amount of funding available for reimbursement and the benefit terms and conditions.[83]

### *Excepted Benefit HRAs*

Excepted benefits are a group of benefits that either (1) are exempted from all federal private health insurance requirements in any circumstances or (2) are exempted from all federal private health insurance requirements only when specified conditions are met.[84] Per federal statute, there are four categories of excepted benefits, one of which is limited excepted benefits.[85] *Limited*

[80] Individual coverage HRAs (ICHRAs) are similar to qualified small employer HRAs (QSEHRAs) in that both operate as stand-alone HRAs that can be used to purchase individual market coverage. However, only small employers can offer QSEHRAs, whereas all employers can offer ICHRAs.

[81] More specifically, ICHRAs can be integrated with any individual policy that satisfies the annual limit and preventive care requirements. This includes individual coverage on and off the individual health insurance exchanges, catastrophic plans, transitional plans (or grandmothered plans), and fully insured student health insurance coverage. It does not include short-term, limited-duration insurance or health care sharing ministries. 84 *Federal Register* 28899-28900, 28923-28926.

[82] 84 *Federal Register* 28898.

[83] An ICHRA does not fail the test of *on the same terms* because employees' HRA contributions vary due to age and family size.

[84] A diverse collection of insurance benefits can be considered excepted benefits, including auto liability insurance, limited-scope dental and vision benefits, benefits for long-term care, specific disease coverage, and supplemental Medicare plans (i.e., Medigap plans). For more information on excepted benefits, see "Excepted Benefits" in CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*.

[85] One category is exempt from complying with all federal health insurance requirements in all circumstances; the other three categories are exempt from complying with all of the requirements only when specified conditions are met. 26 U.S.C. §9832(c).

*excepted benefits* are exempt from federal health insurance requirements only when specified conditions are met. To be a limited excepted benefit, the benefit must be provided under a separate insurance policy or otherwise cannot be an "integral part" of a group health plan.[86] Benefits that can be considered a limited excepted benefit include limited-scope dental or vision benefits, benefits for long-term care, and "other similar, limited benefits as are specified in regulations."[87]

The 2019 tri-agency rule established a way in which HRAs could be offered as a limited excepted benefit. In doing so, the three agencies applied certain rules to this type of HRA so it is consistent with the statutory framework of excepted benefits generally.[88] Per regulations, to be considered an excepted benefit, HRAs must satisfy several criteria; the HRAs (1) cannot be an integral part of the plan and must be offered alongside another (non-HRA) group health plan, (2) must provide benefits that are limited in scope (maximum contribution for 2022 is $1,800), (3) generally cannot provide reimbursement for health insurance coverage premiums, and (4) must be made available under the same terms to all similarly situated individuals.[89] As an excepted benefit, this type of HRA is exempt from the self-insured group health plan requirements and therefore does not need to be integrated with another health insurance plan.[90]

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## Disclaimer



[86] 26 U.S.C. §9831(c)(1).

[87] 26 U.S.C. §9832(c)(2).

[88] 84 *Federal Register* 28933.

[89] 26 C.F.R. §54.9831-1(c)(3)(viii).

[90] 26 U.S.C. §9831(c).