America's Health
Insurance Plans

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org

December 27, 2018

The Honorable Alexander Acosta
Secretary of Labor
200 Constitution Ave NW
Washington, D.C. 20210

The Honorable Alex Azar
Secretary of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

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

Submitted via the Federal Regulations Web Portal, http://www.regulations.gov

RE: Health Reimbursement Arrangements and Other Account-Based Group Health Plans (REG–136724–17)

Dear Secretaries Acosta, Azar, and Mnuchin:

America's Health Insurance Plans (AHIP) appreciates the opportunity to provide comments in response to the Notice of Proposed Rulemaking (NPRM) issued by the Departments of Labor, Health and Human Services, and the Treasury ("Tri-Agencies") that would expand the permitted uses of Health Reimbursement Arrangements (HRAs), published October 29, 2018 in the Federal Register.

AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public/private partnerships that improve affordability, value, access, and well-being for consumers.

If properly regulated and implemented, access to new HRA options will give employers and consumers more choices on where to get their health insurance. With proper safeguards and careful planning, HRAs will create new opportunities for businesses of all sizes to offer new coverage options to their employees while strengthening the individual market with new potential enrollees. However, enforceable safeguards and non-discrimination protections are essential for these options to work for Americans. Clear rules on when an HRA can be offered, what types of plans can be purchased using these funds and on what terms will be key. In our comments below, we offer recommendations on how these new arrangements can best expand choice and competition while protecting consumers and the individual and employer health insurance markets, providing patients more choices, and strengthening the health care system.

To achieve these goals and promote access to affordable, comprehensive health coverage, we detail the following recommendations in the enclosed comments. Our comments are summarized in greater detail below:

- **Protect consumers by strengthening non-discrimination protections and ensuring access to comprehensive health coverage.** Protecting consumers with pre-existing health conditions and promoting access to affordable coverage will require strong non-discrimination provisions. The proposed rule recognizes these goals, and we strongly recommend the Administration strengthen these protections in the final rule to ensure coverage remains affordable for every American. Any weakening of these protections risks significant harms for both the individual and employer provided coverage markets and the members they serve.

- **Maintain market stability and prohibit the use of Integrated HRAs to purchase short-term limited duration insurance (STLDI).** The success of Integrated HRAs depends on employees having access to a range of choices of affordable, comprehensive health coverage. We strongly believe that an Integrated HRA as a benefit offering should reimburse only major medical coverage. Such coverage will protect consumers from financial harm upon an illness or injury and ensure a balanced risk pool.

- **Take steps to protect employer provided coverage and supplemental benefit offerings.** As a cornerstone of the U.S. health care system, employer-provided coverage, and the innovations it has brought to health coverage nationwide, should be protected. We ask the agencies to consider the impact of these new arrangements on employer-provided coverage and how to best advance innovations across market segments. Ensuring that employers may continue to offer a range of supplemental benefits, such as dental and vision coverage, in addition to an Integrated HRA is essential for the health and financial security of the 181 million Americans who receive coverage through work.

- **Ensure coverage is affordable for employees.** We support the goal of the proposed rule to allow employers to provide access to individual market coverage; however, this coverage should be affordable and meet their needs. We are concerned about scenarios where some employees would have paid less for coverage due to eligibility for the premium tax credit.

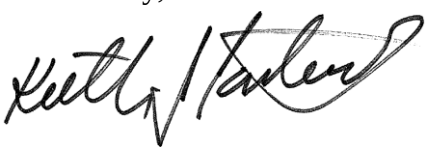
- **Preserve HIPAA Excepted Benefits.** Excepted Benefits provide greater access to health coverage that promotes financial security for specific needs. We appreciate the proposed rule creates a new type of HRA to expand access to Excepted Benefits. However, we urge the tri-agencies to allow reimbursement from an Excepted Benefit HRA only for existing HIPAA Excepted Benefits, which do not include STLDI.

- **Allow Adequate Time to Implement New Arrangements.** As with any change of this size and complexity, adequate planning time is required. We recommend extending the

applicability date at least 18 months from publication of the final rule so that health insurance providers and employers may adequately prepare for new benefit offerings.

Thank you for the opportunity to comment on these proposed rules. Please contact Adam Beck at 202-778-3208 or abeck@ahip.org with any questions on our comments.

Sincerely,



Keith Fontenot
Executive Vice President, Policy and Strategy
America's Health Insurance Plans

DETAILED COMMENTS

Comments on Individual Market Health Reimbursement Accounts

I. Protect Consumers by Strengthening Non-Discrimination Protections and Ensuring Access to Comprehensive Health Coverage

If finalized, this rule creates new opportunities for employers to offer health benefits or access to health coverage to their employees. As an organization dedicated to ensuring all Americans have access to affordable, comprehensive health coverage through the free market – regardless of health status – we support new coverage opportunities for employers and their employees.

Both traditional employer-provided coverage and individual health insurance provide comprehensive coverage and must meet minimum federal and standards. HIPAA Excepted Benefits complement this coverage by allowing consumers to efficiently access health and financial security coverages that provide additional protection to meet their needs. If this proposed rule is finalized, the nature of employer coverage will likely shift for many, such that potentially millions will be enrolled in employer-supported individual market coverage for the first time. Therefore, it is important to emphasize the distinctions between types of coverages, why employer-provided coverage is a preferred means of offering health benefits, and why risk pools that avoid adverse selection are critical for consumers.

By covering more than half of all Americans – 181 million people[1] –employer-provided health coverage is a cornerstone of the US health care system and a preferred method of financing coverage and care. Not only does coverage at work provide a cost-efficient means of enabling a majority of Americans to access and receive health coverage, it allows for employers to invest in their employees' health and financial security, provides a source of innovation in health care, and improves productivity. We believe that state and federal policies should strengthen, support, and expand access to employer-provided coverage.

Individual health insurance markets have traditionally been regulated primarily at the state level. The enactment of the Affordable Care Act (ACA)brought sweeping changes to how individual health insurance is regulated, as well as how consumers may access coverage, including improving affordability for millions with the introduction in 2014 of premium tax credits and a federal requirement for a single risk pool. With more than 16 million Americans enrolled in individual health insurance coverage, most state risk pools have gradually steadied as these new individual market products continue to adapt.

[1] U.S. Census Bureau, "Health Insurance Coverage in the United States: 2017." (https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf)

Health insurance and coverage markets of all types are interconnected, particularly given that most Americans are enrolled in multiple types of coverage throughout their lifetime. Medicaid enrollees regularly transition to employer-provided coverage, those with employer-provided coverage often enroll in individual coverage upon a career change, and Medicare beneficiaries include past-enrollees from all types of coverage. The success of or challenges in any particular market can be affected by developments in the other markets. Balanced risk pools are central to any insurance arrangement, and consumers participating in any of these markets can be negatively impacted when risk pools become unbalanced due to adverse selection. Changes in risk pools can result from unintended shifts or intentional manipulation of risk pools, with even small percentages of risk shifting having the potential to increase premiums. To prevent this adverse selection, we strongly support provisions in the proposed rule to minimize risk pool manipulation and adverse selection.

Policy guardrails are essential to both protect against adverse selection and non-discrimination. One critical guardrail is requiring that consumers be enrolled in comprehensive health coverage to protect against risk shifting that can increase premiums, particularly for older Americans and those with pre-existing conditions or other significant health conditions. Additionally, ensuring that employees who are directed out of the group market to access comprehensive health coverage through the individual market must be assured of a stable individual market in order for the changes proposed in this rule to succeed.

For most Americans, when they enroll in employer-provided coverage today, they know they are enrolling in a group health plan that will cover their health needs regardless of a pre-existing condition. They will also likely enjoy the benefits of coverage that includes wellness programs, care coordination, and other health improvement tools that group health plans offer. We must ensure that when employees and their families enroll in coverage through an Integrated HRA, they are similarly participating in comprehensive coverage that will be there for them when they are sick, injured, or working to manage a chronic health condition.

Non-Discrimination Protections (Proposed 26 CFR § 54.9802-4(c), 29 CFR § 2590.702-2(c), 45 CFR § 146.123(c))

We strongly support the inclusion of the non-discrimination provisions, such as the requirements to offer an HRA to the same class of employees on the same terms and urge the tri-agencies to include these protections in the final rule. These provisions act as guardrails against discrimination against people with pre-existing conditions. Such guardrails accomplish this by preventing risk shifting that would lead to increased premiums and potentially leave employees – particularly older, lower income, or less healthy employees – exposed to possible discrimination. Without strong guardrails in place, these arrangements are unlikely to succeed and could have significant, detrimental impacts on health insurance markets nationwide.

We appreciate that the importance of these provisions was stressed in your October 22, 2018 op-ed in the *Wall Street Journal*, stating "[w]e…propose carefully constructed guardrails to protect

the individual market."[2] Below we include detailed recommendations on how these protections can be strengthened to further ensure that these guardrails will provide real barriers to discrimination based on pre-existing conditions and mitigate adverse selection. Some of the classes prescribed by the tri-agencies should be eliminated or modified to further deter risk pool manipulation and clear enforcement mechanisms must be established.

Specifically, we support and urge the tri-agencies to include in a final rule non-discrimination provisions to require that:

- An individual participating in an Integrated HRA enroll in individual health insurance coverage and substantiate/verify their enrollment.
- An employer may not offer an election between an Integrated HRA and a traditional Group Health Plan to the same class of employees.
- An employer must offer the Integrated HRA on the same terms to all employees in a class.

Classes of employees should be based only on factors that have a clear, bona fide relationship to employment, rather than anything that can be a direct or indirect classification based on likely health risk. Classes should not be permitted that can be used to segment employees with pre-existing conditions and offer them different coverage options than healthy employees. If such classes are permitted, it will create an opportunity for employers to direct employees with pre-existing conditions to the individual market while continuing to offer employer coverage to healthier employees. This would result in increased premiums for those who purchase coverage on the individual market, create coverage inequities that disadvantage employees with chronic health conditions, cause higher premium subsidies at greater taxpayer expense, and lead to higher premiums for those who are not eligible for premium subsidies. Simply put, it would result in harm to patients and run counter to our shared goals of improving the health and wellbeing of all Americans.

We urge the tri-agencies to reduce the number of defined classes in the final rule by eliminating the class of employees that includes those under the age 25 and the class based on a rating area. We also recommend altering the treatment of former employees to be limited to those not yet eligible for Medicare. Further, we are concerned about employers potentially creating classes or combination classes in a manner that unduly segments risk and urge the tri-agencies to include in any final rule a minimum size requirement for any class or combination class, equal to or greater than a set percentage of the workforce.

- **Under Age 25:** The class of employees under age 25 has no bona fide relationship to employment. By relying solely on age as a distinction, this class would allow for employers to effectively segment favorable risk. The other classes, such as part-time or

[2] Alexander Acosta, Steven Mnuchin, and Alex Azar: "New Health Options for Small-Business Employees." *Wall Street Journal*, October 22, 2018. https://www.wsj.com/articles/new-health-options-for-small-business-employees-1540249941?mod=searchresults&page=2&pos=17

seasonal employees, are based on clear employment distinctions rather than the nature of the persons themselves.

- **Rating Area Class:** With respect to the rating area class, we are concerned that grouping employees by rating area as a class could create unintended harm, particularly as rating areas can be used as pretext for classification based on likely health status. Given that there are often significant variations between the plan availability and function of an exchange in a particular state, we recognize that some geographic distinctions are necessary. Multi-state employers may wish to offer an Integrated HRA to employees, but recognize that employees at work-sites in certain states may have access to fewer individual market plan offerings, which could necessitate offering a traditional group health plan to those employees based solely on their state of residence. Therefore, as an alternative we urge the tri-agencies to allow employers to establish a class based on the state of an employee's residence, but not the geographic rating area.

- **Establishing a Threshold to Constitute a Class:** For those classes included in the final rule, we suggest requiring that the class include a minimum number of employees, such as requiring at least 10 percent of eligible employees to be included in the class. This will help avoid cherry-picking risk, as well as aid in enforcement, as the relationship between employees in a class will be more easily identifiable.

- **Employer vs. Control Group:** Further, classes should be determined on an employer-by-employer basis rather than a determination based on the entire control group (i.e., two or more employers with common ownership). We urge the tri-agencies to clarify this in a final rule.

- **Treatment of Former Employees (Retirees):** We urge the tri-agencies to revise the rule to allow only former employees (including retirees) who are not eligible for Medicare to participate in an Integrated HRA. For eligible former employees, we support their participation in the class in which they were considered immediately prior to retirement. The proposed rule would apply to all former employees, including retirees who are otherwise eligible for Medicare. While not listed as a distinct class, the class treatment of former employees should be limited to early retirees in the final rule. This distinction would be of particular importance in situations where a retiree has already been offered or accepted retiree health benefits and/or other retirement benefits from the employer who decides to no longer offer a traditional group health plan.

- **Request for Comment on Additional Classes:** The tri-agencies requested comments on whether any additional classes would be prudent. After careful consideration, we recommend against the inclusion of or delineation of additional classes in the final rule. Based on our assessment, we conclude that additional classes would increase the likelihood of risk pool manipulation and employee discrimination. The increased

granularity and complexity of too many classes increases the risk of adverse selection in the individual market in such a way that could severely harm consumers.

Employer Notice (Proposed 26 CFR §54.9802-4(c)(6), 29 CFR § 2590.702-2(c)(6), 45 CFR § 146.123(c)(6))

Implementing the non-discriminations protections and other aspects of the rule requires employers to give timely notice to employees about their options, including the ability to opt-out of an Integrated HRA. We support the elements of this notice requirement but recognize for many employers, this could create an administrative burden. Therefore, we urge the tri-agencies to develop a model notice that employers may adapt, as well as to clarify that such notices may be delivered electronically.

We also believe certain information should be included in the employer notice to employees. This would include a disclosure that those who are enrolled in Medicare are ineligible to enroll in coverage through an Integrated HRA, and an attestation that the individual receiving HRA funds acknowledges the funds may be treated as taxable income, including with penalties, for any month the individual is not enrolled in individual health insurance coverage. This work could be done collaboratively with the Department of Labor (DOL) and the National Association of Insurance Commissioners (NAIC).

Enforcement

The non-discrimination provisions must be backed by clear and meaningful enforcement authority from the federal government. We urge the tri-agencies to detail in a final rule how the Departments intend to enforce the features of the rule that are not self-executing, including authority for periodic audits.

As a template, we recommend an enforcement structure similar to that which the Employee Benefits Security Administration (EBSA) uses to enforce other aspects of Title I of the Employee Retirement Income Security Act (ERISA), specifically the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Distinct from MHPAEA, the tri-agencies would not be issuing regulations directly responsive to legislation, but we believe the requirements of the ACA do require enforcement to ensure compliance with various sections, particularly Public Health Service Act (PHSA) sections 2711 (prohibiting health plans from including annual or lifetime dollar maximums on services considered Essential Health Benefits) and 2713 (requiring health plans to cover certain preventive services without cost-sharing), both of which are central to this rulemaking. Prior to this rule taking effect, we suggest the tri-agencies sign a Memorandum of Understanding (MOU) similar to the MOU that governs the MHPAEA enforcement responsibilities of the different agencies.

Without these protections intact in the final rule, there could be sweeping, negative impacts on coverage markets nationwide, leaving millions paying more for coverage or finding themselves uninsured or underinsured. For example, employers could improperly shift select employees into the individual market on the basis of age, health status, geography, perceived health status, or

other indicators of risk. As a result of intentional risk shifting, premiums will increase, particularly for individuals with chronic health conditions or other significant health needs, leading to a reduction in care utilization. The downstream impacts of this on the U.S. health care system could be costly, particularly if millions are enrolled in non-comprehensive coverage or forego coverage, leading to an increase in uncompensated care and exacerbating long-term illnesses when treatment is not affordable.

Recommendations:

- **Reduce the permissible classes by eliminating the rating area class and the class of employees under age 25, replacing the rating area class with a class based on residence in a particular state.**
- **Limit the treatment of former employees to limited to early retirees who have not yet achieved Medicare eligibility.**
- **Require a minimum threshold to constitute a class, based on a percentage of eligible employees within a class.**
- **Determine classes based on each individual employer, rather than a control group.**
- **Develop a model notice for employers that may be delivered electronically.**
- **Establish clear enforcement procedures through a tri-agency Memorandum of Understanding.**

II. Maintain the Stability of Health Insurance Markets

The success of Integrated Health Reimbursement Arrangements as a benefit offering depend on the ability of employees to purchase affordable individual market coverage that meets their needs. While premiums have gradually steadied in many states, the long-term stability of the individual market is not yet assured. We encourage the Departments to consider the state of individual markets nationwide before finalizing this rule and to prioritize efforts to promote stability and affordability in the individual market. Some measures, such as federal reinsurance funding, require legislative action, and we encourage the Departments to work with Congress to advance efforts to improve the individual market.

Short-Term Limited Duration Insurance

One of our industry's core principles is that comprehensive health coverage is essential to provide long-term health and financial security to all Americans. Certain forms of coverage that would not be considered comprehensive and do not meet the statutory definition of "individual health insurance" – such as short-term limited duration insurance (STLDI) – should not be permitted to be integrated with an HRA. Under the final rule, integration with a group HRA should require the substantiated and verified enrollment of an employee in individual health insurance, as defined by section 2791(b)(5) of the PHSA. [3]

[3] "The term 'individual health insurance coverage' means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance."

The NPRM invites comments specifically on whether STLDI should be permitted to be integrated with an HRA. We strongly urge the tri-agencies to prohibit this in any final rule. Permitting HRAs to be integrated with STLDI would open the door to employers replacing coverage that is prohibited from discriminating based on pre-existing conditions with coverage that may charge more for preexisting conditions or deny enrollment outright. It could also lead to significant increases in individual market insurance premiums in states where a significant number of employees are offered Integrated HRAs by their employer. In cases where an employer offers the Integrated HRA option, if the HRA can be used to purchase STLDI, employees without costly health conditions may disproportionately choose STLDI, and employees with high cost health conditions would likely disproportionately enroll in the individual market. This will increase premiums in the individual market for everyone, increase taxpayer spending on premium tax credits, and put the cost of coverage further out of reach for individuals who do not qualify for premium subsidies.

Those who elect to enroll in STLDI may find themselves lacking sufficient coverage when faced with an injury or illness. Permitting an HRA to be integrated with STLDI and regarding that integrated product as satisfying the requirements of Section 4980H (employer mandate) would also run counter to clear Congressional intent in passing the Affordable Care Act.

The ACA established requirements that coverage offered by an employer must not include annual dollar limits on services considered Essential Health Benefits or deny coverage to an individual with a pre-existing health condition or modify the individual's premium based on an existing health condition. STLDI may not satisfy the requirements in the ACA necessary to avoid penalties under 4980H, and be contrary to the intent of Congress in requiring coverage sold through the individual or small group markets to meet the requirements of Sections 2711 and 2713. In several places, PPACA requires evidence of Minimum Essential Coverage (MEC), a term defined in statute at 26 USC § 5000A(f)(1), which does not include STLDI or any coverage resembling STLDI. Given the statutory emphasis on ensuring there are offers of MEC, it is imperative the tri-agencies implement regulations that maintain both the definition and intent of MEC.

Election Between an Integrated HRA and Group Health Plan (Proposed 26 CFR §54.9802-4. 29 CFR § 2590.702-4, 45 CFR § 146.123-4)

Maintaining the integrity of risk pools in the individual market is crucial to ensuring that Americans of all income levels and health status have access to affordable coverage. As proposed, these rules would prohibit an employer from offering employees a choice of an Integrated HRA or a traditional group health plan. We support this prohibition and strongly urge the tri-agencies to explicitly include it in a final rule.

Without such a prohibition, some employers may be incentivized to shift risk, whether intentionally or unintentionally, in such a way that older employees or those with pre-existing conditions are encouraged to enroll in an Integrated HRA rather than the group health plan. This

would hurt consumers and small businesses, as even a small percentage of this type of risk dumping will noticeably increase premiums, particularly for individuals and small businesses.

Special Enrollment Periods (Proposed 42 CFR §155.420)
The individual market, including the Federal Marketplace and state-based Exchanges, relies upon a defined annual open-enrollment period with strictly-defined Special Enrollment Periods (SEP) for individuals and families meeting certain criteria. We support the creation of a new individual market SEP to ensure employees, and their dependents, who newly gain access to individual health insurance when an employer offers an Integrated HRA or are provided a Qualified Small Employer Health Reimbursement Arrangement (QSHERA) during the calendar year.

Creating an individual market SEP for employees who are newly eligible for an Integrated HRA or QSHERA mid-year would ensure that eligible employees are able to take advantage of this offer from their employer and enroll in coverage without having to wait until the next individual market open enrollment period. Without an SEP, employees who are offered an Integrated HRA or QSHERA would not be able to enroll in coverage at the time it is offered and not only miss out on a significant benefit offered by the employer but may also face a gap in coverage. Thus, we agree that newly gaining access to individual market coverage through an employer's offer of an Integrated HRA or QSHERA should trigger an SEP, if the employee is not already eligible for an existing SEP.

While we support a SEP for individuals newly eligible for an Integrated HRA through their employer, we recommend the Departments not make an SEP available for mid-year changes to the employer's HRA or QSHERA benefit to be consistent with similar existing SEPs. We are concerned that offering an SEP for employees to change plans mid-calendar year in response to an updated employer benefit could have unintended consequences for employees. If an employee currently enrolled in individual market coverage becomes eligible for an SEP because their employee updates their HRA or QSHERA benefit mid-calendar year, the employee would be eligible to change to a new individual market plan. This would allow the employee to take advantage of a change in the benefit offered by the employer, particularly if the generosity of the HRA or QSHERA benefit increases significantly. But, in changing plans, the employee's accumulators—including deductibles, copays, coinsurance, and other costs attributable to the annual out-of-pocket maximum—would reset. This could impact the employee's out-of-pocket spending and could negate any potential benefit to the employee of changing plans to take advantage of an update to their HRA or QSHERA.

To minimize unintended consequences for employees, employers should consider aligning an offer of an Integrated HRA or providing a QSHERA with the individual market open enrollment period—or, at minimum, aligning any updates of their HRA or QSHERA benefit with the calendar year. When an employer offers an Integrated HRA or provides a QSHERA, the employer is not making a direct offer of coverage. Instead, the employer is offering a benefit that the employee, and his or her dependents, can use to independently purchase coverage through the

individual market. The employee will be subject to the rules and practices associated with individual market coverage, including those related to accumulators. Employers who update the HRA or QSHERA benefit mid-year could place their employees in a difficult position of having to decide between changing coverage to take advantage of an increased benefit or delaying this benefit by waiting several months until the next open enrollment period to avoid resetting their accumulators. While we support offering an SEP to employees who newly gain access to an Integrated HRA or QSHERA, we recommend the Departments direct participating employers to align their updates to these benefits with the individual market open enrollment period to avoid disadvantaging their employees.

Finally, we support providing this SEP with a first of the month effective date, following the date of plan selection, and the option for advance availability when employees newly gain access to an Integrated HRA or QSHERA. We agree that a first of the month effective date and option for advance availability is consistent with existing SEPs for similar situations such as loss of minimum essential coverage or new eligibility for APTC due to loss of employer-sponsored coverage. In the final rule, CMS should clarify whether this SEP would be subject to pre-enrollment verification.

Verification and Substantiation (Proposed 26 CFR §54.9802-4(c)(5), 29 CFR § 2590.702-2(c)(5), 45 CFR § 146.123(c)(5))

Among the most important protections for the stability of the individual market contained in this NPRM is the requirement that an individual who accepts funds through an Integrated HRA must actually and verifiably enroll in individual health insurance coverage. The verification and substantiation requirements detailed in the proposed rule could be overly burdensome to many employers and insurance providers. We recommend the tri-agencies rely on an attestation from the employee that they have enrolled in individual health insurance coverage with penalties for misrepresentation as part of the enforcement policies of the Departments.

The proposed rule, if finalized, would create a significant change in the manner of selecting and enrolling in health insurance coverage for potentially millions of employees accustomed to enrolling through their employer. We are concerned that without proper support, many employees offered an Integrated HRA may fail to effectuate enrollment in coverage due to the onus shifting onto them and their unfamiliarity with the enrollment processes in individual market coverage. We urge the agencies to work with the private sector, including employers, insurance providers, consumer organizations, the NAIC and insurance brokers, to develop training and materials that would aid employees in navigating a new means of enrolling in health benefits.

Recommendations:

- **Prohibit integration of an HRA with Short-Term Limited Duration Insurance.**
- **Create a new Special Enrollment Period, but align future enrollments to the calendar year.**

- **Prohibit employers from offering an election between an Integrated HRA and a Group Health Plan.**
- **Require an employee attestation as a method of verification and substantiation.**
- **Consider the learning curve of employees enrolling in individual market coverage.**

III. Protect Employer Provided Coverage and Supplemental Benefit Offerings

Additional Input on Impacts on Employer-Provided Coverage

Employer-provided coverage is a cornerstone of the American health care system, not merely a means of paying for care or enabling access to coverage. Employer coverage has been at the forefront of many health coverage innovations including but not limited to promoting wellness and driving a transition to paying for value over volume in health care. Integrated HRAs have the potential to substantially alter the nature of employee health benefits offered in the United States.

Among the more popular aspects of employer provided coverage, both for businesses and their employees, are workplace wellness programs. We are concerned that the incentives to offer these programs may be reduced if an employer were to eliminate traditional group health coverage. We urge HHS to consider the need to proceed with a wellness program demonstration project for the individual market, as authorized and required by the ACA. We recommend the tri-agencies issue a Request for Information (RFI) seeking input on how Integrated HRAs could disrupt employer-provided coverage and impact the entire health care system. Input received in response to this RFI should guide future regulations in this area. Specifically, we recommend exploring the impact of new HRA options on workplace wellness programs and value-based payment arrangements.

This RFI is essential to ensure that coverage for millions of Americans – and the advancements employers and health plans have made in serving the majority of Americans with employer-provided coverage – is not rolled back. While these new HRA offerings may result in new consumer choices, given the potentially sweeping impact on the entire health care system, more needs to be considered by a wider array of stakeholders beyond the technical aspects or tax consequences of integrating coverage.

Permitted Reimbursement of Excepted Benefits (Proposed 26 CFR §53.9802-4, 29 CFR §2590.702-4, 45 CFR §146.123-4)

Voluntary and Excepted Benefits provide additional health and financial security that are essential for millions of Americans to access care, such as dental and vision, and manage risk in situations such as a disability. As many employers are likely to offer Integrated HRAs to their employees as their sole health benefit offering, we want to ensure that those with an Integrated HRAs also have access to Excepted Benefits, as currently defined by 42 U.S. Code § 300gg-91(c). Individuals who enroll in individual health insurance coverage through an Integrated HRA should have access to Excepted Benefits they may purchase on an individual basis, recognizing that some employers may not offer such benefits as a group product. We recommend the tri-

agencies clarify that nothing in the final rule would preclude an employer who offers an Integrated HRA from offering a separate HRA through which solely Excepted Benefit premiums could be reimbursed.

Exclusion from ERISA (Proposed 29 CFR §2510.3-1(l))
A majority of Americans enrolled in employer-provided health plans are in plans governed by ERISA. Preemption from state insurance laws, as afforded by ERISA, is essential for these plans to be able to effectively operate. The proposed rules detail a set of conditions that prevent an individual health insurance product from being treated as a group health plan or health and welfare benefit under ERISA.

While we recognize the need for these conditions and support the purpose of avoiding conflicts of interest, we are concerned that the strict nature of some of the conditions may lead to unintended consequences, including employers whose good faith actions result in an individual plan being governed by ERISA. If these conditions are to be included in a final rule, we recommend a safe harbor for good faith efforts to comply with the conditions or de minimis violations and ask for further clarity, including written examples, of what would violate the conditions. An existing safe harbor, the "voluntary plan safe harbor" currently exists for employers who pay premiums for excepted benefits through a Section 125 Cafeteria Plan (29 CFR § 2510.3-1(j)). A safe harbor for employers reimbursing premiums through an Integrated HRA could conform to the existing voluntary plan safe harbor.

As drafted, the proposed rule is ambiguous on whether the conditions are a "safe harbor" or whether non-compliance automatically subjects the arrangements to ERISA. Further, apparently conflicts between case law and DOL advisory opinions on the matter create further ambiguity[4] that a final rule could clarify, addressing whether these conditions qualify as a safe harbor, similar to the "voluntary plan safe harbor."

Should a final rule contain these conditions and the language about treating affected individual health insurance plans as subject to ERISA, there will be substantial unintended consequences on other markets. For example, Medicare secondary payer rules would be triggered if a plan is considered an ERISA group health plan when the law does not intend for individual health insurance coverage to be a primary payer. Other legal and regulatory requirements, particularly those imposed by HIPAA, ACA, and MHPAEA would be affected as well, creating substantial confusion for insurance providers, plan sponsors, and state insurance departments. Additionally, there would be impacts on determining whether the plan is subject to tax provisions, including the section 9010 Health Insurance Tax. Given the potential impacts for issuers of individual

[4] *See, e.g., Johnson v. Watts Regulator Co*., 63 F.3d 1129 (1st Cir. 1995); *Hansen v. Continental Ins. Co*., 940 F.2d 971 (5th Cir. 1991); *Gaylor v. John Hancock Mutual Life Ins. Co.*, 112 F.3d 460 (10th Cir.1997); *Zavora v. Paul Revere Life Ins. Co*., 145 F.3d 1118 (9th Cir. 1998). *But see Stuart v. Unum Life Ins. Co. of America*, 217 F.3d 1145 (9th Cir. 2000) (distinguishing *Zavora* and concluding that a plan cannot be excluded from ERISA coverage when an employer fails to satisfy any one of the four requirements of the safe harbor). Advisory opinions on the topic include: DOL Adv. Op. 77-54; DOL Adv. Op. 94-23A; DOL Adv. Op. 94-26A.

health insurance coverage, a safe harbor should exist for those issuers who would be affected by the actions of an employer who violates the conditions.

We are concerned that, as drafted and without a clear safe harbor, the conditions that affect ERISA treatment of these plans would present a high likelihood that actions outside the control of employers would result in violations. For example, many employers who choose to offer an Integrated HRA to their employees may do so through participation in a private exchange. Many private exchanges operate on closed model, meaning they offer only select individual health insurance plans. Employers who utilize private exchanges should not be treated as endorsing or selecting an individual health insurance plan, which under the proposed rules would make that plan subject to ERISA. Additionally, most employers work with licensed health insurance brokers to facilitate enrollment in health plans, with many brokers serving as a direct point-of-contact for employees. Brokers may endorse or otherwise direct employees to a particular plan with no involvement by the employer, violating the conditions set forth in the proposed rule. Employers should not be penalized for actions outside of their control.

Recommendations:

- **Issue an RFI to solicit public input on how these arrangements may impact employer-provided coverage and health plan innovations.**
- **Clarify that funds in an Integrated HRA may be used to purchase excepted benefit coverages, so long as Integrated HRA requirements to be enrolled in individual health coverage are satisfied.**
- **Clearly establish a safe harbor, similar to the existing "voluntary plan safe harbor" under ERISA, for employers who act in good faith to not endorse or select a particular health plan, along with clear examples of what would violate the conditions. Establish a similar safe harbor for issuers of individual health insurance coverage.**

IV. Promote Affordability of Coverage

Determinations of Affordability and Tax Credit Eligibility (26 CFR § 1.36B-2)

The proposed rule includes numerous implications for an employee's eligibility for section 36B premium tax credits (PTC). We support the inclusion of an opt-out opportunity that must be afforded to enrollees at least once annually. When an employee opts-in to the Integrated HRA, it is essential that the offer of an Integrated HRA only be considered an offer of MEC if the HRA is integrated with individual health insurance coverage. We refer back to earlier comments emphasizing that coverage that is not individual health insurance, such as STLDI, should not be eligible for integration.

The proposed rule gives thoughtful consideration to the role of plan affordability in determining eligibility for PTC. We believe basing the calculation on the lowest-cost silver plan in that rating

area is appropriate. We urge the tri-agencies to develop tools for both employers and employees to make determinations of affordability.

The same terms requirements in the proposed rule will likely aid with affordability, and we support allowing modifications of contribution amounts based on age and family size. Similar to the limits on premiums as part of community rating rules, we recommend the age-based contribution adjustments be limited to the age band required by law for the individual market, currently set at a 3:1 ratio between the eldest and youngest individuals. Such a rating band would be consistent with section 2071(a) of the ACA, with uniformity supporting implementation for insurance providers and plan sponsors. Without limits, employers would have the option to vary their reimbursements based on age to an extent that encourages higher enrollment in individual market coverage among older employees and spouses, which would lead to adverse selection.

Recommendations:

- **Develop tools for both employers and employees to make determinations of affordability.**
- **Establish an age band for contribution variations, consistent with existing Marketplace rules.**

V. Allow Adequate Time to Implement New Arrangements

The effective date in the proposed rules is insufficient to allow Integrated HRAs to be properly designed, offered and administered. Given the highly regulated nature of health insurance products, the timeframe required to submit annual premium rates, and the time required to determine said rates through actuarial analyses, there must be more time than the less than one year envisioned in the proposed rule. We recommend the effective date be no earlier than January 1, 2021, or eighteen (18) months following publication of the final rule, whichever is later.

Recommendation:

- **Delay an applicability date until at least 18 months following the publication of a final rule.**

Comments on Excepted Benefits Health Reimbursement Accounts

Offering voluntary coverage options beyond major medical coverage to employees and their families is a key benefit of employer-provided coverage and essential to promoting health and financial security. We support the goals of the tri-agencies in seeking to expand the ability of employers to provide these types of coverage offerings to their employees. Below, we detail why only Excepted Benefits, as currently defined, should be accessible through these arrangements.

I. Preserve HIPAA Excepted Benefits

Qualified Reimbursements and Definition of Excepted Benefits (26 CFR § 54.9831-1, 29 CFR § 2590.732, 45 CFR § 146.145)
The proposed rule allows for Excepted Benefit HRA funds, limited in amount, to be used for the purchase of Short-Term Limited Duration Insurance. As we have commented previously with respect to the Integrated HRA, we strongly believe that allowing STLDI premiums to be paid with these funds undermines the purpose of the group health plan, hinders risk pool stability, and potentially exposes employees to serious financial risk.

We oppose the inclusion of categories of coverage and financial products that are not HIPAA Excepted Benefits, as defined at 42 U.S.C. § 300gg-91(c), in the list of products that may be purchased with Excepted Benefit HRA funds. Excepted Benefits are a category created by statute and long defined at the state level. They were first recognized at the federal level in HIPAA. Excepted Benefits are limited in nature and are not offered, marketed or sold as primary medical coverage or as a substitute for such coverage and for this reason are exempt from requirements that apply to primary medical coverage. Excepted Benefits are fundamentally different from STLDI, which is designed and offered as a form of primary medical coverage. Beyond our concerns about the negative impacts of permitting the purchase of STLDI, this rule should not include any provisions that redefine Excepted Benefits and what types of products are included. In particular, the tri-agencies should make it clear that STLDI is not an Excepted Benefit.

Maximum Contribution Amount
We support placing monetary limits on Excepted Benefit HRA funds. We believe the $1,800 limit, to be indexed, as proposed by the tri-agencies is reasonable but would also support an adjusted limit based on family size so long as the Excepted Benefit HRA is limited to the reimbursement of HIPAA Excepted Benefits rather than STLDI. The measure of inflation in the proposed rule is consistent with current tax law, and we support that as the standard for annual adjustments of this amount.

Permitting Reimbursement of all Health Excepted Benefits
The proposed rule refers to "coverage that consists solely of excepted benefits," which supports a broad reading of the types of health Excepted Benefits that may be paid for through an HRA. We support such an approach, and recommend that the final rule clarify that HRAs may be used not only to pay for insurance that pays health benefits based on expenses incurred (e.g., most vision and dental coverage), but also Excepted Benefit health coverage--specifically hospital indemnity and fixed indemnity health coverage and coverage for a specified disease or illness as described in PHSA § 2791(c)(3), ERISA § 733(c)(3), and Internal Revenue Code §2791(c)(3).

Recommendations:

- **Allow reimbursement from an Excepted Benefit HRA only for existing HIPAA Excepted Benefits, which do not include Short-Term Limited Duration Insurance.**

- **Adjust the benefit amount to increase with family size if reimbursements are limited to HIPAA Excepted Benefits.**
- **Clarify that all health Excepted Benefits, including Excepted Benefit health indemnity coverage, may be purchased through an HRA.**
- **Require an adequate notice to consumers that Excepted Benefit coverages are not intended as a substitute for major medical coverage and do not qualify as Minimum Essential Coverage.**