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Managing Editor
Leslie Small
lsmall@aishealth.com

Senior Reporter
Peter Johnson

Data Reporter
Jinghong Chen

Executive Editor
Jill Brown Kettler

MLRs Run Sky-High for Newly Public Insurer Startups in 3Q

The third quarter of 2021, to put it mildly, was a tough one for three out of the four startup health insurers that have gone public in the past year.

In particular, individual market-focused Oscar Health, Inc. and Bright Health Group, Inc. struggled with controlling medical costs despite their rising revenues. Oscar recorded a $212 million net loss — eclipsing its net loss of $79 million in the third quarter of 2020 — and a medical loss ratio (MLR) of 99.7%, while its revenues rose 336% year over year. Bright Health reported a $296 million loss (compared with a $59 million loss in the year-ago quarter) and a 103% MLR, and its revenues jumped 206%. Health insurers typically try to keep their MLRs in the mid-80% range to comply with federal regulations while also tightly managing medical costs.

Although Oscar did struggle in the third quarter, "Bright was the bigger disaster," says Ari Gottlieb, a principal at the consulting firm A2 Strategy Group.

Indeed, in a Nov. 11 note to investors, Citi analyst Ralph Giacobbe noted that Bright Health's MLR of 103% "came in well above our 87.8% estimate" as COVID-related costs (540 basis points) and unfavorable risk adjustment (900 basis points) "hampered the stat."

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Frustration Grows Over 'Relentless' Employer Plan Premium Rise

The premium costs of employer-sponsored health plans increased by 4% this year, according to the Kaiser Family Foundation's (KFF) annual Employer Health Benefits Survey. KFF analysts and health care purchasers alike say the annual growth rate in health care costs — employer plan premiums for a family have grown by 47% since 2011 and 283% since 1998, according to KFF — causes unsustainable financial strain for both employers and plan members.

KFF also identified several emerging trends in employer coverage driven by cost growth and the COVID-19 pandemic. Deductibles and other forms of member cost sharing have increased in recent years. The share of employees in high-deductible plans declined slightly in 2021, but accounted for roughly a quarter of employer enrollment, a similar figure to recent years. Employer insurance experts have mixed opinions on whether these trends will continue. Meanwhile, in response to the pandemic, firms expanded their telehealth offerings and behavioral health benefits this year (see infographic, p. 8).

But health plan purchasers tell AIS Health that health care cost growth has once again become their most important challenge now that firms have adjusted to the new pandemic normal, even though this year's premium growth was relatively modest compared to the last few years.

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"Over the years, we've compared the cost of family coverage — the premium — to the cost of a new car. And this year the annual cost to cover a family of four is almost the same," KFF's Matthew Rae said during a Nov. 16 briefing on the survey.

"The increase in cost is unsustainable for American employers," Dan Mendelson, CEO of Morgan Health, tells AIS Health, a division of MMIT. Morgan Health is JPMorgan Chase Co.'s health care services and venture capital arm. "Costs keep going up. During the pandemic year, what you see is that employers absorbed more of that cost. My sense is that many employers really felt like they could not pass on the cost of the increased expense to employees given what's going on with the pandemic."

"It's encouraging that the COVID pandemic has not caused widespread disruption to employer-sponsored health benefits. The employer-sponsored system showed a fair amount of resiliency in the face of the pandemic. And in fact, we did see some improvements, such as increased access to services via telehealth and improved access to behavioral health services," Bill Kramer tells AIS Health. Kramer is executive director for health policy at the Purchaser Business Group on Health (PBGH).

"But I think it's frustrating and discouraging because so much does need to change. I'll point specifically to the relentless increase in premiums," Kramer adds. "It's just the same story over and over again. No matter what's going on, premiums go up, no matter what's going on with the economy. With improvements in care and emphasis on equity, premiums [still] just continue to grow steadily…we've made little or no progress in addressing the enormous inefficiency and waste in our health system."

All that said, premium growth was lower than it has been in recent years.

"Compared to the rapid premium increases of the early 2000s, we saw relatively modest premium increases this year. On average, family premiums increased about $900, or 4%. You can compare this to a 5% increase in workers' earnings and roughly a 2% increase in inflation through the first three months of the year," Rae said.

However, Mendelson points out that "the fact that there was a respite for a year does not take the pressure off of the broader cost trends and everything that goes with it. From my perspective, employers really need to get a lot more aggressive about ensuring that there's value that's coming from the plans that they're operating."

Lower Utilization Played a Role

Rae said the slower premium growth could be partially attributed to depressed utilization. He pointed out that the survey found utilization continued to stall in 2021, as patients were wary to return to health care facilities with COVID-19 still spreading. Several large, publicly traded carriers also reported utilization below "baseline" in their most recent earnings calls, though they said persistent COVID-19 costs meant that overall medical costs were similar to previous years.

In any case, "workers can be asked to cover vastly different portions of the premiums at different firms," Rae explained. "One of the ways this is important is in regards to small firms. Covered workers at small firms often face relatively high premium contributions to include dependents. Three in 10 workers at small firms contribute more than half the premium for family coverage."

"The other way that plan enrollees pay for health care is cost sharing when they use services," Rae continued. "Deductibles in particular have grown in recent years. Among workers with a general annual deductible for single coverage, the average deductible is just about $1,700.…Over time, both the percentage of covered workers with a

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Senior Reporter, Peter Johnson; Managing Editor, Leslie Small; Executive Editor, Jill Brown Kettler

deductible and the average deductible have increased."

According to the survey:

✦ ***67% percent of covered workers in firms offering health benefits can choose from one or more PPOs*** (preferred provider organization plans);

✦ ***58% work in firms that offer one or more HDHP/SOs*** (high deductible health plans and/or those with a savings option);

✦ ***23% work in firms that offer one or more HMOs*** (health management organizations);

✦ ***10% work in firms that offer one or more POS*** (point-of-service) plans; and

✦ ***2% work in firms that offer one or more conventional plans***

The survey also found that small companies are more likely to offer high-deductible plans and limit access to other types of plans. According to the survey, 60% of small firms reported that "at least some workers can only choose HDHP/SO" plans, while that was true for only 31% of large companies. Overall, 26% of workers covered by employer health insurance were enrolled in a high-deductible plan.

Health care purchasing experts tell AIS Health that employers are beginning to realize that high-deductible plans have deep flaws.

"More and more of the data seems to show that there are some unintended negative consequences from high-deductible health plans, especially for lower-income employees," Candice Sherman, CEO of the Northeast Business Group on Health (NEBGH), tells AIS Health. NEBGH is a purchaser group whose members include large firms, such as Comcast Corp. and Verizon Inc., unions and public employee plans. Its members also include the nation's largest health insurance carriers: UnitedHealthcare, CVS Health Corp. and its Aetna arm, Anthem, Inc., and Cigna Corp.

"There's been some loosening up of the regulations that allows some first-dollar coverage for high-value classes of medications and services, which is certainly helpful. But I do think that [plan sponsors] are looking at high-deductible plans a little bit more closely," Sherman says. She points out that high deductibles can deter patients from accessing necessary care. Sherman says plan sponsors have begun to revamp their benefit offerings to address diversity, equity and inclusion concerns over the last year — and points out that high-deductible plans' deterrent effects are disproportionately harmful to people of color, who generally have less household wealth than white people due to institutional racism.

"I think the issue of equity versus equality is an interesting issue to contemplate when it comes to these kinds of things," Sherman points out. "We may have a desire to treat everyone equally. But what does that mean in terms of people's ability to actually access and receive quality health care?"

HDHP Use Has 'Flattened Out'

The future of high-deductible plans is unclear. Kramer says that "it appears that the use of high deductible plans has flattened out in recent years" as employers have had "a recognition that that benefit design's usefulness has flattened. It's not worthwhile pushing that further. Most employers have recognized the need to do much more than that."

However, Mendelson expects high-deductible plans will capture a larger share of the employer market in the future.

"I expect high deductible plans to continue to grow," Mendelson says. "I think that the respite that you see this year is a result of the pandemic and the desire of employers to enable employees to engage. I think that employers have to do something at this point. Whether it's high-deductible plans, or [what] I think [is] a better strategy for employers — moving into value-based arrangements that hold providers accountable for improving affordability and health equity….But high-deductible plans [are an option] if you aren't going to put in the time and effort required to structure arrangements like that."

Despite the gloom about prices, improved telehealth benefits were a bright spot. The survey found that 95% of employer plans now cover some sort of virtual care, up from 85% in 2020. And 19% of small employers and 35% of large employers increased the number of covered telehealth services covered by their health plan, while 15% of small employers and 27% of large employers reduced or eliminated virtual care cost sharing.

Behavioral Health Resources Increase

The same is true of behavioral health benefits, albeit on a smaller scale. The survey found that 16% of employers "developed new [behavioral health] resources, such as an employee assistance program," while "31% of employers expanded the ways through which enrollees could get mental health or substance abuse services, such as through telemedicine."

"Telehealth has the potential to address patient needs and patient interests very cost effectively," Mendelson explains.

"I think telehealth was an under-utilized technology before the pandemic, and now people recognized how

well it can work from a patient's point of view, as well as the provider's point of view," Kramer adds. "I think there's tremendous opportunity. That's been demonstrated. Now I think we need to do is figure out a way to integrate telehealth services with a person's overall care… not simply an add on or something that actually might contribute to more fragmentation of services."

Contact Kramer via James Chisum at james@millergeer.com, Mendelson via Pamela Harris at pamela.l.harris@jpmorgan.com and Sherman via Ed Emerman at eemerman@eaglepr.com.

by Peter Johnson

Biden Admin Issues New Price Transparency Rule for Insurers

The Biden administration — having already opted to keep Trump administration-era health care price transparency regulations on the books — has now issued a new set of transparency requirements aimed at health insurers specifically.

The interim final rule with request for comments (IFC), titled "Prescription Drug and Health Care Spending," will require group and individual market health plans as well as Federal Employees Health Benefits Program carriers to submit a wealth of prescription drug and health care spending data to the federal government no later than Dec. 27, 2022. At least one industry analyst doesn't anticipate the regulation will have a particularly significant effect on health insurers — though that may not stop them from protesting.

"We do not see any meaningful impact in the near term regarding this rule, especially as enforcement does not go into effect until December 2022 and details around pricing as a result of this rule would not come until June 2023 at the earliest," Citi equities analyst Ralph Giacobbe advised investors on Nov. 18. "That said, we expect pushback from the industry, both related to the administrative burden and greater understanding of how the data will be used given sensitivities around competitive intel."

Major industry trade group AHIP did not respond to AIS Health's request for comment by press time.

According to a CMS fact sheet, the IFC will require health plans to submit the following information annually to HHS, the Dept. of Labor and the Treasury Dept.:

- ***General information regarding the plan or coverage;***
- ***Enrollment and premium information,*** including average monthly premiums paid by employees versus employers;
- ***Total health care spending,*** broken down by type of cost (hospital care, primary care, specialty care, prescription drugs, and other medical costs, including wellness services), including prescription drug spending by enrollees versus employers and issuers;
- ***The 50 most frequently dispensed brand prescription drugs;***
- ***The 50 costliest prescription drugs by total annual spending;***
- ***The 50 prescription drugs with the greatest increase in plan or coverage expenditures from the previous year;***
- ***Prescription drug rebates, fees and other remuneration paid by drugmakers to the plan or issuer in each therapeutic class of drugs,*** as well as for each of the 25 drugs that yielded the highest amount of rebates; and
- ***The impact of prescription drug rebates, fees and other remuneration on premiums and out-of-pocket costs.***

HHS and the Labor and Treasury departments will turn that information into biennial reports, starting in 2023, that detail "prescription drug pricing trends and the impact of prescription drug costs on premiums and out-of-pocket costs." The IFC is the fourth regulation related to the No Surprises Act and transparency requirements outlined in the Consolidated Appropriations Act of 2021. ✧

by Leslie Small

3Q Brings Strife for Startups

continued from p. 1

"While we believe expectations were low into the 3Q print, the magnitude of the MLR and lowered guidance along with likely questions around trajectory and ability to manage what could be another volatile year in 2022 will likely drive shares lower," Giacobbe added. Bright Health's stock dipped from $7.28 per share before its earnings report to $4.95 at market close on the day it reported quarterly results, Nov. 11, and it has not since recovered.

"Up until this quarter, Bright had actually performed not terribly," Gottlieb observes, but he says he was unsurprised to see that the startup had a challenging third quarter after noting Oscar's results for the period. "The bulk of Bright's business is still individual, and they're following the same strategy as Oscar without the inflated tech and admin spending. They're a follower of Oscar, and they've followed them down to the depths of stock prices," Gottlieb tells AIS Health, a division of MMIT.

In a Nov. 17 note to investors, Giacobbe wrote that in addition to the near-term challenges facing Bright Health, there's "the overhang of a potential equity offering in the near future," which the company alluded [to] during

its third-quarter earnings call. "While the capital raise would help fuel the growth aspirations for the company, it comes at the cost of dilution, and also comes amid an operating environment that is producing a much weaker earnings stream for BHG," he wrote.

Oscar and Bright blamed their struggles partly on the influx of enrollees they gained during the pandemic-driven special enrollment period (SEP) on the Affordable Care Act exchanges, citing the fact that it was more difficult to capture risk scores for members who joined midyear.

Risk scores — a numeric value that represents the relative expenditures a plan is likely to incur for an enrollee — are a critical part of the ACA's risk adjustment program, which involves transferring funds from plans with lower-risk enrollees to plans with higher-risk enrollees.

Cigna Corp., in its recent third-quarter earnings call, said that high utilization among SEP customers drove up the firm's health care costs, and Centene Corp. said that having such members enroll midyear results in "more limited risk adjustment opportunity, both in terms of having the acuity reflected in risk adjustment, and then just the calendar of having them less than 12 months."

Still, Centene's MLR was 88.1% in the quarter while Cigna's was 84.4% — both much lower than Oscar's 99.7% and Bright's 103%.

Insurers Get Their Wish With Repeal of Medical Device Rule

CMS repealed a proposed Trump-era regulation that would have required Medicare to cover experimental "breakthrough" medical devices that have been approved by the FDA but not cleared for Medicare use through a national coverage determination. Insurer groups opposed the rule and urged the Biden administration to revoke it, while the medical device industry's largest trade group championed it as a breakthrough for patients.

"Although we continue to be in favor of enhancing access to new technologies, we are mindful that they may have unknown or unexpected risks and must first ensure such technologies improve health outcomes for Medicare beneficiaries. The Medicare program needs to implement policies that balance access and appropriate safeguards," said CMS Administrator Chiquita Brooks-LaSure in a Nov. 12 press release on the decision. CMS said it will begin to develop an alternative policy to ensure speedy access to breakthrough technologies.

The rule, called the Medicare Coverage of Innovative Technology and Definition of "Reasonable and Necessary" (MCIT/R&N) final rule, was one of dozens of regulations pushed through in the waning days of the Trump administration. The Biden administration paused rulemaking in the months following the transition to review those rules, and wound up repealing many of them. Other eleventh-hour Trump administration rules have faced legal challenges over alleged violations of the Administrative Procedures Act.

Safety was the main issue AHIP raised in an Oct. 12 comment letter to CMS opposing the rule.

"AHIP's primary concerns with the MCIT pathway relate to its failure to fully and appropriately evaluate safety, efficacy, and value for the Medicare population prior to or post-coverage and its failure to allow for swift action to protect beneficiaries if it becomes apparent that a particular device can be harmful to the Medicare population," wrote Elizabeth Cahn Goodman, AHIP's executive vice president for government affairs. "In addition, our comments on the final rule noted a number of unaddressed operational issues, including how and when CMS would communicate to health insurance providers information on benefit category and appropriate billing codes."

The trade association for medical device manufacturers, the Advanced Medical Technology Association (AdvaMed), denounced CMS's decision in a Nov. 12 statement.

"The MCIT rule was truly transformational for Medicare patients and doctors looking for life-saving and life-enhancing breakthrough medical technology to diagnose and treat diseases. We are disappointed in the decision made today to repeal that rule without an established pathway to quickly get these FDA-approved devices to seniors who need them most," said AdvaMed CEO Scott Whitaker.

Both groups said they wanted to work with the agency to develop a new regulation.

by Peter Johnson

Despite their challenges, Oscar and Bright Health executives expressed optimism during their third-quarter conference call with investors.

Oscar Co-Founder and CEO Mario Schlosser, for example, said that "looking ahead, we remain focused on continued growth to increase the scale of our businesses, which will be a driver of improved bottom-line results over time, and we are targeting profitability in our insurance business in 2023."

Gottlieb, however, says he doubts that goal is realistic given Oscar's track record of mounting losses.

Oscar's plan for 2023 appears to be, "achieve profitability at the insurance company level, eradicate COVID globally and reverse climate change," Gottlieb says. "They're going to accomplish all those things in 2023, because I think they're all equally likely."

Meanwhile, Clover Health Investments Corp., a Medicare Advantage-focused startup insurer, recorded an MLR of 102.5% and a $34 million loss for the third quarter. Alignment Healthcare, Inc., which also focuses on the MA market, was the only start-up out of the quartet whose MLR of 85.7% is more in line with what major publicly traded insurers aim for each quarter — although the insurer did go from a $10 million gain in the year-ago quarter to a $45 million loss.

Like Oscar and Bright, Clover saw its revenues balloon year over year — from $169 million in the third quarter of 2020 to $427 million in the most recent quarter — while Alignment's revenue increased more modestly, from $247 million to $293 million.

"Alignment's report was boring and not interesting at all, and I mean that in a good way. They have people who know how to run a health plan, and they continued executing," Gottlieb remarks.

With Clover, however, "it's almost as if they are defiantly refusing to actually hire people who know how to run a health plan," he tells AIS Health. He cites the fact that "they continue to run elevated MLRs over 100 for the quarter, something well-run Medicare Advantage plans do not do, and the fact they continue to be growth-challenged in new markets and post massive losses (even excluding Direct Contracting and the tech platform), which persists since others like Alignment who have experienced health plan leaders have figured out how to profitably grow."

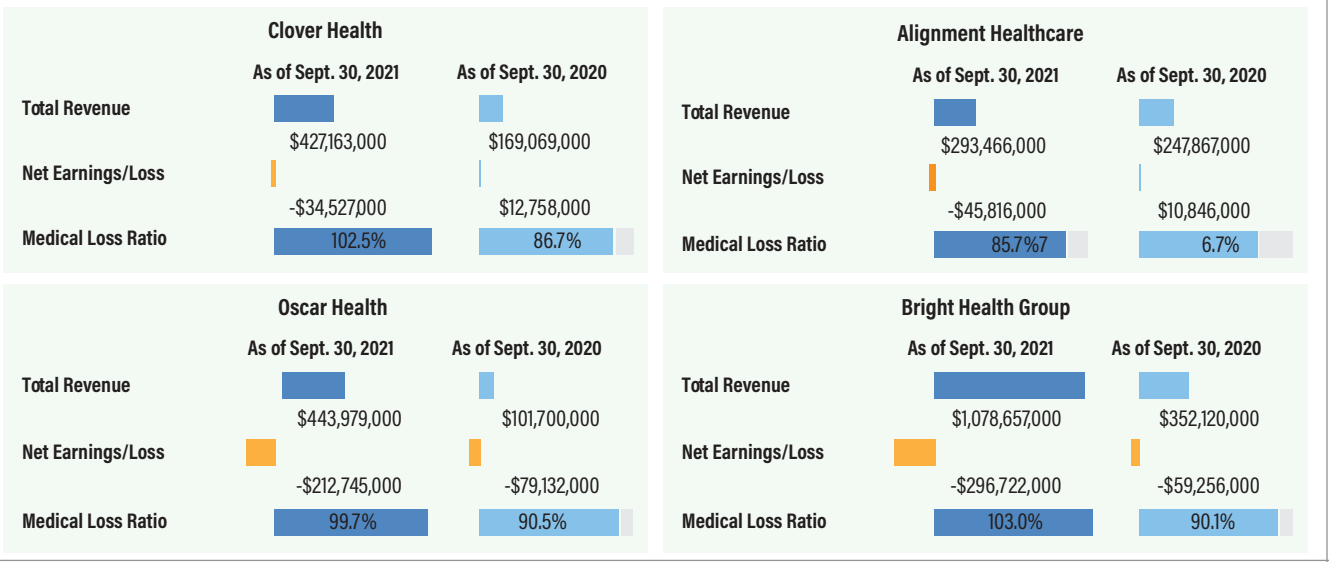
Clover is participating in the CMS Global and Professional Direct Contracting Model, which aims to lower costs and improve care quality for fee-for-service Medicare beneficiaries, but previously has had to lower its estimates of how many lives it will gain through that model.

Contact Gottlieb at ari@a2strategy.com. ✧

by Leslie Small

Newly Public Startup Insurers' Third-Quarter Financial Results

by Jinghong Chen



SOURCES: Clover Health Investments, Corp., Alignment Healthcare, Inc., Oscar Health, Inc. and Bright Health Group, Inc. Visit https://bit.ly/3niSIJF, https://bit.ly/30scGJr, https://bit.ly/3cfnBby and https://bit.ly/3Fil2AQ.

News Briefs

✦ ***CVS Health Corp. on Nov. 18 unveiled executive moves, as well as new store formats designed to "drive higher engagement with customers."*** The firm, which owns health insurer Aetna, will also close approximately 300 stores per year for the next three years. On the executive front, Prem Shah will fill the newly created role of chief pharmacy officer, and he and Michelle Peluso will become co-presidents of CVS Health's retail business. Neela Montgomery, current executive vice president and president of CVS Retail/Pharmacy, will leave the company at the close of 2021. Meanwhile, CVS's new store formats will include sites dedicated to offering primary care services and an enhanced version of HealthHUB locations, alongside traditional CVS Pharmacy locations, the company said.

✦ ***So far during the annual open enrollment period for the Affordable Care Act marketplace, 1,624,000 people have selected plans on HealthCare.gov.*** That includes 774,000 in the first week and 851,000 in week two for the OEP than began on Nov. 1 and will run through Jan. 15, according to CMS. Those signup figures only include the 33 states that use HealthCare.gov; data from states that run their own enrollment platforms typically is released at the end of open enrollment.

✦ ***Anthem, Inc. plans to acquire the New York-based long-term care plan Integra Managed Care, the insurer said on Nov. 10.*** Integra serves 40,000 Medicaid members and provides a care management team consisting of a registered nurse, social worker and coordinator. Felicia Norwood, executive vice president of Anthem's Government Business Division, said in a statement that the acquisition aligns with the insurer's goal of growing its Medicaid business. The deal is expected to close by the end of the second quarter of 2022, subject to customary conditions.

✦ ***AHIP's board of directors has elected David Holmberg as its new chair, effective on Jan. 1, 2022.*** Holmberg, who is president and CEO of Highmark Health, will take the reins from Humana Inc. President and CEO Bruce Broussard. The trade group's board also welcomed two new members: Cain Hayes, president and CEO of Point32Health, and Eric Hunter, president and CEO of CareOregon.

✦ ***Starting in January 2022, Humana will offer a new solution for type 2 diabetes care for its employer group members, available via Virta Health.*** Virta's treatment option is "designed to help people reverse their type 2 diabetes through individualized nutritional therapy and continuous remote medical care — allowing patients to achieve normal blood sugar while eliminating the need for diabetes-specific medications," per a Nov. 8 press release. Ninety-four percent of patients involved in a peer-reviewed clinical trial of Virta's treatment were able to decrease or eliminate their insulin dosage at one year, and an average of 12% saw sustained weight loss.

✦ ***CMS recently announced that it will extend postpartum Medicaid coverage for residents of both New Jersey and Virginia, moves that are part of the Biden administration's strategy to "address the nation's crisis in pregnancy-related deaths."*** People enrolled in Medicaid and CHIP in those two states will now be able to keep their coverage for 12 months after childbirth, or regain coverage within that 12-month period. In Virginia, the move will impact nearly 6,000 people, while over 8,000 New Jersey residents will be affected. Both coverage extensions are made possible by amending existing demonstration programs in those states and by taking advantage of provisions in the American Rescue Plan.

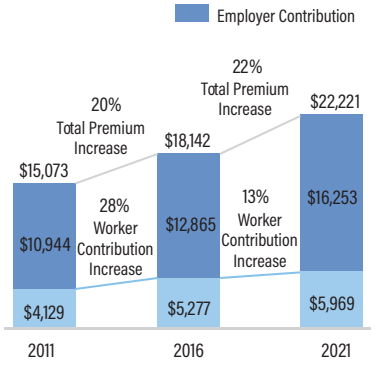
✦ ***Independence Health Group, Inc., the parent company of Independence Blue Cross, will begin using Google Cloud's data and analytics platform.*** The company said the move will "create a more forward-looking system to store and analyze data that is secure, scalable, and cost effective" as well as help deliver "a more personalized experience for members and improve care coordination by providing clinical insights in a much faster, real-time manner." Separately, Independence Blue Cross is rolling out a new care management and advocacy solution called IBX Better Health Champion. The solution "brings together award winning engagement tools; predictive analytics; the personalized outreach and support of a multi specialty care management team; and an enhanced customer service experience from a dedicated team at Independence," and it will be available to the insurer's self-funded employer customers starting Jan. 1, 2022.

Employer Plans in 2021: Premiums, Telemedicine Coverage Rise

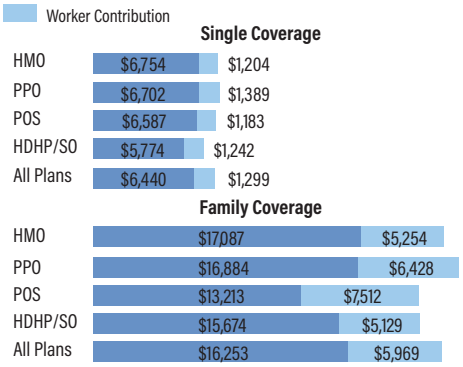
by Jinghong Chen

The average annual premium for employer-sponsored health insurance increased 4% to $7,739 for single coverage and $22,221 for family coverage, respectively, this year, according to the Kaiser Family Foundation 2021 Employer Health Benefits Survey. In recent years, high-deductible plans with a savings option have been gaining popularity. About 22% of firms offered an HDHP/SO and 28% of covered workers were enrolled in such a plan in 2021, representing slight declines compared with previous years. Meanwhile, the COVID-19 pandemic has increased the use of telemedicine, as 95% of firms with 50 or more workers offered telemedicine coverage in their largest health plan, up from 85% last year. In addition, about 65% of firms with 50 or more workers made changes to enhance their telemedicine benefits after the beginning of the pandemic.

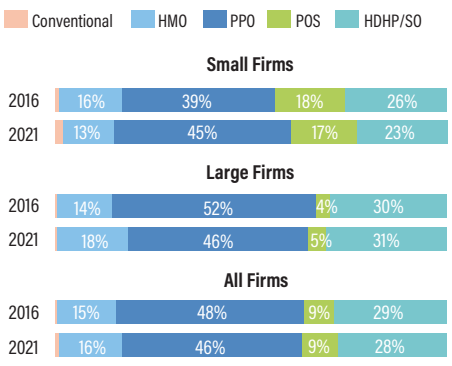
Average Annual Worker & Employer Premium Contributions for Family Coverage



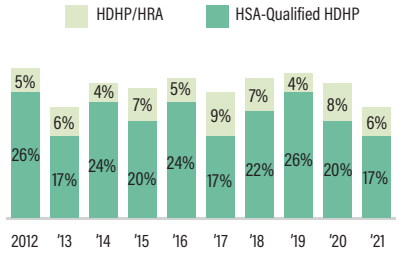
Average Annual Worker & Employer Premium Contributions by Plan Type, in 2021



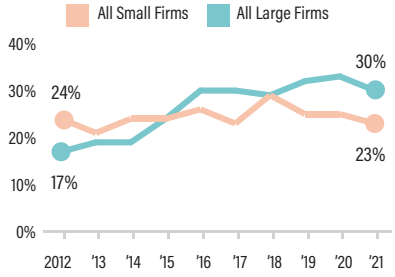
Distribution of Health Plan Enrollment for Covered Workers, by Plan Type & Firm Size, in 2016 and 2021



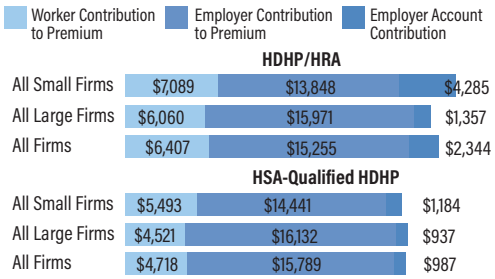
% of Firms That Offer an HDHP/HRA and/or an HSA-Qualified HDHP



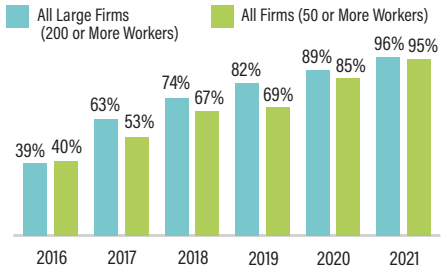
% of Covered Workers Enrolled in an HDHP/SO



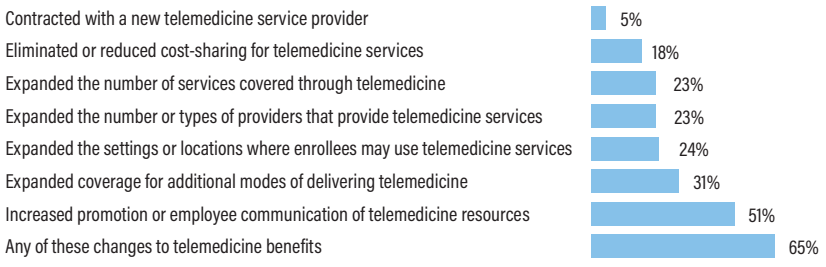
Total Annual Costs for Covered Workers in HDHP/SOs for Family Coverage



% of Firms Whose Plan With the Largest Enrollment Covers Telemedicine



Changes Made to Telemedicine Benefits During COVID



NOTES: Small firms have 3-199 workers and large firms have 200 or more workers. HMO is a health maintenance organization. PPO is a preferred provider organization. POS is a point-of-service plan. HDHP/SO is a high-deductible health plan with a savings option. HRA is a health reimbursement arrangement. HSA is a health savings account.

SOURCE: Kaiser Family Foundation Employer Health Benefits Survey, 2021. Visit https://bit.ly/3wY9NMb.