COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

440 1st St. NW, Suite 430 Washington, DC 20001
o: 202.808.8850 w: CAHC.NET

December 28, 2018

The Honorable Steven Mnuchin
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

The Honorable Alexander Acosta
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, D.C. 20210

The Honorable Alex Azar
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: REG-136724-17
Submitted via www.regulations.gov

Dear Secretaries Mnuchin, Acosta and Azar:

The Council for Affordable Health Coverage (CAHC) welcomes the opportunity to comment on the notice of proposed rulemaking (NPRM) entitled Health Reimbursement Arrangements and Other Account-Based Group Health Plans (REG-136724-17) issued by the U.S. Departments of the Treasury, Labor, and Health and Human Services. CAHC is a broad-based alliance with a singular focus: bringing down the cost of health care for all Americans. Our membership represents a broad range of interest-organizations representing small and large employers, manufacturers, retailers, insurers, patient groups, and physician organizations.

Employers are the largest purchasers of health care services and coverage in this country, and they are leading the way in innovation and the shift toward value in the private market. While premiums in the employer market, where the majority of Americans receive their coverage, have remained relatively stable compared to the individual market, costs are rising more than twice as fast as wages. This is largely due to rapid increases in the cost for medical services, and federal mandates and regulatory burdens under the Affordable Care Act (ACA). In fact, these rising costs are a primary contributor to premium growth, and as costs continue to outpace economic growth, it makes coverage less affordable and more out of reach for millions of Americans.

CAHC supports efforts to expand options in the health care marketplace for employers of all sizes and their employees. Consumer directed health products (CDHPs), such as health reimbursement arrangements (HRAs), are an important strategy to both pay for an reduce health costs. We strongly supported and advocated for the qualified small employer HRA (QSEHRA) program in the 21st Century Cures Act (P.L. 114-255) to allow small businesses to offer an HRA without penalty if certain qualifications were met. We are pleased that the proposed rule builds on this program by expending the availability of HRAs to all sizes of employers through two avenues: 1) an HRA for purchase of an individual health coverage (IHC); and 2) an HRA for purchase of excepted benefits. As the Departments

work to finalize the rules regarding the expanded use of HRAs, we would like regulators to take into consideration the following comments.

HRA for Individual Health Coverage Purchase

More than 181 million Americans receive health coverage through the employer-sponsored system. Yet with enactment of the ACA and its numerous costly and burdensome requirements and mandates, many employers, and especially small businesses, have been unable to make an offer of coverage to their employees. In fact, the number of small businesses offering group health insurance has declined by 25 percent since 2010. Currently, less than half of small businesses offer any kind of health insurance to their workers. Small business owners still want to provide meaningful benefits that help their employees obtain health coverage and care at affordable rates as a means of both attracting top talent in a competitive labor market and helping to keep their employees healthy. An employer offer of an HRA for the purchase of IHC helps to achieve this goal.

CAHC applauds the Departments for the development of the proposed rule to expand the offer of an HRA for the purchase of IHC by employers of all sizes. We welcome the flexibility that the proposed rule provides by enabling an employer to offer an HRA for IHC purchase to a specific class of employees. For the smallest of businesses or even ones that are on the cusp of the ACA's applicable large employer (ALE) threshold, having the ability to offer an HRA for IHC purchase to their full-time employees will help attract and retain talent and grow their business with the security of a healthy workforce. For larger employers who had the flexibility to offer an HRA to their part-time employees prior to the ACA, the proposed rule lifts the ACA ban on this arrangement and helps provide financial security to these employees.

Further, in order for an HRA for IHC purchase to truly succeed for employers and employees alike, the individual coverage marketplace must be stabilized and strengthened. Coverage under the ACA is in peril across the country. Premiums are rising at double digit rates and more insurers have left the market since the ACA's enactment than have joined, lowering competition and choices for consumers. Addressing these shortcomings is a prerequisite step towards creating viable, competitive and workable markets for consumers. HHS should also ensure guardrails in the final rule to ensure that the new HRA options do not lead to segmentation that undermines the individual or employer markets.

Employer/Employee Burdens

As the Departments seek to finalize these rules and provide further guidance regarding interaction with current ACA requirements such as the employer mandate and its reporting requirements, CAHC urges caution in not creating new administrative compliance requirements that will be onerous and costly to employers. Specifically, we suggest the following:

- Burdensome and overly complicated and complex verification and notification processes may deter employers from offering an HRA for IHC purchase. For example, a monthly verification process will be burdensome to even the smallest of employers.
- We also recommend providing employers with a sample template for the notice to employees of interaction with premium tax credit eligibility in the Exchanges.

- Finally, we recommend the 90 Day notice be adjusted to coincide with the annual Open Enrollment period when employees need the information or when a new plan is started.

Maximizing Coverage

To help Individual Coverage HRAs be a viable solution for more employers, we recommend allowing "stacking" tax credits and HRA contributions and for employees to be able to accept both on a pre-tax basis. Because this would be a significant change, we suggest two other intermediate options:

1. Allow HRA contributions to cover qualified medical expenses or excepted benefits only for individuals also receiving a tax credit. The tax benefits would flow to different purposes and would not constitute double dipping. For example, an individual working full-time making $25,000in salary would qualify for a $600/month tax credit. If the employer offers an Individual Coverage HRA of $500/month the individual will pick exchange coverage. Allowing the $600/month tax credit to help pay cover premiums and the employer's $300/month HRA allowance for cost-sharing and medical expenses or excepted benefits only, would help address the substantial increase in cost sharing seen under the ACA. It would also address the silver loading incentive related to changes in cost sharing reduction subsidies.

2. IRS should clarify whether an employee receiving tax-credits can accept an HRA contribution from an employer on a taxable basis under the rules of the HRA. Some small businesses would be more compliant as a result.

If the Departments choose not to make changes in this area, it is important that the final rules retain choice between tax credits or HRA contributions.

Transition from QSEHRA to Individual Coverage HRA

Some employers currently using QSEHRA will transition to Individual Coverage HRAs or Excepted Benefit HRAs. The final rules should include a road map that address compliance issues about the transition process and any potential issues such as carry-over amounts to make this transition process as smooth as possible.

The final rules should also include Special Enrollment for new HRAs or QSEHRAs or material changes to an HRA or QSEHRA. Employees should be able to make changes to their coverage during the year if their employer modifies or changes their HRAs.

Classes of Employees

The Departments ask whether employers should be able to offer employees a choice between a traditional group health plan or an HRA integrated with individual health insurance coverage (p.38; Section II.A.2.a). While CAHC supports flexibility for both employers and employees, this approach raises several practical concerns that could undermine employer coverage. For example, if employees in the same class could choose between a traditional group health plan and an HRA with individual coverage it would be difficult in estimating participation and adverse selection issues may arise in an employee pool.

The final rule should require a plan sponsor to only offer an Integrated HRA or a traditional group health plan, but not both, to a single class of employees.

Private Exchanges and 1332 Waivers

CAHC encourages the use of private Exchanges for individual coverage integrated with an HRA. The Departments should clarify what conditions must be met by a Private Exchange in order for coverage purchased though such an exchange is not subject to ERISA. The Departments should also permit HRA integration with individual coverage purchased in a state with a 1332 Waiver.

HSAs

CAHC supports allowing an employee to fund an HSA that can be used with an HSA-compatible policy purchased with HRA funds. We request the Departments provide clarity that an HRA that does not provide reimbursement for out-of-pocket expenses is compatible with a health savings account (HSA).

HRA for Excepted Benefits

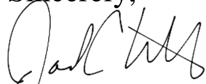
Excepted benefit products are specifically exempt from Affordable Care Act (ACA) and other health insurance rules including Health Insurance Portability and Accountability Act (HIPAA) regulations. They comprise a wide variety of plans including critical illness, accident, hospital indemnity and many others. More than 50 million Americans are insured on limited benefit insurance plans to ensure they have the tools to stay on their feet in the face of an emergency. These plans are a means to help Americans prevent a troubling accident from becoming a devasting bankruptcy.

As the Departments work to finalize the proposed rule, we urge the proposed Excepted Benefit HRA maximum of $1,800 per year (p. 63; Section II.B.2) should be increased for age and family size factors. Almost all the major excepted benefit types are tied to family size. It would be unfair and impractical, and would reduce the value and attractiveness of an excepted benefit HRA, to have one limit without considering number of dependents. For simplicity, the proposed rules could include a 2x limit for employees with dependents.

Conclusion

CAHC commends the Departments on its work to expand HRA availability and utilization. Employers are seeking more options to combat the relentless rise in health costs and premiums and an offer of an HRA for IHC purchase could be a viable option to many employers and employees. The proposed expansion of an HRA for excepted benefits will help provide employees with financial security and peace of mind. CAHC looks forward to continuing to work with the Departments and Congress to make health care more affordable and accessible for all Americans.

Sincerely,



Joel C. White
President