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Background Information on Health Coverage Options Addressed in Executive Order 13813

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Summary

On October 12, 2017, President Trump issued Executive Order (E.O.) 13813, entitled "Promoting Healthcare Choice and Competition Across the United States." E.O. 13813 directs specified agencies to consider regulatory or sub-regulatory approaches to expand access to three unrelated, private-sector health coverage options: association health plans (AHPs); short-term, limited-duration insurance (STLDI); and health reimbursement arrangements (HRAs). This report answers frequently asked questions (FAQs) about E.O. 13813 and subsequent rulemaking and provides background information about AHPs, STLDI, and HRAs.

Association health plan is an umbrella term that represents a spectrum of arrangements that provide health coverage to a collective body of employers or individuals (e.g., self-employed persons). AHP coverage may be provided through different types of organizations, including but not limited to trade associations, professional societies, and chambers of commerce. Given the absence of a federal definition for either *association health plan* or *association coverage*, applicable federal agencies have indicated that a given AHP should be regulated according to the characteristics of the organization offering the AHP coverage and plan enrollees. Generally, association coverage is addressed through sub-regulatory guidance. The vast majority of AHPs provide either individual or small-group coverage, as determined by federal regulatory agencies. On January 5, 2018, the Department of Labor issued a proposed regulation that would amend the federal definition of *employer*. The proposed amendment potentially could allow certain AHPs that currently are regulated as individual or small-group coverage to be regulated as large-group coverage instead, and it could encourage the formation of new AHPs. Such a change would reduce the overall scope of federal requirements applicable to those AHPs. AHP proponents argue that the proposed changes would expand coverage options and reduce premiums for certain consumers. AHP opponents argue that those changes would raise premiums for consumers with greater health care needs, particularly in the individual market.

Short-term, limited-duration insurance is a type of health insurance that generally is designed to fill gaps in health insurance coverage, particularly for individuals transitioning from one type of coverage to another. STLDI is defined in regulations as health insurance coverage with a maximum duration of three months (including any extensions a consumer may request) that is marketed and issued with disclaimer language about the coverage not being considered minimum essential coverage for purposes of avoiding the individual mandate penalty. Beyond this definition, STLDI is not subject to federal requirements applicable to health coverage. On February 21, 2018, the Departments of Health and Human Services (HHS), Labor, and the Treasury jointly issued proposed regulations that would increase the maximum duration of STLDI from 3 months to 12 months, make policy extensions easier, and modify the required disclaimer language. Proponents of expanding access to STLDI argue that these changes would provide more insurance options for consumers; opponents of the proposed changes have emphasized the potential negative impacts on the risk pool for the individual market for comprehensive coverage.

Health reimbursement arrangements are employer-established arrangements that pay or reimburse employees for substantiated medical care expenses up to a maximum dollar amount. HRAs are funded solely by employers; employees cannot contribute to HRAs. Payments and reimbursements from an HRA for an employee's substantiated medical care expenses (and those of the employee's spouse and dependents) are excluded from the employee's income and employment taxes. In general, employers may offer to employees only HRAs that are integrated with another group health plan (that is not an HRA). Although HRAs are governed under the federal tax code, they are not explicitly authorized by legislation. Generally, HRAs are addressed

through sub-regulatory guidance. As of the publication date of this report, the agencies identified in E.O. 13813 (Treasury, Labor, and HHS) have not published guidance or proposed regulation on HRAs in response to the order.

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Introduction

On October 12, 2017, President Trump issued Executive Order (E.O.) 13813, entitled "Promoting Healthcare Choice and Competition Across the United States." E.O. 13813 generally aims "to facilitate the purchase of insurance across state lines and the development and operation of a healthcare system that provides high-quality care at affordable prices for the American people."[1] The order addresses three unrelated, private-sector health coverage options: association health plans (AHPs); short-term, limited-duration insurance (STLDI); and health reimbursement arrangements (HRAs).

This report answers frequently asked questions (FAQs) about E.O. 13813 and subsequent rulemaking and provides background information about AHPs, STLDI, and HRAs. Given that these health coverage options operate in distinct parts of the private market and have different regulatory histories, the background FAQs include discussion of policy issues uniquely relevant to each option.

Executive Order 13813

E.O. 13813 directs specified agencies to "consider proposing regulations or revising guidance, consistent with the law" to expand access to AHPs, increase availability of STLDI, and expand the availability and permitted use of HRAs. See **Table 1** for information about which agencies were given directives, what was stated in those directives, when agencies were directed to respond, and the status of their activities.

Table 1. Directives to Federal Agencies Under Executive Order 13813

Health Coverage Option	Directive	Federal Agency	Time Frame	Status of Activity
Association Health Plans (AHPs)	"Consider proposing regulations or revising guidance, consistent with law, to expand access to health coverage by allowing more employers to form AHPs."	Department of Labor	Within 60 days of October 12, 2017	The Department of Labor issued proposed regulations on January 5, 2018. Comments were due on or before March 6, 2018.
Short-Term, Limited-Duration Insurance (STLDI)	"Consider proposing regulations or revising guidance, consistent with law, to expand the availability of STLDI."	Departments of Health and Human Services (HHS), Labor, and the Treasury	Within 60 days of October 12, 2017	The Departments of HHS, Labor, and the Treasury issued proposed regulations on February 21, 2018. Comments were due on or before April 23, 2018.

[1] Executive Order (E.O.) 13813, "Promoting Healthcare Choice and Competition Across the United States," 82 *Federal Register* 48385, October 17, 2017. The executive order was issued on October 12 and published in the *Federal Register* on October 17.

Health Coverage Option	Directive	Federal Agency	Time Frame	Status of Activity
Health Reimbursement Arrangements (HRAs)	"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 coverage."	Departments of HHS, Labor, and the Treasury	Within 120 days of October 12, 2017	No public activity.

Source: Executive Order 13813, "Promoting Healthcare Choice and Competition Across the United States," 82 *Federal Register* 48385, October 17, 2017.

The environment in which E.O. 13813was announced is dynamic. Like other viable industries, the private health insurance market evolves as stakeholders make decisions in response to or anticipation of conditions outside of their immediate control (such as economic conditions) or decisions made by other stakeholders. For instance, regulators may affect the regulatory environment through legislation. Depending on the scope of the legislative changes, insurers may change their behavior in terms of the geographic areas in which they operate, the types of insurance products they sell, how much they charge in premiums, etc. In turn, consumers, employers, and other purchasers of insurance may adjust their behavior in response to both legislative and market changes. In more recent years, the health insurance market has undergone significant change due to the effects of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), particularly in the individual and small-group segments of that market. While the total number of persons with health coverage in those market segments has increased overall, compared to enrollment prior to ACA enactment, the costs of coverage have continued to increase. There are legislative and other proposals that take different approaches to address ongoing issues. E.O. 13813 appears to primarily target concerns about health insurance costs for consumers and access to less-regulated coverage options in the individual and small-group markets.

Background

Understanding the sources of private health insurance coverage and how such coverage is regulated at the federal level may be useful in providing the context in which federal agencies may respond to E.O. 13813's directives (see text box).

Sources and Regulation of Private Health Insurance Coverage

Most Americans with private health insurance coverage obtain such coverage as part of a group of people drawn together by an employer or other organization, such as a union. Groups generally are formed for some purpose other than obtaining insurance (e.g., employment). The applicability of federal rules to group coverage varies based on characteristics of the plan sponsor (e.g., employer), including the following:

- **Size**: Group coverage may be offered in the small-group or large-group market. In general, the small-group market includes groups with 50 or fewer employees and the large-group market includes groups with more than 50 employees.
- **Funding Arrangement**: Group coverage may be offered by a fully insured plan sponsor, a scenario in which the plan sponsor purchases health coverage from a state-licensed issuer. The issuer assumes the risk of providing health benefits to the sponsor's enrolled members. Alternatively, group coverage may be offered by

a sponsor that self-funds (or self-insures) the coverage. A sponsor that self-insures sets aside funds and pays for health benefits directly. Under this scenario, the sponsor itself bears the risk for covering medical claims.

Consumers may obtain health insurance—outside of a group—in the individual (or nongroup) health insurance market. In this market, consumers purchase insurance directly from an issuer.

The scope of federal requirements applicable to private health plans is broad. Existing federal requirements apply to the offer (e.g., dependent coverage for children under the age of 26), issuance (e.g., guaranteed issue), generosity (e.g., essential health benefits), and pricing ("single risk pool") of health plans, among other issues. The applicability of these requirements vary according to the characteristics discussed above. (For discussion of federal health insurance requirements and applicability to various plan types, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.)

Federal health insurance provisions are codified in three statutes: the Public Health Service Act (PHSA), the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code (IRC). The PHSA applies to health insurance issuers in the group and individual markets and to self-funded, nonfederal governmental group plans. ERISA applies to private-sector employee benefit plans; government and church plans are exempt from ERISA. The IRC applies to all group health plans (including church plans) but does not apply to governmental plans and health insurance issuers.

Some types of insurance products do not have to comply with one or more federal requirements. In some cases, these products are offered in one of the segments of the private market described above (such as the individual market) but are regulated differently compared to other products sold in that market segment. For example, certain health plans are grandfathered by the Affordable Care Act (ACA; P.L. 111-148, as amended) and are allowed to continue to be offered even if they did not comply with all of the ACA's requirements. In addition, some types of insurance products are explicitly exempted from group or individual insurance requirements, because such products are substantively different from conventional insurance. For example, insurance products that cover a narrow set of benefits (e.g., dental-only coverage) or are limited in duration are exempt from the federal requirements discussed above.

Since applicability of federal requirements is contingent on the characteristics of a given health plan, E.O. 13813's directives—while all seeking to expand availability of a given health option—target different aspects of private health coverage. For instance, the order's AHP directive addresses definitions in the Employee Retirement Income Security Act of 1974 (ERISA) that align with the executive order's intention of "allowing [small businesses] to group together to self-insure or purchase large group health insurance."[2] In contrast, STLDI is private insurance that is designed for individuals. Unlike AHPs or STLDI, through which individuals receive coverage, an HRA is an account authorized under the tax code that pays for or reimburses employees' medical expenses. Given the substantive differences among these three health options, applicable policy issues, current federal requirements, and possible changes identified under the executive order differ.[3] Moreover, the scope of applicable regulations and guidance varies across the three coverage options, contributing to the different changes identified in the executive order (and related proposed rules).

Although the focus of this report is E.O. 13813 and federal regulation of private health insurance coverage, it should be noted that states are the primary regulators of insurance and state laws apply to most types of private coverage.[4] In some cases, however, state laws do not apply, as with self-insured arrangements (with exceptions) and tax-advantaged health accounts (such as HRAs) that are authorized under the federal tax code. Furthermore, in some cases state laws may apply

[2] Ibid., p. 48385.

[3] For information indicating the applicability of selected federal requirements to association health plans (AHPs) and short-term, limited-duration insurance (STLDI), among other coverage options, see Exhibit 2 in Kevin Lucia, Justin Giovannelli, Sabrina Corlette et al., *State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market*, The Commonwealth Fund, March 2018, at http://www.commonwealthfund.org/publications/fund-reports/2018/mar/state-regulation-coverage-options-outside-aca.

[4] Discussion of specific state requirements is included only to the extent they are directly relevant to changes proposed by the Administration, in accordance with E.O. 13813.

where federal requirements do not; for example, states may apply requirements to limited-benefits coverage, even though the federal government exempts such coverage from federal requirements.

Association Health Plans (AHPs)

What Is an Association Health Plan?

Fundamentally, an association health plan brings together employers or individuals and provides health insurance coverage. Because federal statute does not define *association health plan* (or *association coverage*), AHP is colloquially used to represent a wide spectrum of arrangements that provide health coverage through different types of organizations, including but not limited to trade associations, professional societies, and chambers of commerce. Although discussions about AHPs often focus on small businesses, large businesses also may participate in the collective purchasing of health insurance through AHPs. An organization that sponsors health coverage through an AHP may purchase insurance through a state-licensed issuer or self-fund the health coverage it offers. AHP coverage for individuals may include self-employed persons and sole proprietors.

The specific characteristics of a given AHP and its participants determine the applicability of federal law. (See "How Are AHPs Currently Regulated?" for a discussion about these issues.)

Given that AHP coverage is provided through collective bodies of large groups, small groups, and/or individuals and may be fully insured or self-funded, and given that such coverage is federally regulated according to those defining features, there is no separate, singular market for AHPs. Moreover, AHPs may encompass arrangements beyond what is implied by the term association. Although individuals and employers may join associations through which they receive membership benefits, such as health coverage, there are other relevant arrangements. For example, instead of joining a trade association, some employers may participate in a *purchasing pool* or *purchasing alliance*: an organization explicitly established for the purpose of providing health coverage. These and other arrangements were acknowledged in guidance concerning association coverage; association coverage is coverage offered through "entities that may be called associations, trusts, multiple employer welfare arrangements ('MEWAs'), purchasing alliances, or purchasing cooperatives."[5] The lack of uniformity across AHPs also contributes to the paucity of data regarding the count of such plans.[6]

[5] Centers for Medicare & Medicaid Services, "Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations," September 1, 2011.

[6] For example, one study used data from a 1997 employer survey to produce the first national estimates about employers that collectively purchased health coverage: Stephen H. Long and M. Susan Marquis, "Pooled Purchasing: Who Are The Players?," *Health Affairs*, vol.18, no.4 (July/August 1999). Although the study produced summary statistics on this specific population, a notable limitation is that the survey drew from an employer list that excluded self-employed individuals—a population that is often mentioned as benefitting from collective purchasing.

How Do AHPs Operate Within the Private Health Insurance Market?

AHPs play a unique role in that individuals or employers obtain coverage as a collective body instead of as separate individuals or employers.

The practice of individuals or employers joining together to obtain coverage has a long history, well preceding the ACA.[7] The intention behind these efforts is to replicate the natural advantages larger groups have in the private health insurance market. A larger group means more individuals over which the group can spread insurance risk. The larger the group, the less likely that serious medical experiences of one or a few persons will result in catastrophic financial loss for the entire group.[8] Also, the administrative costs associated with managing health benefits are lower (as a share of premiums collected) for larger groups compared with small groups and individuals. In the case of a very large group, the group may be able to exert greater market power in negotiations with issuers. In addition to these market advantages, there are fewer federal requirements imposed on the large-group market compared with the small-group or individual market (such as fewer benefit mandates and restrictions on rate setting), which may act as an incentive to establish a large-group AHP.[9]

How Are AHPs Currently Regulated?

As discussed previously, neither *association health plan* nor *association coverage* is defined in federal statute. Instead, relevant federal agencies have indicated that a given AHP should be regulated according to the characteristics of the organization offering the AHP coverage and plan enrollees. For example, AHP coverage provided by a hypothetical association of freelance photographers generally would be regulated as individual coverage at the federal level. Similarly, coverage provided through an association consisting of employers would be regulated according to the features of that association, such as size of employers (small or large) and funding arrangement (fully insured or self-funded). Overall, the vast majority of AHPs provide either individual or small-group coverage, as determined by federal regulatory agencies (see the following discussion about regulatory activities at the Department of Labor [DOL] and the Department of Health and Human Services [HHS]).[10]

AHP coverage that is provided through an association of employers is regulated under ERISA, under the jurisdiction of DOL. ERISA-regulated plans are subject to a variety of requirements,

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[7] For example, see Government Accountability Office (GAO), *Access to Health Insurance: Public and Private Employers' Experience with Purchasing Cooperatives*, HEHS-94-142, May 1994, at http://www.gao.gov/products/HEHS-94-142.

[8] The insurance risk faced by small groups, and the effect of such risk on premiums, was mitigated in part by the single risk pool provision in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). For a discussion about this provision, see American Academy of Actuaries, "Risk Pooling: How Health Insurance in the Individual Market Works," at https://www.actuary.org/content/risk-pooling-how-health-insurance-individual-market-works-0.

[9] For additional information about the applicability of ACA requirements on private health plans, by market segment and funding arrangement, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

[10] See Centers for Medicare & Medicaid Services, "Application of Individual and Group Market Requirements Under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or Through, Associations," September 1, 2011, p. 3, at https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf.

including fiduciary standards and reporting and disclosure requirements.[11] The coverage itself is subject to multiple requirements related to benefits, premiums, cost-sharing requirements, and other consumer protections.[12] Generally, DOL regulates AHPs as a type of multiple employer welfare arrangement (MEWA): an arrangement through which two or more employers, not subject to collective bargaining, provide health and other benefits to employees (and their dependents). DOL's regulation of AHPs has relied on sub-regulatory guidance, typically in the form of advisory opinions.[13] Among the factors reviewed by DOL in these opinions, the agency considers whether there is a genuine relationship between the association and the employer members of that association, whether the association acts in the interest of those members, and whether the employers exercise control over the plan (*commonality of interest* standard).[14] It is through these advisory opinions that DOL has concluded that in most instances an association is *not* considered an employer for purposes of regulating the association coverage. Instead, the employers who comprise the association membership constitute individual employers who are the sponsors of distinct employer plans. The determination of which entity constitutes the employer significantly affects the application of federal requirements, given that the size for one large association may greatly differ from the sizes of each member employer.

In addition to ERISA, AHPs are subject to requirements under the Public Health Service Act (PHSA). Similar to ERISA, regulation of AHPs under the PHSA depends on the characteristics of the AHP sponsor and coverage. Whether an AHP is considered coverage for individuals, small groups, or large groups or a self-funded plan substantively affects the scope of requirements under the PHSA.[15] HHS guidance has concluded that "in most situations involving employment-based association coverage, the group health plan exists at the individual employer level and not at the association-of-employers level."[16] Consequently, the size of each association member (i.e., employer) determines whether the coverage is regulated as small-group or large-group coverage. Also, association coverage that is *not* provided in connection with a group health plan is not group coverage for PHSA purposes; such coverage would be subject to individual insurance requirements. For example, coverage provided through an association consisting only of self-employed persons with no employees of their own would not be considered a group health plan at the federal level. Therefore, it would be regulated as individual insurance.

How Has Federal Regulation of AHPs Changed in Recent Years?

The ACA included only a couple of narrowly drafted provisions related to the regulation of AHPs.[17] Nonetheless, the ACA modified and added multiple requirements applicable to health

[11] 29 U.S.C. §§1101-1114, 1021-1031.

[12] For additional background, see Department of Labor (DOL), "Health Plans & Benefits: ERISA," at https://www.dol.gov/general/topic/health-plans/erisa#doltopics.

[13] To access these advisory opinions, see DOL, "Advisory Opinions," at https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions.

[14] For example, see DOL, Advisory Opinion 2017-02AC, May 16, 2017.

[15] See Table 1 in CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

[16] Centers for Medicare & Medicaid Services, "Application of Individual and Group Market Requirements Under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or Through, Associations," September 1, 2011, p. 3, at https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf.

[17] Prior to the ACA, federal law required issuers in the small-group market to accept every small employer that applied for such coverage (*guaranteed availability* provision). However, an issuer that made small-group coverage available *only* through one or more bona fide associations was exempt from that provision. The ACA expanded guaranteed availability and deleted the exemption for bona fide associations. In other words, small-group issuers may continue to offer coverage to bona fide associations, but such coverage also must be made available to small groups that are not

issuers and the insurance products they sell. Consequently, association coverage is subject to federal requirements added or amended by the ACA.[18] For example, prior to the ACA, there were few federal requirements regarding coverage for specific benefits. The ACA substantively expanded benefit mandates by requiring issuers in the small-group and individual insurance markets to offer the *essential health benefits* (EHB), 10 broad categories of health services and items (e.g., maternity and newborn care). Large-group issuers and self-funded plans are exempt from the EHB requirement.[19]

What Changes to AHPs Have Been Proposed in Response to E.O. 13813?

On January 5, 2018, DOL issued a proposed regulation concerning AHPs.[20] In keeping with the directives stated in E.O. 13813 (see **Table 1**), the rule proposes to expand the definition of *employer* for the purpose of sponsoring group coverage and relaxing the *commonality of interest* standard (see "How Are AHPs Currently Regulated?"). The rule proposes, among other things, that an association formed primarily or solely for the purpose of sponsoring a group health plan, and whose membership is comprised of employers either in the same industry or operating in the same geographic area, would meet the definition of employer under ERISA. The rule also would treat *working owners* simultaneously as employers and employees, essentially allowing self-employed persons and sole proprietors who meet specified requirements to sponsor AHP coverage and receive such coverage. In addition, the rule includes certain nondiscrimination provisions to prohibit an association from basing membership, eligibility for health benefits, and premiums on *health factors*.

DOL sought comments on a number of issues addressed in the proposed rule, including the commonality of interest standard, the definition of working owner, and nondiscrimination requirements. The rule did not explicitly provide a definition for *association health plan,* nor did it amend the applicability of "existing generally applicable federal regulatory standards governing ERISA plans."[21] Collectively, the changes proposed in the rule would allow AHPs currently regulated as small-group or individual coverage at the federal level to be regulated as large-group coverage instead, as long as the group meets the size definition of a large group.[22] Consequently, AHPs could be subject to fewer federal requirements overall if the proposed changes were finalized, such as the EHB example described previously and certain provisions concerning the

association members. For additional information, see Department of Health and Human Services (HHS), "Bona Fide Association Coverage," 78 *Federal Register* 13425, February 27, 2013. The ACA also included a provision to provide DOL with more authority to combat fraudulent or struggling multiple employer welfare arrangements (MEWAs). DOL may issue a cease-and-desist order to a fraudulent MEWA and seize the assets of an MEWA in financial hardship. Moreover, the ACA requires MEWAs to register with DOL prior to operating. For additional information, see DOL, "Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation," at https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/enforcement/healthcare-fraud.

[18] See CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

[19] See 42 U.S.C. §18032(b).

[20] U.S. Department of Labor, "Definition of 'Employer' Under Section 3(5) of ERISA-Association Health Plans," 83 *Federal Register* 614, January 5, 2018.

[21] Ibid., p. 625.

[22] As discussed in the textbox, "Sources and Regulation of Private Health Insurance Coverage," large groups are those with more than 50 employees.

determination of premiums.[23] The reduced regulatory burden could affect the regulation of current AHPs and encourage the formation of new AHPs. (For additional background and discussion about key legal considerations related to the AHP proposed rule, see CRS Legal Sidebar LSB10078, *Association Health Plans: Some Key Aspects of the Labor Department's Proposed Rule*.)

In the preamble to the proposed AHP rule, DOL states that allowing associations to "offer health coverage to their members' employees under a single plan may ... offer many small businesses more affordable alternatives than are currently available to them in the individual or small-group markets."[24] DOL also states that these regulatory changes may prompt businesses that currently do not offer coverage and uninsured individuals to form associations. The agency notes that concerns about risk selection (specifically, healthy individuals being drawn out of the existing private market into AHPs) prompt the inclusion of the provisions prohibiting discrimination based on health factors.

There are differing opinions about the potential impact of the proposed changes. AHP proponents argue that the proposal will not only lead to an expansion of coverage options but also lower premiums for those options.[25] However, AHP opponents argue that the offer of such coverage will have adverse effects on certain consumer groups and the private market. For example, large-group AHPs would be allowed to offer coverage that is less comprehensive than EHBs, potentially rendering such coverage less valuable to consumers with high health care needs. Moreover, the option of less comprehensive coverage for a lower premium may draw out healthy consumers from the individual and small-group markets. This shift in enrollment to AHPs may potentially lead to higher premiums for consumers outside of AHPs, particularly in the individual market.[26] AHP proponents counter that inclusion of nondiscrimination provisions in the proposed rule, and the continued applicability of federal requirements not modified by the rule, provides adequate protections for consumers.[27]

Can AHPs Offer Health Insurance "Across State Lines"?

Technically, no. The concept of selling insurance across state lines is precisely that—allowing state-licensed issuers to sell the same insurance product in multiple states, without complying with each state's unique set of requirements. A handful of states have enacted legislation to allow

[23] The differences in regulatory requirements applicable to large groups compared to small groups and individuals are indicated in Table 1 in CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

[24] U.S. Department of Labor, "Definition of "Employer" Under Section 3(5) of ERISA-Association Health Plans," 83 *Federal Register* 614, January 5, 2018, p. 619.

[25] For example, see Sally C. Pipes, Pacific Research Institute, "Trump's AHP Rule Makes Health Care Affordable Again," January 22, 2018, at https://www.pacificresearch.org/trumps-ahp-rule-makes-health-care-affordable-again/; and National Association of Realtors, "NAR Expresses Support for Proposed Association Health Plan Rule," at http://rismedia.com/2018/03/07/nar-expresses-support-proposed-association-health-plan-rule/.

[26] For example, see America's Health Insurance Plans, "How Association Health Plans Impact Enrollment and Premiums," February 28, 2018, at https://www.ahip.org/report-how-association-health-plans-impact-enrollment-and-premiums/; and American Academy of Actuaries, "Actuaries Suggest Focus on Risk and Financial Security Issues to Policymakers Ahead of State of the Union Speech," January 25, 2018, at http://www.actuary.org/files/Actuaries%20Suggest%20Focus%20on%20Risk%20and%20Financial%20Security%20Issues.pdf.

[27] For example, see Christopher E. Condeluci, Esq, Testimony Before the Committee on Education and the Workforce, Subcommittee on Health, Employment, Labor, and Pensions, Hearing on Expanding Affordable Health Care Options: Examining the Department of Labor's Proposed Rule on Association Health Plans, March 20, 2018, at https://edworkforce.house.gov/uploadedfiles/testimony_condeluci_revised_3.20.18.pdf.

the sale of insurance across state lines.[28] As mentioned previously, AHPs pool together employers or individuals. An AHP is not a state-licensed issuer.

A point of confusion with these two concepts—AHPs and selling insurance across state lines—is related to the current treatment of self-funded health plans. Under ERISA, self-funded plans *generally* are exempt from state laws that relate to employment-based benefits.[29] For example, a large employer with employees in a number of states may ignore state-specific benefit mandates and instead offer the same set of health benefits in multiple states if the employer self-funds those benefits. The practice of self-funding health coverage in multiple states mirrors the concept of an issuer selling insurance across state lines, even though a self-funded plan technically is not insurance and the plan sponsor (employer, association, or other group) is not a state-licensed issuer. An exception to this regulatory approach applies to MEWAs. Regardless of how MEWAs are funded (fully insured or self-funded), they are currently subject to federal laws and certain state laws, such as state solvency standards and state benefit mandates.[30]

What Is the History of AHP Bills? What Changes Do They Propose?

Bills with AHP provisions have been introduced since at least the 103rd Congress,[31] but such legislative provisions have not been enacted. Although the proposed AHP provisions have varied in scope and detail, the bills that have been introduced since the 105th Congress have common elements: amendment to ERISA to define AHPs (sometimes referred to as *small business health plans*), requirements applicable to sponsors of AHPs, and exemption from certain state requirements. More recently, provisions to establish AHPs were included in legislative proposals that would repeal or make substantive modifications to selected ACA provisions.[32] In general, the AHP proposals would define the types of entities that constitute AHPs and allow such plans to be considered large-group coverage for federal regulatory purposes. Moreover, some of these proposals would exempt such plans from certain state requirements. Overall, the legislative AHP proposals were much broader in scope than the narrow focus of E.O. 13813.

Short-Term, Limited-Duration Insurance (STLDI)

What Is Short-Term, Limited-Duration Insurance?

STLDI is a type of health insurance that is generally designed to fill gaps in having health insurance coverage, particularly for individuals transitioning from one type of coverage to another.

[28] According to the National Conference of State Legislatures (NCSL), six states allow this practice. For more information, see NCSL, "Allowing Purchases of Out-of-State Health Insurance" at http://www.ncsl.org/research/health/out-of-state-health-insurance-purchases.aspx.

[29] 29 U.S.C. §1144(a).

[30] If the AHP rule is finalized as proposed, it is unclear whether and how state law would apply to self-funded AHPs. For a discussion about the relevant issues, see CRS Legal Sidebar LSB10078, *Association Health Plans: Some Key Aspects of the Labor Department's Proposed Rule*.

[31] See S. 2296, Health Security Act, in the 103rd Congress.

[32] See "Better Care Reconciliation Act" in CRS Report R44883, *Comparison of the American Health Care Act (AHCA) and the Better Care Reconciliation Act (BCRA)*, and the following bills introduced during the 115th Congress: H.R. 277, H.R. 1072, H.R. 1101, and S. 222.

The term *short-term, limited-duration insurance* is not defined in federal statute; rather, it is defined in regulations. The current definition of STLDI (finalized October 2016, enforced beginning April 2017) is health insurance coverage that meets two conditions.

- One, it must be provided "pursuant to a contract with an issuer that: has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder with or without the issuer's consent) that is less than 3 months after the original effective date of the contract."[33] In layman's terms, this means that an STLDI policy can last a maximum of three months, including any extensions a consumer may request. A consumer might be able to purchase a one- or two-month policy and extend it up to the three-month limit, but the consumer would not be able to purchase and then extend a three-month policy. However, subject to state law, there are ways that consumers can currently buy consecutive short-term policies, as discussed in "How Do STLDI Plans Operate in the Private Health Insurance Market?"
- And two, the coverage must include information in its contract and application materials about the coverage not being considered minimum essential coverage for purposes of the individual mandate penalty.[34] (See **Table 2**.)

Although STLDI plans are sold in the individual market,[35] STLDI is not considered individual health insurance coverage for the purpose of federal requirements. Significantly, STLDI issuers are not subject to *guaranteed issue*—the federal requirement to accept every applicant for coverage (provided the applicant agrees with the terms and conditions of the insurance offer). Instead, STLDI applicants can be denied coverage based on health status-related factors. The questions on "How Do STLDI Plans Operate in the Private Health Insurance Market?" and "How Is STLDI Currently Regulated?" provide more information about this and other federal requirements in relation to STLDI plans.

How Do STLDI Plans Operate in the Private Health Insurance Market?

STLDI is intended to fill gaps in health insurance coverage. This type of insurance could be relevant for someone who has left a job and needs temporary coverage until he or she finds a new job (or exhausts a new job's coverage waiting period). Examples of others who might consider it are young adults who have turned 26 and are no longer eligible to be covered by their parents but do not yet have their own job-based coverage, a person who has retired but is not quite eligible for Medicare, or someone who travels internationally often and is in the United States only for brief, intermittent periods.

Consumers may have coverage options besides STLDI that can fill the gaps in these examples, such as enrolling in an individual plan through their state's health insurance exchange during an

[33] 45 C.F.R. §144.103.

[34] Ibid. STLDI is identified as not being minimum essential coverage in regulations (26 C.F.R. §1.5000A-2(d)). Individuals who do not maintain minimum essential coverage and have not received an exemption from the individual mandate could be subject to a penalty for each month of noncompliance. The mandate and its associated penalty are in effect through 2018; however, the 2017 tax revision effectively eliminates the penalty beginning in 2019 (i.e., individuals who do not comply with the mandate will not be subject to a penalty beginning in 2019).

[35] Although individual market coverage may be sold through health insurance exchanges, STLDI is sold only in individual markets off the exchanges.

annual open enrollment period (OEP) or a special enrollment period (SEP), if they qualify;[36] enrolling in their spouse's group coverage plan; or electing COBRA continuation coverage if eligible.[37] But in some cases—for example, if someone is outside of any OEPs and does not qualify for an SEP—STLDI may be the only alternative to being uninsured.

STLDI plans typically have no OEPs, meaning people can purchase them at any time. Provided STLDI is sold in their state and an STLDI issuer is willing to cover them,[38] people may be able to gain coverage in less than a day.[39] However, per current definition, STLDI plans can be no longer than three months and are not renewable. When a short-term plan expires, a consumer could—subject to state law—reapply for another plan, but his or her application could be denied based on any new health conditions that have arisen. The consumer's premiums also could increase, and any amounts applied to his or her deductible under one short-term plan would not apply to the new deductible.[40] In states that permit it, some STLDI issuers allow consumers an option of "pre-purchasing" consecutive plans; for example, a consumer could purchase a set of four three-month plans. This option generally would guarantee coverage through those four plans, but deductibles likely would reset each time.[41]

To the extent they are able, given duration limitations, some consumers seek STLDI not just as gap coverage but as their indefinite source of coverage. STLDI plans typically offer lower premiums than more comprehensive health insurance plans offered through the group or individual markets. However, as STLDI plans are not subject to federal requirements that apply to individual and certain group plans,[42] they also typically have higher consumer cost-sharing requirements, cover fewer benefits, can charge higher premiums based on health status, and can exclude benefits based on applicants' preexisting health conditions.[43] And because STLDI plans cannot be sold through the health insurance exchanges, individuals cannot apply premium tax credits or cost-sharing subsidies to STLDI plans. Because STLDI plans do not qualify as

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[36] For more information about exchange open enrollment and special enrollment periods, see CRS Report R44065, *Overview of Health Insurance Exchanges*.

[37] Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA; P.L. 99-272), certain employees are eligible to continue their job-based health insurance coverage after leaving the job. For more information, see DOL, *COBRA Continuation Health Coverage FAQs*, at https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/cobra-continuation-health-coverage-compliance.

[38] STLDI plans are not sold in at least four states, either directly (MA, NJ, and NY) or indirectly (RI) due to state regulations. See Kevin Lucia, Justin Giovannelli, Sabrina Corlette et al., *State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market*, The Commonwealth Fund, March 2018, at http://www.commonwealthfund.org/publications/fund-reports/2018/mar/state-regulation-coverage-options-outside-aca. STLDI issuers can deny coverage based on health status-related factors; see "What Is Short-Term, Limited-Duration Insurance?"

[39] One example of an issuer offering STLDI plans "on the spot" is eHealth: https://www.ehealthinsurance.com/short-term-health-insurance.

[40] A premium is an amount paid for health insurance, usually monthly. A deductible is an amount that must be paid by the enrollee as benefits are used, before the issuer will pay for most covered benefits in a policy term (typically annually, for plans other than STLDI).

[41] For example: Insubuy, "National General STM – State Specific Rewrite and Multiple Application Rules," at https://www.insubuy.com/national-general/temporary-health-insurance/; Pivot Health, "Short Term Health Insurance [Dropdown topic: Short term health insurance vs. Obamacare health insurance plans]," at https://www.pivothealth.com/short-term-health-insurance/.

[42] See text box entitled "Sources and Regulation of Private Health Insurance Coverage" and questions on "What Is Short-Term, Limited-Duration Insurance?" and "How Is STLDI Currently Regulated?"

[43] For more information, see American Academy of Actuaries, "Comments on Short-term, Limited Duration Insurance," April 6, 2018, at https://www.actuary.org/files/publications/STLD_Comment%20Letter_040618.pdf.

minimum essential coverage, individuals covered under STLDI plans could be subject to a penalty for not complying with the individual mandate to maintain minimum essential coverage.[44]

STLDI plans constitute a very small portion of the U.S. health insurance market. In 2016, issuers earned about $146 million in premiums for STLDI plans, compared to $63.25 billion in premiums for comprehensive major medical plans in the individual market. At the end of 2016, STLDI plans covered about 161,000 lives, whereas comprehensive major medical plans covered 13.6 million.[45]

How Is STLDI Currently Regulated?

STLDI plans are sold in the individual market, but STLDI plans are not considered individual health insurance coverage for the purpose of federal requirements. Thus, they do not have to comply with federal requirements that apply to individual insurance, such as those related to covered benefits and cost-sharing structures. For example, STLDI plans do not have to cover the EHB;[46] they do not have to comply with the prohibition of annual or lifetime limits on coverage of the EHB; and based on health status-related factors, they can deny coverage altogether, deny coverage for specific benefits, or charge higher premiums. See "What Is Short-Term, Limited-Duration Insurance?" and "How Do STLDI Plans Operate in the Private Health Insurance Market?" for additional discussion.

Still, STLDI plans are subject to state regulations, which may address a variety of issues including licensing requirements, marketing rules, benefit mandates, and more. In the case of STLDI plans, states may set a shorter maximum duration than the federal government's, or they may prohibit the sale of STLDI plans altogether. Thus, the type and availability of STLDI plans may vary from state to state, and there are four states in which STLDI plans are not available at all.[47]

How Has Federal Regulation of STLDI Changed in Recent Years?

On October 31, 2016, the Departments of HHS, Labor, and the Treasury ("Departments") updated the definition of STLDI to the one discussed in "What Is Short-Term, Limited-Duration Insurance?": health insurance coverage provided "pursuant to a contract with an issuer that (1) has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder *with or without* the issuer's consent) that is less than *3 months* after the original effective date of the contract" (emphasis added) and (2) includes information in its

[44] See footnote 34.

[45] Note that the current definition of STLDI plans went into effect in 2017, so these data are applicable to plans sold when the previous definition was in effect. See "How Has Federal Regulation of STLDI Changed in Recent Years?" Data cited are available at National Association of Insurance Commissioners, *2016 Accident and Health Policy Experience Report*, July 2017, at http://www.naic.org/prod_serv/AHP-LR-17.pdf. See "short term medical" plans versus "comprehensive major medical" plans, both in the "individual business" category, as reported on pages 13-15. Note, however, that these data may underestimate STLDI enrollment because they do not count the STLDI coverage that some issuers offer through group coverage. See American Academy of Actuaries, "Comments on Short-term, Limited Duration Insurance," April 6, 2018, at https://www.actuary.org/files/publications/STLD_Comment%20Letter_040618.pdf.

[46] For more information about essential health benefits, see CRS Report R44163, *The Patient Protection and Affordable Care Act's Essential Health Benefits (EHB)*.

[47] Kevin Lucia, Justin Giovannelli, Sabrina Corlette et al., *State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market*, The Commonwealth Fund, March 2018, at http://www.commonwealthfund.org/publications/fund-reports/2018/mar/state-regulation-coverage-options-outside-aca.

contract and application materials about the coverage not being considered minimum essential coverage for purposes of the individual mandate penalty (see **Table 2**).[48] This updated STLDI definition went into effect beginning January 1, 2017, but was not enforced until April 1, 2017.

Prior to that, STLDI was defined as health insurance coverage provided "pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder *without* the issuer's consent) that is less than *12 months* after the original effective date of the contract" (emphasis added).[49]

Thus, the primary changes in the October 2016 final rule were the decrease in the maximum length of STLDI plans from 12 months to 3 months, the change in the language "without" to "with or without,"[50] and the addition of the required disclaimer (see **Table 2**). In the October 2016 final rule, the Departments stated that they made these changes because STLDI plans were not being bought or sold as the gap-coverage products they were intended to be. Individuals were purchasing STLDI as their primary source of coverage, and issuers were providing renewals of STLDI coverage that extended the duration beyond 12 months. The Departments noted concerns about the impacts of increased STLDI enrollment on the remaining risk pools—and thus the issuer and consumer costs—in the ACA's health insurance exchanges. In general, STLDI plans may be more attractive to relatively younger and healthier individuals. If they leave the exchanges and purchase STLDI policies instead, this could cause individual market premiums to increase for those who remain. In turn, this could lead to greater governmental outlays for premium tax credits. The Departments also noted concerns that individuals purchasing STLDI may not be aware that those plans offer fewer benefits and consumer protections than ACA-compliant plans and that even with STLDI coverage, consumers still could be subject to a penalty per the ACA's individual mandate to maintain minimum essential coverage.

Opponents of the 2016 changes stated that consumers should be able to maintain their STDLI coverage as long as they desire, particularly those who do not qualify for premium tax credits or cost-sharing subsidies for exchange coverage and otherwise were facing increasing premiums.[51]

What Changes to STLDI Have Been Proposed in Response to E.O. 13813?

The October 2017 executive order requested the Departments to consider revising guidance on STLDI within 60 days of that order. On February 21, 2018, the Departments issued proposed regulations that would include the following changes to STLDI, if finalized:[52]

[48] 45 C.F.R. §144.103.

[49] Department of the Treasury, DOL, and HHS, "Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers Under HIPAA Titles I & IV, Final Rule," 69 *Federal Register* 78719-78799, December 30, 2004.

[50] The language "with or without the issuer's consent," enacted via the October 2016 final rule, is intended to restrict renewals of STLDI policies.

[51] For example, Michael F. Cannon, "Trump Executive Order Could Save Millions from ObamaCare," Cato Institute, October 12, 2017, at https://www.cato.org/blog/trump-executive-order-could-save-millions-obamacare; Roger Klein, "Bring Back Short-Term Health Insurance Plans – It's Only Fair," *The Hill*, April 27, 2018, at http://thehill.com/opinion/healthcare/385220-bring-back-short-term-health-insurance-plans-its-only-fair.

[52] Department of the Treasury, DOL, and HHS, "Short-Term, Limited-Duration Insurance," 83 *Federal Register* 7437-7447, February 21, 2018.

- The maximum duration of STLDI would be increased back to what it was prior to the 2016 final rule—less than 12 months, rather than less than 3 months. In fact, the definition would revert to exactly what it was before: "health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder *without* the issuer's consent)[53] that is less than *12 months* after the original effective date of the contract" (emphasis added).[54]
- Issuers still would be required to include language in the contract and any application materials informing consumers that the STLD plan is not subject to certain federal requirements. However, modifications were suggested to the language that was finalized in October 2016, and the new proposed rule included different versions to be used before and after January 1, 2019, due to the changing relevance of the individual mandate penalty (see **Table 2**).
- The Departments sought comments on the conditions under which issuers should be allowed to offer policy continuations beyond 12 months and on what processes, including federal standards, may streamline the reapplication process for consumers and issuers. This change could allow issuers to offer, and consumers to select, STLDI policies as their indefinite health insurance coverage rather than as a gap-filler between having other types of coverage.

Whereas the October 2016 changes were made in an effort to restrict the use of STLDI plans as long-term coverage rather than gap coverage, the Departments suggest that the changes in the February 2018 proposed rule could provide more flexibility for consumers purchasing insurance in the individual market, including those who do not qualify for the ACA's premium tax credits or cost-sharing subsidies for exchange plans. The February 2018 proposed rule acknowledges that these changes, especially in conjunction with the coming zeroing out of the individual mandate penalty, could adversely affect the exchange markets (as discussed in "How Has Federal Regulation of STLDI Changed in Recent Years?").[55]

Opponents of the currently proposed changes have emphasized the potential negative impacts on the risk pool for the individual market for comprehensive coverage (including individual exchanges), in terms of shifts in enrollment away from this market, premium increases for those who remain in this market, and increases in federal outlays for premium tax credits.[56]

Comments were due April 23, 2018. Changes would be effective 60 days after publication of the final rule, although the Departments sought comments on whether a mid-year effective date would be disruptive in any way. As written, this rule would not affect states' existing ability to

[53] The language "with the issuer's consent," in place prior to 2016 and proposed again in February 2018, is intended to make it easier for consumers to extend or renew their policies, although subject to issuer approval, as issuers are still allowed to deny coverage for preexisting conditions, including any that may have arisen during the current policy term.

[54] Department of the Treasury, DOL, and HHS, "Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers Under HIPAA Titles I & IV, Final Rule," 69 *Federal Register* 78719-78799, December 30, 2004.

[55] Department of the Treasury, DOL, and HHS, "Short-Term, Limited-Duration Insurance," 83 *Federal Register* 7437-7447, February 21, 2018. See page 7443.

[56] For example, Linda J. Blumberg, Matthew Buettgens, and Robin Wang, "Updated: The Potential Impact of Short-Term Limited Duration Policies on Insurance Coverage, Premiums, and Federal Spending," Urban Institute, March 14, 2018, at https://www.urban.org/research/publication/updated-potential-impact-short-term-limited-duration-policies-insurance-coverage-premiums-and-federal-spending; Christina Lechner Goe, "Non-ACA-Compliant Plans and the Risk of Market Segmentation," National Association of Insurance Commissioners, March 2018 at http://www.naic.org/meetings1803/cmte_conliaison_2018_spring_nm_additional_materials.pdf (report is pages 1-32 of a larger set of presentation materials).

enact the same or more restrictive regulations on STLDI plans, including setting shorter maximum durations or prohibiting them altogether.

Table 2. Changes in Language Required to be Displayed on STLDI Contracts and Application Materials

(all versions must be displayed "prominently" and "in at least 14 point type")

October 2016 Final Rule	February 2018 Proposed Rule, Version 1	February 2018 Proposed Rule, Version 2
Effective January 1, 2017; enforced April 1, 2017.	Would be effective 60 days after final rule published, with respect to policies having a coverage start date before January 1, 2019.	Would be effective 60 days after final rule published, with respect to policies having a coverage start date on or after January 1, 2019.
"This is not qualifying health coverage ('minimum essential coverage') that satisfies the health coverage requirement of the Affordable Care Act. If you don't have minimum essential coverage, you may owe an additional payment with your taxes."	"This coverage is not required to comply with federal requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you understand what the policy does and doesn't cover. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. Also, this coverage is not 'minimum essential coverage.' If you don't have minimum essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month."	"This coverage is not required to comply with federal requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you understand what the policy does and doesn't cover. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage."

Source: 45 C.F.R. §144.103 and Departments of Health and Human Services, Labor, and the Treasury, "Short-Term, Limited-Duration Insurance," 83 *Federal Register* 7437-7447, February 21, 2018. See pg. 7446.

Note: STLDI = Short-term, limited-duration insurance.

Health Reimbursement Arrangements (HRAs)

What Are Health Reimbursement Arrangements?

HRAs are employer-established arrangements that pay or reimburse employees for substantiated medical care expenses up to a maximum dollar amount. HRAs are one type of tax-advantaged health care account. HRAs are similar to, but not the same as, other types of tax-advantaged health care accounts, such as flexible spending accounts and health savings accounts.

HRAs are funded solely by employers; employees cannot contribute to HRAs directly or through salary-reduction agreements. Payments and reimbursements from an HRA for an employee's (and the employee's spouse and dependents) substantiated medical care expenses are excluded from the employee's income and employment taxes.[57] If a distribution is, or can be, made for the

[57] The term *medical care* is defined at 26 U.S.C. §213(d). The definition includes 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 premiums, and

payment or reimbursement of anything other than a medical care expense, all distributions from the HRA in that tax year are included in income (in other words, the HRA loses its tax-advantaged status).

Employers are not limited in the amount they may contribute to an employee's HRA, and employers need not actually fund HRAs until employees draw on them; the accounts may be simply notional. In addition, reimbursements can be limited to amounts previously contributed. Unused balances may be carried over indefinitely, though employers may limit the aggregate carryovers. The carryovers must be used for medical care expenses. Employers may set up HRAs in such a way that employees who change jobs or retire may take the funds in their HRA with them, but employers are not required to do so. Employers may not offer HRAs through cafeteria plans.[58]

In general, employers may offer to employees only HRAs that are integrated with another group health plan (that is not an HRA). An HRA is integrated with a non-HRA group health plan if it meets specified requirements, including that the employer offering the HRA also offers a non-HRA group health plan and each employee provided an HRA is enrolled in a non-HRA group health plan. HRAs may not be integrated with health insurance coverage that is not a group health plan, such as a plan offered in the individual market. (This integration requirement is a fairly recent development; for more details, see "How Has Federal Regulation of HRAs and QSEHRAs Changed in Recent Years?")

Employers may provide HRAs to current and former employees, including retirees (regardless of the employee's or retiree's Medicare eligibility and enrollment). The integration requirement does not apply to HRAs that cover fewer than two current employees. Self-employed individuals are not eligible for HRAs.

What Are Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs)?

QSEHRAs are similar to HRAs in that they also are employer-established arrangements that pay or reimburse employees for substantiated medical care expenses;[59] however, QSEHRAs and HRAs differ in a number of ways. QSEHRAs are not subject to the HRA integration requirement. In fact, an employer that provides a QSEHRA is prohibited from offering a group health plan to its employees.[60] However, an employee is eligible for tax-advantaged distributions from a QSEHRA only if the employee has minimum essential coverage. These characteristics encourage

qualified long-term care expenditures, and long-term-care insurance premiums that do not exceed certain amounts. However, the term does not include medications unless prescribed by a doctor, and thus health reimbursement arrangement (HRA) funds cannot be used for over-the-counter medications (except those prescribed by a physician). Employers may restrict the types of medical and health services that are eligible for reimbursement from the list of medical care expenses.

[58] 26 U.S.C. §125 allows employers to establish cafeteria plans, which are benefit plans that offer employees a choice between taxable and nontaxable benefits without being taxed on the value of the benefits if employees select the latter.

[59] For more information about qualified small employer health reimbursement arrangements (QSEHRAs), see CRS Report R44730, *Increasing Choice, Access, and Quality in Health Care for Americans Act (Division C of P.L. 114-255)*.

[60] It should be noted that only employers that are not considered applicable large employers (ALEs) for purposes of the employer shared responsibility provision (often referred to as the employer mandate) established under 26 U.S.C. §4980H are allowed to offer QSEHRAs. In other words, an employer that meets the size requirement to offer a QSEHRA cannot be subject to the employer mandate (because it does not meet the size requirement to be an ALE).

employees who are provided a QSEHRA to obtain health insurance coverage outside of their employment (e.g., a health plan offered in the individual market).

Although any employer may offer an HRA, only small employers may offer QSEHRAs. In this case, a *small employer* is one with fewer than 50 full-time-equivalent employees. Payments and reimbursements from a QSEHRA cannot exceed specified dollar amounts. For 2018, those dollar amounts are $5,050 per year for self-only coverage or $10,250 per year for coverage that includes family members. Employers may provide QSEHRAs only to current employees (i.e., QSEHRAs are not available to former employees, such as retirees).

How Do HRAs and QSEHRAs Operate Within the Private Health Insurance Market?

In general, tax-advantaged health accounts, such as HRAs and QSEHRAs, are intended to help cover an account holder's (and spouse's and any dependents') unreimbursed medical care expenses (e.g., expenses not covered by insurance). Both HRAs and QSEHRAs are employer-established accounts; neither is available to individuals unless it is offered by an individual's employer or the individual is a spouse or dependent of an individual who has an HRA or QSEHRA.[61]

The respective rules governing HRAs and QSEHRAs provide that each account supplements health insurance coverage. The HRA integration rule provides that an individual must have employer-sponsored coverage in order to have an HRA. The rules governing QSEHRAs provide that an individual must have some type of minimum essential coverage in order to have a QSEHRA.[62]

How Are HRAs and QSEHRAs Currently Regulated?

Both HRAs and QSEHRAs are regulated under the Internal Revenue Code (IRC) and guidance from the Internal Revenue Service (IRS).

The tax status of HRAs is governed by IRC Section 105, which allows health plan benefits used for medical care to be exempt from employees' income taxes, and IRC Section 106, which applies the same tax advantage to employer contributions to health plans. However, HRAs are not explicitly authorized by legislation and are not named in the IRC. The IRS first affirmed that HRAs could be a tax-advantaged way to pay for unreimbursed medical expenses in guidance issued in 2002, so long as they meet certain criteria.[63]

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[61] In this way, HRAs and QSEHRAs are similar to flexible spending accounts (FSAs) and different from health savings accounts (HSAs), as FSAs are employer-established accounts but HSAs are individual-established accounts.

[62] The types of coverage that are considered minimum essential coverage are identified in 26 U.S.C. §5000A and its implementing regulations. 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), as well as private insurance (e.g., employer-sponsored insurance and nongroup, or individual, insurance). The definition of minimum essential coverage is not affected by the effective repeal of the individual mandate penalty that goes into effect in 2019.

[63] IRS Rev. Rul. 2002-41 and IRS Notice 2002-45.

QSEHRAs were established in legislation,[64] are defined in the tax code at IRC Section 9831(d), and their tax status is governed by IRC Sections 105 and 106. The IRS issued substantive guidance on the requirements that apply to QSEHRAs on October 17, 2017.[65]

How Has Federal Regulation of HRAs and QSEHRAs Changed in Recent Years?

Possibly the most salient change to federal rules governing HRAs has to do with the establishment of the integration requirement described in "What Are Health Reimbursement Arrangements?"

Prior to the establishment of the integration requirement, employers were allowed to offer stand-alone HRAs. That is, an employer could offer an HRA without having to offer a group health plan and without ensuring that employees had coverage under a group health plan. Because HRA funds can be used to pay premiums, employees could use stand-alone HRAs to purchase health insurance coverage (which was not offered by their employers), such as coverage offered in the individual market.

The integration requirement effectively prohibits employers from offering stand-alone HRAs. The integration requirement was established in guidance issued jointly by the Departments of HHS, Labor, and the Treasury in September 2013.[66] The guidance determined that, in general, an HRA must be integrated with another group health plan (that is not an HRA) to comply with two requirements that apply to group health plans. The two requirements were established under the ACA and are described below.

- **Prohibition on Annual Limits**: Group health plans are prohibited from having dollar limits on the amount the plan will spend for covered health benefits during a plan year.
- **Preventive Services Requirement**: Group health plans must provide coverage for certain preventive health services without imposing cost sharing.

Employers that offer group health plans that do not comply with one or both of these requirements—including an HRA that is not integrated with a non-HRA group health plan—could be subject to an excise tax of $100 per day per employee covered under the noncompliant arrangement.

The guidance (and subsequent follow-up guidance) specifically addresses HRAs that pay or reimburse employees for health insurance coverage purchased in the individual market. In general, the guidance provides that an HRA that can be used for such purposes may not be integrated with a non-HRA group health plan and therefore is not in compliance with the prohibition on annual limits and the preventive service requirement.[67]

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[64] QSEHRAs were established under the 21st Century Cures Act (P.L. 114-255).

[65] IRS Notice 2017-67.

[66] IRS Notice 2013-54; DOL Technical Release 2013-03. The agencies reasoned that the two requirements should apply because HRAs generally are considered group health plans under IRC §9832(a), ERISA §733(a), and the Public Health Service Act (PHSA) §2791(a). The guidance also applies to employer payment plans under which an employer provides reimbursement of premiums for an employee's nongroup health insurance policy.

[67] The IRS identifies circumstances in which the restriction on using HRA funds for coverage purchased in the nongroup market does not apply. For example, the restriction does not apply to retiree-only HRAs, defined as having fewer than two current employees on the first day of the plan year. Similarly, the restriction does not apply to HRAs

The guidance issued in September 2013 was effective for plan years beginning January 1, 2014, for large employers, those with 50 more full-time-equivalent employees. Small employers, those with fewer than 50 full-time-equivalent employees, had to comply with the requirements for plan years beginning after June 30, 2015.[68]

QSEHRAs were established under the 21st Century Cures Act (P.L. 114-255) in response to the HRA integration requirement. Eligible employers were allowed to provide QSEHRAs beginning in 2017; the IRS issued substantive guidance on QSEHRAs on October 17, 2017.[69]

What Changes to HRAs and QSEHRAs Have Been Proposed in Response to E.O. 13813?

As of the date of this report, the Secretaries of the Treasury, Labor, and HHS have not proposed changes to HRAs. However, guidance issued by the IRS on October 17, 2017, regarding requirements that apply to QSEHRAs included the following statement.[70]

> In addition, Executive Order 13813 (82 Fed. Reg. 48385, Oct. 17, 2017), directed the Secretaries of the Treasury, Labor, and Health and Human Services to consider revising guidance, to the extent permitted by law and supported by sound policy, to increase the usability of health reimbursement arrangements (HRAs), expand employers' ability to offer HRAs to their employees, and to allow HRAs to be used in conjunction with non-group coverage. The guidance provided in this notice addresses each of those objectives. The Treasury Department (Treasury) and the Internal Revenue Service (IRS) anticipate that the Departments will issue additional guidance in the future in response to Executive Order 13813.

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that reimburse or directly pay the premiums for nongroup policies that offer only excepted benefits. *Excepted benefits* are defined at 26 U.S.C. §9831(b) and include, among other things, accident-only coverage, disability income, and certain limited-scope dental and vision benefits. For more information, see IRS Notices 2013-54, 2015-17, and 2015-87.

[68] IRS Notice 2015-17. The transition relief applies to all employers that are not considered applicable large employers (ALEs) for purposes of 26 U.S.C. §4980H (shared responsibility for employers regarding health coverage). In general, employers with fewer than 50 full-time equivalent employees are not considered ALEs, but see 26 U.S.C. §4980H and its implementing regulations for details about determining ALE status.

[69] IRS Notice 2017-67.

[70] Ibid.

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