



# Health Care Reform in Indian Country

Self-Governance Communication & Education

Self-Governance Tribes Striving Towards Excellence in Health Care

## Update on Rule Regarding Health Reimbursement Arrangements (HRAs) and Other Account-Based Group Health Plans (CMS-9918-F/TD 9867)<sup>1</sup>

### Application to Tribes and Tribal Members

March 26, 2026 (updated)

This brief provides information to Tribes on a 2019 final rule that establishes federal regulations regarding health reimbursement arrangements (HRAs) and other account-based group health plans, including provisions allowing the integration of these plans with individual health insurance coverage (referred to subsequently as “individual coverage HRAs”), such as coverage available through a Health Insurance Marketplace (Marketplace). Although this final rule does not include any Indian-specific provisions, the rule has implications for Tribal citizens who enroll in health insurance coverage through a Marketplace, for Tribes that offer coverage, and for Tribal providers serving individuals enrolled in coverage through a Marketplace.

Employees and their family members who (1) are enrolled Tribal members, (2) participate in an individual coverage HRA, and (3) enroll in individual market health insurance coverage through a Marketplace gain access to comprehensive Indian-specific cost-sharing protections established under the Patient Protection and Affordable Care Act (Affordable Care Act, or ACA).<sup>2,3</sup> And for Tribes (1) offering health insurance

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*Is it possible to access the ACA comprehensive Indian-specific cost-sharing protections and do so through employer-sponsored coverage? Now, the answer is “yes.” For Tribes and Tribal employees who are looking to reduce health insurance premium costs, as well as reduce out-of-pocket costs for Tribal members, this new rule might be helpful.*

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coverage as an employer or (2) considering operating Marketplace Sponsorship programs as a Tribal government, this final rule might provide new opportunities to access federal (cost-sharing) subsidies and increase revenues. In addition, it is important to note that, in general, neither employer contributions to, nor employee reimbursements from, an individual coverage HRA are subject to federal income or

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<sup>1</sup> This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Doneg McDonough, TSGAC Technical Advisor, at [DonegMcD@Outlook.com](mailto:DonegMcD@Outlook.com).

<sup>2</sup> In contrast, enrolled Tribal members who enroll in Marketplace coverage through the Small Business Health Options Program (SHOP) established under the Affordable Care Act (ACA) are not eligible for premium tax credits (PTCs) or the Indian-specific cost-sharing protections.

<sup>3</sup> For more information on the Indian-specific cost-sharing protections, see the TSGAC Webinar titled “Enrollment of Tribal Citizens and Other Indian Health Service (IHS) Eligible Individuals in Health Insurance Coverage Through a Marketplace, Including Use of Tribal Sponsorship” and dated November 12, 2019, at <https://www.tribalseg.org/wp-content/uploads/2020/03/TSGAC-PP-for-AI-AN-Marketplace-Enrollment-CMS-Assister-Webinar-2019-11-12a-rev.pdf>.

employment taxes.<sup>4</sup>

## **BACKGROUND**

This final rule, issued on June 20, 2019, by the Centers for Medicare and Medicaid Services (CMS) and the Departments of Labor and Treasury (collectively, the Departments), establishes regulations regarding HRAs and other account-based group health plans.<sup>5</sup> Specifically, this final rule:

- Allows the integration of HRAs and other account-based group health plans with individual health insurance coverage (or Medicare), under certain conditions;
- Provides a special enrollment period in the individual market for employees who newly gain access to an individual coverage HRA;
- Establishes rules regarding premium tax credit (PTC) eligibility for employees who are offered an individual coverage HRA;
- Establishes conditions under which certain HRAs and other account-based group health plans qualify as limited excepted benefit HRAs; and
- Clarifies that the individual health insurance coverage for which premiums are reimbursed by an individual coverage HRA does not become part of an Employee Retirement Income Security Act (ERISA) plan, provided that certain requirements are met.

This final rule took effect on August 19, 2019. The provisions in this final rule generally apply to *plan years* beginning on or after January 1, 2020, although certain provisions apply to *tax years* beginning on or after January 1, 2020.

## **INDIAN-SPECIFIC PROVISIONS**

This final rule does not include any Indian-specific provisions. However, as mentioned above, this final rule provides access to comprehensive Indian-specific cost-sharing protections (*i.e.*, limited cost-sharing variation (L-CSV) protections) established under the ACA when an employee who is an enrolled Tribal member uses funds made available through an individual coverage HRA and enrolls in health insurance coverage through a Marketplace.<sup>6</sup> Likewise, if a spouse or dependent of an employee is an enrolled Tribal member and enrolls in Marketplace coverage through the use of HRA funds, this individual also could access the L-CSV protections. For enrolled Tribal members, the average annual savings from the L-CSV protections is estimated at approximately \$2,100 per enrollee.<sup>7</sup>

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<sup>4</sup> In effect, individual coverage HRAs extend the tax advantage for traditional group health plans (exclusion of premiums, and benefits received, from federal income and payroll taxes) to HRA reimbursements of individual health insurance premiums. See the IRS guidance titled “FAQs on New Health Coverage Options for Employers and Employees: Individual Coverage and Excepted Benefit Health Reimbursement Arrangements” and dated June 13, 2019, at [https://www.irs.gov/pub/irs-utl/health\\_reimbursement\\_arrangements\\_faqs.pdf](https://www.irs.gov/pub/irs-utl/health_reimbursement_arrangements_faqs.pdf).

<sup>5</sup> See CMS-9918-F/TD 9867, “Health Reimbursement Arrangements and Other Account-Based Group Health Plans” (84 FR 28888), at <https://www.govinfo.gov/content/pkg/FR-2019-06-20/pdf/2019-12571.pdf>.

<sup>6</sup> In an e-mail dated April 7, 2020, CMS confirmed that individuals “who are members of a federally recognized tribe and who are ineligible for APTC for any reason (including because they have an ICHRA [individual coverage HRA]) are ineligible for the zero cost-sharing Indian CSR, but remain eligible for the limited cost-sharing Indian CSR.”

<sup>7</sup> In addition, the annual premiums for bronze-level Marketplace coverage are typically lower than the premiums for employer-sponsored coverage.

- For regular Marketplace enrollment, under federal regulations, enrolled Tribal members enrolling in individual market Marketplace coverage are eligible for one of two types of comprehensive Indian-specific cost-sharing protections.
  - Enrolled Tribal members who have a household income between 100% and 300% of the federal poverty level (FPL) and who are eligible for PTCs can enroll in zero cost-sharing variation (Z-CSV) plans.
  - All other enrolled Tribal members can enroll in L-CSV plans, regardless of their income level or their PTC eligibility.
- For Marketplace enrollment under this final rule, employees and their family members who are enrolled Tribal members and who are offered an individual coverage HRA are considered to have access to creditable coverage.<sup>8</sup>
  - These individuals are not eligible for PTCs.
  - However, these individuals (employees and their family members who are enrolled Tribal members) would qualify for the Indian-specific L-CSV protections.

Further, average health insurance premiums for the Marketplace coverage could be substantially lower than the average premium costs the employer (and employee) currently pay—particularly given that enrolled Tribal members can enroll in the lower-cost bronze plans and not have increased out-of-pocket costs (as they are eligible for comprehensive cost-sharing protections). For example, the annual premium for single coverage under the nationwide Blue Cross Blue Shield Basic plan offered through the Federal Employees Health Benefits Program (FEHBP) was \$7,898 in the 2020 plan year open enrollment period. In contrast, the annual premium for the lowest-cost Marketplace bronze plan (Premier Bronze Saver 3500, offered by Tufts Health Plan) for a 40-year-old individual living in Dukes County, Massachusetts, was \$5,133 in the 2020 plan year.

Finally, a Tribal clinic that has chosen to bill Medicaid as a Tribal federally-qualified health center (Tribal FQHC), under an alternative payment methodology established by a state that provides for payment of the OMB encounter rate for clinic services, would receive no less than the OMB encounter rate for services provided to Tribal and non-Tribal patients who are enrolled in health insurance coverage through a Marketplace.<sup>9</sup>

#### **DEFINITIONS**

- **Account-based group health plan:** An employer-sponsored group health plan that provides reimbursement for medical care expenses (as defined below), subject to a maximum fixed-dollar amount for a specific period (*e.g.*, a calendar year).

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<sup>8</sup> Non-Tribal members who are offered an individual coverage HRA also are considered to have access to “creditable coverage” and, therefore, are not eligible for PTCs.

<sup>9</sup> See TSGAC issue brief “Requirements for Payment and Other Protections to Indian Health Care Providers under Marketplace Health Plans”, at: <https://www.tribalselfgov.org/health-reform/2020-health-actions/>.

- **Employer payment plan:** A type of account-based group health plan under which an employer reimburses employees for some or all of the cost of premiums for individual health insurance coverage or other non-employer-sponsored coverage.
- **HRA:** A type of account-based group health plan funded solely by employer contributions (*i.e.*, with no employee contributions) that provides reimbursement for medical care expenses incurred by employees (or their spouse or dependents), with reimbursements excluded from employee income and wages for federal income tax and employment tax purposes.
- **Medical care expenses:** As defined at 26 CFR 213(d), amounts paid for (1) the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; (2) transportation primarily for and essential to medical care; (3) qualified long-term care services; or (4) health insurance or qualified long-term care insurance.
- **Qualified small employer health reimbursement arrangement (QSEHRA):** A type of HRA that is available to qualified employers (*i.e.*, employers that are not considered an applicable large employer (ALE), as defined at 26 CFR 4980H(c)(2), and do not offer a group health plan to any employees, and is not considered a group health plan under federal law.

## SUMMARY OF MAJOR PROVISIONS

### *Individual Coverage HRAs*

This final rule allows employers to provide to current and former employees (and their dependents<sup>10</sup>) HRAs and other account-based group health plans<sup>11</sup> integrated with individual health insurance coverage<sup>12</sup> (*i.e.*, individual coverage HRAs), under certain conditions. Employers can specify which medical care expenses—*e.g.*, premiums, non-premiums (such as cost-sharing), or particular medical care expenses—qualify for reimbursement under individual coverage HRAs.

This final rule does not allow employers to offer both a traditional group health plan and an individual coverage HRA to the same class of employees. However, employers can offer a traditional group health plan to one class of employees (*e.g.*, full-time employees) and offer an individual coverage HRA to a separate class of employees (*e.g.*, part-time employees), as no employee receives both options. This final rule specifies 10 classes of employees, as follows:

1. Full-time employees;
2. Part-time employees;
3. Salaried employees;

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<sup>10</sup> “Dependent” in this context refers to “any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant,” as defined at 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103.

<sup>11</sup> “Other account-based group health plans” include health flexible spending arrangements and employer payment plans but exclude QSEHRAs, medical savings accounts, health savings accounts, or cafeteria plan premium arrangements.

<sup>12</sup> “Individual health insurance coverage” includes individual market coverage, as well as fully insured student health coverage, but excludes short-term, limited-duration coverage, coverage that consists solely of excepted benefits, health care sharing ministries, and TRICARE.

4. Non-salaried (*e.g.*, hourly) employees;
5. Employees who work in the same health insurance coverage rating area;
6. Seasonal employees;
7. Employees included in a unit of employees covered by a particular collective bargaining agreement (or an appropriate related participation agreement) in which the health plan sponsor participates;
8. Employees who have not satisfied a waiting period for coverage;
9. Employees who are non-resident aliens with no U.S.-based income;
10. Employees who are employees of an entity that hired the employees for temporary placement at an entity that is (1) not the common law employer of the employees and (2) not treated as a single employer with the entity that hired the employees for temporary placement.

This final rule allows employers to identify additional classes of employees based on a combination of 2 or more of the 10 classes (*e.g.*, full-time seasonal employees or part-time hourly employees); in some cases, minimum size requirements apply to certain classes of employees.

In addition, this final rule generally requires employers offering an individual coverage HRA to a class of employees to offer the HRA on the same terms to all individuals within the class.<sup>13</sup> This final rule also includes special rules regarding offering individual HRAs to new hires and former employees. Under separate federal regulations, it is understood that Tribal employers can offer different health insurance coverage options to employees in different business units.<sup>14</sup> For example, a Tribal employer can offer an individual coverage HRA to employees in one business unit (*e.g.*, Tribal government central administration) and a traditional group health plan to employees in other business units (*e.g.*, Tribal hospital and resort employees).

#### *Employee Participation*

Under this final rule, to participate in an individual coverage HRA, employees must enroll in individual health insurance coverage that complies with sections 2711 and 2713 of the Public Health Service Act (PHS Act) (*e.g.*, Marketplace coverage).<sup>15,16</sup> Employees who participate in an individual coverage HRA and lose or end enrollment in their individual health insurance coverage must forfeit any reimbursements from the HRA; the

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<sup>13</sup> However, employers can offer higher HRA contributions based on employee age (capped at three times as much as the contribution to the youngest HRA participant) or family size; all HRA participants in the same class of employees must receive the same increase based on age or family size.

<sup>14</sup> See TSGAC issue brief, “Options for Tribal Employers under the ACA’s Employer Shared Responsibility Payment Rules: ALE Members” at <https://www.tribalseg.gov/wp-content/uploads/2016/10/TSGAC-Brief-ACA-Applicable-Large-Employer-Member-Pay-or-Play-Guide-2016-09-30.pdf>.

<sup>15</sup> Section 2711, as added by the ACA, generally prohibits group health plans and health insurance issuers offering group or individual health insurance coverage from establishing for any individual any lifetime or annual limits on the dollar value of essential health benefits (EHBs). Section 2713, as added by the ACA, requires non-grandfathered group health plans, and health insurance issuers offering non-grandfathered group or individual health insurance coverage, to provide coverage for certain preventive services without imposing any cost-sharing requirements for these services.

<sup>16</sup> Under this final rule, employers do not have to confirm that the health insurance coverage in which HRA participants enroll complies with sections 2711 and 2713; rather, this final rule implements an approach under which all individual health insurance coverage is considered compliant with sections 2711 and 2713.

HRA will reimburse medical care expenses for these individuals only through the termination date of their coverage.

#### *Special Enrollment Period*

This final rule also authorizes a special enrollment period in the individual market, both inside and outside the Marketplace, for employees (and their dependents) who newly gain access to an individual coverage HRA.<sup>17</sup> Under this final rule, these employees can enroll in individual health insurance coverage or change their coverage during a 60-day period before or after the first day on which coverage under the HRA (or a QSEHRA) takes effect.

#### *Verification and Notification Requirements*

This final rule requires individual coverage HRAs to adopt reasonable procedures to confirm that participants are enrolled in, or will enroll in, qualifying individual health insurance coverage. In addition, this final rule generally requires individual coverage HRAs to provide detailed written notices to each participant at least 90 days before the beginning of each plan year.

#### *Effect on Employee Eligibility for Marketplace PTCs*

This final rule specifies that an employee who is offered an individual coverage HRA and participates in the HRA (along with any eligible dependents who participate in the HRA) is considered to have minimum essential coverage, regardless of the amount of the employer contribution to the HRA. As such, an employee who participates in an individual coverage HRA and enrolls in Marketplace coverage does not qualify for PTCs.

This final rule does allow employees who are offered an individual coverage HRA to opt out of and waive future reimbursements from the HRA on at least an annual basis and in advance of the start of the plan year. In some cases, employees who opt out of an individual coverage HRA can receive Marketplace PTCs. Specifically, under this final rule, employees who (1) opt out of an individual coverage HRA, (2) enroll in Marketplace coverage, and (3) meet eligibility requirements for PTCs can receive the PTCs, *but only if the HRA is considered unaffordable or does not provide minimum value.*<sup>18</sup>

This final rule also establishes an employee safe harbor, under which employees who are offered an individual coverage HRA can rely on a Marketplace determination that the HRA is not affordable, even if the HRA ultimately proves affordable based on actual household income. This means that an employee who opts out of an individual coverage HRA and receives PTCs based on a Marketplace eligibility determination would not have to repay these PTCs later. This final rule allows employees to use this safe harbor as long as

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<sup>17</sup> This provision also applies to employees who newly gain access to a QSEHRA.

<sup>18</sup> Under this final rule, an individual coverage HRA is considered affordable if the required employee contribution to the HRA for a given month does not exceed 1/12 of the product of the household income of the employee for the taxable year and the required contribution percentage, *i.e.* the percentage of household income an employee must contribute for self-only coverage. The required employee contribution is calculated by subtracting (1) the monthly self-only individual coverage HRA amount from (2) the monthly premium for the lowest-cost Marketplace silver plan for self-only coverage. An individual coverage HRA that meets the above affordability standard is considered to provide minimum value. *See* 26 CFR 1.36B-2(c)(3)(i)(B) and (c)(5)(i).

they do not provide the Marketplace with incorrect information concerning an individual coverage HRA “with intentional or reckless disregard for the facts.”<sup>19</sup>

#### *Interaction with Employer Mandate*

Under this final rule, **an employer subject to the ACA employer mandate (i.e., an ALE) generally can meet the associated requirements regarding offering affordable health insurance coverage by offering an individual coverage HRA** to at least 95% of its full-time employees (and their dependents), provided that the HRA is affordable and meets minimum value requirements. The Departments have indicated, however, that smaller employers (non-ALEs that are not subject to the employer mandate) are the employers most likely to offer individual coverage HRAs.

#### *Limited Excepted Benefit HRAs*

This final rule recognizes an additional limited excepted benefit HRA for purposes of federal law. Employers can use a limited excepted benefit HRA to reimburse for excepted benefits, such as limited-scope vision or dental benefits, as well as other types of medical care expenses that do not qualify as excepted benefits. Employers can provide limited excepted benefit HRA contributions of as much as \$1,800.

Under this final rule, to qualify as a limited excepted benefit HRA, an HRA (1) cannot serve as an integral part of a group health plan; (2) must provide benefits that are limited in amount; (3) cannot reimburse for premiums for certain health insurance coverage; and (4) must be offered under the same terms to all similarly situated employees in a class of employees, regardless of any health factors. *Employers cannot offer both an individual coverage HRA and a limited excepted benefit HRA to the same employee.* In addition, employers cannot offer higher limited excepted benefit HRA contributions based on health status or limit enrollment in the HRA to employees who declined to enroll in a traditional group health plan.

#### *Individual Health Insurance Coverage and ERISA Plan Status*

This final rule clarifies that the definition of “group health plan” (ERISA plan) does not include reimbursement of premiums for individual health insurance coverage under an individual coverage HRA, provided that certain requirements are met.

#### **OPTIONS FOR TRIBAL EMPLOYERS**

By creating a new avenue to access Marketplace coverage, this final rule has the effect of providing Tribal employers with an additional option for providing health insurance coverage to employees.

A brief summary is provided below of the potential benefits for Tribal employers offering an individual coverage HRA to employees, in part depending on whether or not the Tribal employer is considered an ALE (i.e., an employer with 50 full-time employees or a combination of full-time and part-time employees equivalent to 50 full-time employees). (See Attachment A for specific examples of health insurance coverage options for Tribal employers).

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<sup>19</sup> Per this final rule, “A reckless disregard of the facts occurs if the taxpayer makes little or no effort to determine whether the information provided to the Exchange is accurate under circumstances that demonstrate a substantial deviation from the standard of conduct a reasonable person would observe. A disregard of the facts is intentional if the taxpayer knows that the information provided to the Exchange is inaccurate.” See 26 CFR 1.36B-2 (c)(5)(iv).

- **For Tribal employers considered ALEs**, offering an individual coverage HRA could have the benefits of lowering health insurance premium costs and, particularly in cases in which the vast majority of employees are enrolled Tribal members, dramatically reducing out-of-pocket medical costs for employees. For example:
  - For the 2020 plan year, the nationwide Blue Cross Blue Shield Basic plan offered through the Federal Employees Health Benefits Program (FEHBP) has a premium of \$7,898 for single coverage, compared with a premium of \$6,181 for the lowest-cost Marketplace bronze plan (EverydayHealth HMO 7000, offered by Blue Cross Blue Shield Arizona) for a 40-year-old individual living in Flagstaff, Arizona.
  - An enrollee in Blue Cross Blue Shield Basic, on average, would have estimated out-of-pocket costs of \$1,678 during the 2020 plan year,<sup>20</sup> while an enrolled Tribal member enrolling in any Marketplace plan (*e.g.*, EverydayHealth HMO 7000) generally would have no out-of-pocket costs, as they would qualify for the comprehensive Indian-specific cost-sharing protections.
  - For Tribal employers with a substantial number of non-enrolled Tribal member employees, the calculations of the costs and benefits to individual employees and their families are different, and this differential impact is important to consider.
  - Under this final rule, employers, including Tribal employers, are able to offer different health insurance coverage options to different “classes of employees,” an allowance that might facilitate providing the most advantageous coverage options to different groupings of employees.
  - In addition, as noted earlier, although “Tribal employees” are not considered a class of employees under the rule, it is possible that Tribal employers could offer an individual coverage HRA to employees in one business unit and group health insurance coverage to employees in other business units.<sup>21</sup>

In addition, as noted above, this option would satisfy the requirements of the ACA employer mandate and preclude any penalties associated with not offering affordable health insurance coverage to employees.

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<sup>20</sup> The estimate of out-of-pocket costs assumes that the Blue Cross Blue Shield Basic plan has an actuarial value of 83% and administrative costs of 20%.

<sup>21</sup> Special rules apply to ALEs comprised of multiple entities (called ALE members). *See* TSGAC issue brief, “Options for Tribal Employers under the ACA’s Employer Shared Responsibility Payment Rules: ALE Members.”

For purposes of determining whether an employer is considered an ALE (*i.e.*, has 50 full-time employees or a combination of full- and part-time employees equivalent to 50 full-time employees), federal regulations at 26 CFR 54.4980H-1(a)(16) provide that all employees from each ALE member are counted *collectively*. But for purposes of determining if an employer owes a shared responsibility payment, federal regulations at 26 CFR 54.4980H-4(d) treat each ALE member *individually*, meaning that each ALE member is responsible for making its own decision as to how to meet ACA employer requirements, as well as for making its own shared responsibility payment, if owed.

Federal regulations do not specify how the IRS will treat Tribal government departments, enterprises, or business units. Instead, the regulations contain a placeholder indicating that the IRS will establish special rules for determining ALE membership for governments at a later date. In the interim, the IRS has said that governments can apply a “reasonable, good faith interpretation” of current regulations to determine whether a governmental department, enterprise, or business unit is treated as an ALE member or as part of the government as a whole.

- **For Tribal employers not considered ALEs**, offering an individual coverage HRA to employees could provide similar benefits. However, a broad-based Tribal Sponsorship program—through which enrolled Tribal member employees (along with other eligible Tribal members) could enroll in Marketplace coverage, rather than employer-sponsored coverage—might serve as a more attractive option, as:
  - Individuals enrolling in Marketplace coverage through a Tribal Sponsorship program might have access to PTCs (which are unavailable when enrolling in Marketplace coverage through an individual coverage HRA).
  - The Tribe, as a non-ALE, would not incur any penalties (*i.e.*, have to make any “shared responsibility payments”) associated with not offering affordable health insurance coverage to employees under the ACA employer mandate.

#### **ADOPTION OF INDIVIDUAL HEALTH COVERAGE HRA OPTION BY TRIBAL EMPLOYERS**

Tribal employers have begun to assess the value of the individual coverage HRA model for offering health insurance coverage to employees (and possibly also to family members of employees). In two instances in which a Tribal employer has adopted an individual coverage HRA for their employees, the aggregate cost of health insurance coverage has been reduced (for the employer and employees), employee “take-up rates” have increased (thereby reducing the number of uninsured Tribal members), out-of-pocket costs have been lowered for Tribal member employees (who are eligible for the comprehensive Indian-specific cost-sharing protections), and revenues at the Tribal clinic have increased as a result of serving a greater number of insured patients and receiving a higher payment rate (the OMB encounter rate) for services provided to the Marketplace enrollees (both Tribal and non-Tribal member employees).

#### **CRITICISMS AND POSSIBLE IMPLICATIONS OF THE NEW FINAL RULE**

Some health policy experts have criticized this final rule as potentially weakening the employer-based health insurance system, as well as potentially shifting higher-cost individuals into the Marketplace, thereby increasing premiums in the Marketplace. In fashioning an employer-based health insurance option using an individual coverage HRA, it is useful to consider, and possibly to avoid, these and other *potential* downsides. The critiques and cautions of this final rule appear below.

- **Loss of health insurance coverage for some employees**, if employers offer individual coverage HRAs, rather than traditional group health plans, and their employees opt out of the HRAs and do not obtain other coverage. According to a different analyst, some gains in health insurance coverage also might occur, if employers that do not currently offer coverage to their employees decide to offer individual coverage HRAs.
- **Reduced access to Marketplace PTCs for some employees**, if no employer coverage was previously offered, potentially resulting in higher premiums for some middle-income employees through individual coverage HRAs.
- **Higher cost-sharing and narrower provider networks for some employees**, as a result of moving from a traditional group health plan to the individual market.
- **Decline in the individual market risk pool (and higher premiums)**, if employers that decide to offer individual coverage HRAs have relatively less healthy workforces. A less likely scenario, noted by

one analyst, is an improvement in individual market risk pool (and lower premiums) if employers that decide to offer individual coverage HRAs have relatively healthy workforces.

- **Increased enrollment in short-term health plans**, which are not subject to ACA insurance market rules, can discriminate against enrollees based on pre-existing medical conditions, and have limited benefits.

#### **ADDITIONAL RESOURCES**

Some additional resources that include discussion and analysis of the provisions of this final rule are available below.

- “Final Rule on Health Reimbursement Arrangements Could Shake Up Markets,” Katie Keith, *Health Affairs* blog (June 14, 2019).  
<https://www.healthaffairs.org/doi/10.1377/hblog20190614.388950/full/>
- “The Trump Administration’s Final HRA Rule: Similar to the Proposed but Some Notable Choices,” Christen Linke Young, Matthew Fiedler, and Jason Levitis, USC-Brookings Schaeffer Initiative for Health Policy (June 14, 2019).  
<https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/06/14/the-trump-administrations-final-hra-rule-similar-to-the-proposed-but-some-notable-choices/>
- “New Rule Could Mean Consumer Confusion, Higher Premiums in Marketplace,” Tara Straw, Center on Budget and Policy Priorities blog (June 21, 2019).  
<https://www.cbpp.org/blog/new-rule-could-mean-consumer-confusion-higher-premiums-in-marketplace>

## Attachment A: Examples of Health Insurance Coverage Options for Tribal Employers

**Example 1** (“Typical”): The Tribal employer offers group health insurance coverage to all employees, paying a significant share (*e.g.*, 80%) of the premiums.

- The Tribal employer makes no shared responsibility payment under the ACA employer mandate (as the employer meets employer mandate requirements)
- All employees have access to comprehensive health insurance coverage
- All employees must pay the remainder of the premiums and any cost-sharing (deductible, copayments, and co-insurance) required when accessing covered services

**Example 2** (“Tribal HRA model”): The Tribal employer offers an individual coverage HRA (in the amount of, for example, the full premium of the bronze level plan for individuals and, if employer contributions are offered for family members, for families (*e.g.*, \$6,100 single; \$18,000 family)) to all employees. [Note: The employer could offer different HRA contributions based on employee age or family size.]

- The Tribal employer makes no shared responsibility payment under the ACA employer mandate (assuming the offer of coverage meets ACA’s employer requirements.)
- Employees opting to participate in the HRA enroll in individual market health insurance coverage through a Marketplace.
- Tribal member employees opting to participate in the HRA and enrolling in Marketplace coverage secure eligibility for Indian-specific cost-sharing protections (meaning they incur no cost-sharing when accessing covered services) and pay no premium if enrolling in a bronze-level plan.
- Other (non-Tribal member) employees pay the remaining portion of premium for bronze, silver, or gold-level coverage and pay plan out-of-pocket costs.
- If the Tribal clinic serving participating employees has chosen to bill Medicaid as a Tribal FQHC, under an alternative payment methodology established by a state that provides for payment of the OMB encounter rate for clinic services, the clinic potentially would receive no less than the OMB encounter rate for services provided to these employees (whether they are Tribal or non-Tribal employees.)
  - For example, under the OMB encounter rate, Tribal clinics receive \$826 for a primary care visit in 2026.
  - Private health insurance issuers, in contrast, pay providers about \$100-\$150 for a primary care visit on average.<sup>22</sup>

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<sup>22</sup> Figures are taken from a recent study that examined payments to 174,561 primary care providers for services furnished to patients with health insurance coverage through four national issuers—Blue Cross and Blue Shield, Cigna, Elevance Health, and UnitedHealthcare—based on issuer-disclosed pricing data as of March 2024. *See* <https://pubmed.ncbi.nlm.nih.gov/41044451/>.