BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

December 20, 2018

The Honorable Charles P. Rettig
Commissioner
Internal Revenue Service
CC:PA:LPD:PR (REG–136724–17)
Room 5205
1111 Constitution Avenue, N.W.
Washington, DC 20044

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 Commissioner Rettig:

The Blue Cross Blue Shield Association ("BCBSA") appreciates the opportunity to provide comments on the Proposed Rule, Health Reimbursement Arrangements and Other Account-Based Group Health Plans, 83 Fed. Reg. 54420 (October 29, 2018; "Proposed Rule").

BCBSA is a national federation of 36 independent, community-based, and locally operated Blue Cross and Blue Shield Plans ("Plans") that collectively provide healthcare coverage for one in three Americans. For more than 80 years, Blue Cross and Blue Shield Plans have offered quality healthcare coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare, and Medicaid.

BCBSA applauds the Departments of Health and Human Services, Labor, and Treasury (collectively, the "Agencies") for recognizing the importance of "guardrails" in structuring Health Reimbursement Arrangements ("HRAs") that may be integrated with health coverage purchased on the individual market (referred to in this comment letter as "ICHRAs"). We think that the Agencies struck an important balance between providing additional alternatives for employers while curtailing the opportunity for some employers to selectively segment risk and shift their highest-cost employees (and their dependents) to the already fragile individual market.

As stated by the Secretaries of the Agencies in their *Wall Street Journal* op-ed, in the Proposed Rule, "We…propose carefully constructed guardrails to protect the individual market." The Secretaries reinforced the importance of these guardrails because "[h]arming the individual market…would make this rule ineffective, since employees would not have attractive coverage

options on the individual market."[1] The Secretaries are correct that the success of the Proposed Rule relies largely on the robustness and stability of the individual market.

While some may argue that these guardrails should be loosened to provide additional flexibility to employers, BCBSA understands that these guardrails were carefully constructed to work together to permit employers to offer new coverage options that enhance choice for employees while protecting against the potential for market segmentation and health factor discrimination against individuals. Because the individual market is less than a tenth of the size of the group market, just a small shift of high-cost persons from the group market to the individual market can have a significant impact on individual market premiums, as we explain in more detail below. We urge the Administration to maintain the guardrails in the Proposed Rule and work to stabilize the market for comprehensive individual health insurance coverage in order to assure that the market works for employers interested in offering HRAs and the millions of people in the United States who do not have access to public or employer-sponsored coverage and rely on individual market coverage today.

Recommendations

Our key recommendations are as follows:

- **Maintain "Guardrails:"** The Agencies should adopt all of the conditions that must be met to be considered an ICHRA that were outlined in the Proposed Rule. Importantly, these conditions must include:
    - Any individual covered by the ICHRA must be enrolled in health insurance coverage purchased in the individual market and must substantiate and verify that they have such coverage;
    - The employer may not offer the same class of employees both an ICHRA and a "traditional group health plan;"
    - The employer must offer the ICHRA on the same terms to all employees in a "class;"
    - Employees must have the ability to opt-out of receiving the ICHRA; and
    - Employers must provide a detailed notice to employees about the ICHRA and what it means to the employee to be covered by an ICHRA.
- **Excepted Benefits HRA:** Short-term limited duration insurance should not be included as a product for which the HRA may be used.

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

- **Status as ERISA Plans:**

    - The Agencies should clarify that the specified conditions are "safe harbors" from ERISA, and that noncompliance with the requirements does not automatically subject the arrangements to ERISA;

    - In the event that an employer group health plan is found to be noncompliant with the ICHRA requirements, the employer's group health plan should be responsible for any obligations needed to comply with ERISA;

    - The Agencies should clarify that a health insurance issuer providing individual market health coverage purchased with an ICHRA need not comply with Medicare Secondary Payer reporting requirements or pay for benefits primary to Medicare in situations where Medicare Secondary Payer rules might technically apply to a group health plan; and

    - The Agencies should specify that an employer cannot use an ICHRA in conjunction with a plan purchased through a private exchange unless the private exchange is designed in such a way as not to constitute selection or endorsement by the employer.

- **Notice Requirements:**

    - A disclosure should be added to the notice that persons who are enrolled in Medicare are not eligible to enroll in individual healthcare coverage and, therefore, cannot meet the requirements to benefit from an ICHRA; and

    - Any self-attestation by an individual receiving HRA funds should include language that for any month the individual receives HRA funds and does not have individual market coverage the funds received from the HRA become taxable income and that falsely attesting to coverage is a tax violation that may be subject to additional penalties.

- **Special Enrollment Periods:** A new special enrollment period will be necessary for employees gaining initial access to an HRA, but there should not be a recurring annual special enrollment period for employees with non-calendar year benefits, as suggested in the Preamble to the Proposed Rule.

- **Monitoring the Impact of the New HRAs:** The Agencies should carefully monitor enrollment in the new HRAs, including tracking this by firm size, and the impact that ICHRA enrollees have on the affordability of individual market coverage. If ICHRAs are having a material negative impact on individual market pricing, modifications should be made to the ICHRA requirements.

Our detailed and additional comments are below.

We appreciate your consideration of our comments and we look forward to working with the Agencies on finalization and implementation of the Proposed Rule. If you have any questions or

want additional information, please contact Richard White at Richard.White@bcbsa.com or 202.626.8613.

Sincerely,

Kris Haltmeyer
Vice President
Legislative and Regulatory Policy
Blue Cross Blue Shield Association

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**BCBSA DETAILED COMMENTS ON
HEALTH REIMBURSEMENT ARRANGEMENTS AND OTHER ACCOUNT-BASED GROUP HEALTH PLANS PROPOSED RULE**

I. Integration Rules for ICHRAs (Proposed 26 C.F.R. § 54.9802-4(c), 29 C.F.R. § 2590.702-2(c), 45 C.F.R. § 146.123(c))

Issue: The Proposed Guardrails are Critical to Preventing Market Segmentation

The Proposed Rule allows employers the additional option of providing an account-based plan, an ICHRA, to classes of their employees to purchase individual market coverage if the employer offering the ICHRA meets certain conditions. BCBSA appreciates the efforts of the Agencies in constructing appropriate guardrails in the Proposed Rule with respect to whom and under what conditions an ICHRA may be offered. These guardrails are crucial. If the rules for offering an ICHRA are not structured correctly, it could negatively impact the affordability of individual market coverage due to market segmentation and could also lead to situations where employees are discriminated against based on their health status.

Recommendation:

The Agencies should adopt all of the conditions that must be met to be considered an ICHRA that were outlined in the Proposed Rule. Importantly, these conditions must include:

- Any individual covered by the ICHRA must be enrolled in health insurance coverage purchased in the individual market and must substantiate and verify that they have such coverage;
- The employer may not offer the same class of employees both an ICHRA and a "traditional group health plan;"
- The employer must offer the ICHRA on the same terms to all employees in a "class;"
- Employees must have the ability to opt-out of receiving the ICHRA; and
- Employers must provide a detailed notice to employees about the ICHRA and what it means to the employee to be covered by an ICHRA.

Generally, BCBSA recommends that all of the detailed requirements related to these conditions should be adopted as proposed. The exception, however, is that we recommend eliminating the separate class for employees under age 25, as discussed later in this comment letter.

Rationale:

As stated in the preamble, the intent of the Proposed Rule is to "increase the usability of HRAs to provide more Americans, including employees who work at small businesses, with additional healthcare options."[2] If not structured with the proper protections, however, the Proposed Rule

[2] 83 Fed. Reg. 54420, 54427 (Oct. 29, 2018).

could allow some employers to shift their highest-cost employees (and their dependents) into the much smaller and currently more fragile individual market. Such risk segmentation would be attractive to some employers because the cost of coverage for employers who are in the large group market, as well as employers who self-insure, is based on the claims experience of their group, and lowering the claims experience of covered employees and dependents by moving them out of group coverage could constitute a significant cost savings for employers.

Even a small shift of high-cost members from the large group market to the individual market has the potential to dramatically increase premiums in the individual market. The size of the large group market greatly exceeds the individual market, so a small shift can have a large impact. An illustration developed by the American Academy of Actuaries ("AAA") shown in Table 1[3] below shows the potential impact on the individual market. In 2016, the AAA estimated that the large group market had 143 million lives, including both insured and self-insured members. In contrast, the Affordable Care Act ("ACA")-compliant individual market had 14 million lives. The difference between these markets is expected to grow even greater in 2019 with the repeal of the individual mandate.

A recent Health Care Cost Institute ("HCCI") analysis[4] looks at statistics on the top spenders in a commercially insured population of individuals who are under age 65. Top spenders are defined as the top five percent of spenders for a given year. The analysis shows that about two of five top spenders (or about 2 percent of the population) are persistent top spenders, meaning that they are top spenders in two consecutive years. The persistent top spenders had average allowed claims of $74,045 for 2015 (Figure 5 of HCCI analysis).

The assumption is that without strong nondiscrimination rules, employers will target persistent top spenders to move to the individual market. As shown in the chart below, even a 10 percent move in top spenders from the large group to the individual market would increase claims by as much as 30 percent per year in the individual market.

The illustration shows that the impact to individual market premiums would be as follows:

Table 1. Illustration of the Potential Effect of Shifting Persistent Top Spenders in the Large Group Market to the Individual Market, 2016

Percent of Persistent Top Spenders in Large Group Market Moving to Individual Market Coverage	Average Annual Claims in Individual Market, After Shift of Top Spenders	Increase in Average Individual Market Claims
0%	$4,411	0%
5%	$5,075	15%
10%	$5,726	30%
25%	$7,605	72%
100%	$15,595	254%

[3] http://www.actuary.org/files/publications/HRA_comments_12_13_2018.pdf
[4] https://www.healthcostinstitute.org/research/publications/hcci-research/entry/top-spenders-among-the-commercially-insured-increased-spending-concentration-and-consistent-turnover-from-2013-to-2015.

Table 1. Illustration of the Potential Effect of Shifting Persistent Top Spenders in the Large Group Market to the Individual Market, 2016

Percent of Persistent Top Spenders in Large Group Market Moving to Individual Market Coverage	Average Annual Claims in Individual Market, After Shift of Top Spenders	Increase in Average Individual Market Claims

American Academy of Actuaries calculations using data from the Kaiser Family Foundation ("KFF"), HCCI, and the Medical Loss Ratio ("MLR") public use file data from the Centers for Medicare and Medicaid Services. Methodology:

- Number of large group enrollees in 2016 = 143 million = Number of group enrollees (157 million, KFF) – Number of small group enrollees (14 million, MLR data); includes both insured and self-funded employers
- Persistent top spenders represent group insurance enrollees in top 5 percent of total spending in 2015 who were also in the top 5 percent of total spending in 2014. HCCI estimates that 39% of the top 5 percent of spenders in 2015 or (1.95 percent of all enrollees) were persistent top spenders.
- Number of persistent top spenders in 2015 = 143 million * 1.95 percent = 2.8 million
- Average claims of persistent top spenders, 2016 = Per capita spending among persistent top spenders in 2015 ($74, 045, HCCI) * assumed trend to 2016 (1.05) – cost-sharing (assumed maximum out-of-pocket limit of $6,000) = $71,747
- Number of individual market enrollees in 2016 = 14 million (MLR)
- Average individual market claims in 2016 = $4,411 (MLR)
- The average claims in the individual market after the shift of top spenders in the group market is calculated as [$4,411*14 million +$71,747 * 2.8 million * percent switching]/(14 million + 2.8 million * percent switching)

As the above estimates demonstrate, without the protections in the Proposed Rule, there could be devastating impacts on the individual market due to the strong financial incentive for some employers to segment their risk and encourage their highest cost employees to enroll in individual market coverage. BCBSA is concerned that offering this sort of arrangement will lead to adverse selection in which higher-cost employees are shifted into the individual market, and raising costs for that market while other employees select group coverage. For example, employers could make the individual market coverage an attractive alternative by paying the entire premium and out-of-pocket cost-sharing, which is limited to $7,900 in 2019, and still come out tens or even hundreds of thousands of dollars ahead annually for a high-cost employee.

Such cost savings by employers are not merely hypothetical. Unfortunately, there are examples of this practice occurring today as evidenced by the following description of an "Affordable Care Plan" ("ACP") option from a "2018 Summary Plan and Plan Description with Revisions Through 1-1-18" accessed on an employer's publicly available website.

THE AFFORDABLE CARE PLAN (ACP)
*** No deductible, no co-pays, no co-insurance**
*** No overall annual or lifetime dollar limits * No pre-existing condition limits**

> The ACP is designed for individuals whose benefits are expected by the Claim Administrator to exceed $50,000 or more in a year. Each year, if you qualify, you may remain in the ACP, or elect to come back to your group major medical plan at any time. Here is how it works. You may select the carrier of your choice on the Exchange market without having to answer health questions or being subject to pre-existing limits. The ACP will pay your premiums, minus any federal government subsidy for which you may be eligible under PPACA. The ACP will also reimburse you for all deductibles, co-pays and co-insurance for both medical and prescriptions under your chosen fully insured health plan with the Exchange carrier of your choice, and these same expenses under the Major Medical both the year you enter and year you leave the ACP option….

The potential for significant and destabilizing impacts on individual market premiums is why it is critical that the protections against market segmentation in the Proposed Rule be retained and not weakened. Each protection is important, both by themselves and in combination, to shield against market segmentation and potential discrimination on health status.

Below we discuss the importance of each proposed requirement:

All Individuals Covered by the HRA are Enrolled in Individual Health Insurance Coverage – To ensure a balanced risk pool is being transferred from the group market to the individual market, it is important that both healthy, and relatively lower-cost, group members and those who are higher-cost enroll in individual market coverage. If individuals are permitted to use ICHRA funds for medical expenses without having to enroll in individual market coverage, there would be a risk that only relatively less healthy individuals would chose to enroll in coverage while younger and healthier individuals would choose to "self-insure" with the ICHRA and not enroll in individual market coverage. Additionally, since the ICHRA receives favorable tax treatment because of its status as a health plan, it makes sense from a policy perspective that funds from the ICHRA be at least somewhat tied to the purchase of health insurance coverage.

ICHRAs should not be integrated with any plan that does not meet the federal insurance reforms that created the structured market needed to make these types of HRAs possible. Without this structured market, where employers can have confidence that employees can obtain comprehensive coverage regardless of medical condition, the proposal to allow ICHRAs to be used to buy individual market policies will not be attractive to employers. Moreover, allowing HRAs to be used for noncompliant coverage would undermine the stability of the risk pool.

Prohibition Against Offering Both an ICHRA and a Traditional Group Health Plan to the Same Class of Employees – We agree with the Agencies that this requirement is necessary to "prevent large-scale destabilization of the individual markets."[5] It is essential that an individual not have the choice between enrolling in an ICHRA and a traditional group health plan.

[5] 83 Fed. Reg. 54420, 54429 (Oct. 29, 2018).

Otherwise, we would see market segmentation caused by incenting high-cost individuals to enroll in individual market coverage (as described in more detail above) as well as potential adverse selection based on differences in benefits, cost-sharing levels, and networks.

Finally, we note that while the preamble discusses the possibility that adverse selection related to benefits, cost-sharing levels, and networks could also occur the opposite way and negatively impact the group market, we believe that this risk is much lower. It is the employer that is empowered with deciding which health benefits to offer. Thus, it is not likely that employers would offer both an ICHRA and a traditional group health plan if the employer anticipated that such a choice would increase claims cost in its traditional group health plan.

Same Terms Requirement – An important distinction between the requirements for ICHRAs and certain other nondiscrimination provisions implemented by the Agencies, such as those for wellness benefits, is that the Proposed Rule prohibits discrimination both for offering less and for offering more generous benefits under an ICHRA. This clarification that the nondiscrimination requirements apply to offering more generous coverage in ICHRAs to less healthy or more costly individuals is essential to preventing the type of selective risk segmentation discussed earlier in this letter. It is critical that this restriction against "benign discrimination" be retained. Note, as discussed above in reference to the ACP, shifting expensive individuals from the group market into the individual market via hefty monetary incentives is already occurring, although to a far less extent than we would see were such a practice was explicitly allowed by the Agencies. In order to ensure the stability of the individual market and the success of the policies in the Proposed Rule, the Agencies must not only abstain from promoting such behavior, they must put a stop to abusive practices that are currently underway.

Classes of Eligible Employees – In the Proposed Rule, the Agencies propose employee classes that have been carefully constructed to provide a balance between providing employers with the flexibility to segment their workforces into classes to which they would normally offer different benefits while limiting their ability to make class distinctions that would have the potential to be easily manipulated in a discriminatory manner (*e.g.*, salary vs. hourly). It is worth noting that the proposed employee classes already provide options to small employers not available through a qualified small employer health reimbursement arrangement ("QSEHRA") as the employer is able to vary the amount contributed to the ICHRA by class, whereas with a QSEHRA the amount contributed must be the same for all employees eligible to participate in the QSEHRA.

Employees Must Have the Ability to Opt-out of Receiving an ICHRA – The provisions in the Proposed Rule related to providing employees with the ability to opt-out of ICHRA coverage should be adopted as proposed. The Proposed Rule is consistent with existing rules related to non-HRA group coverage that serve to protect individuals from being inappropriately barred from qualifying for a Premium Tax Credit ("PTC") under section 36B of the Internal Revenue Code ("Code"). The existing rules allow a person to opt-out of non-HRA group coverage and receive a PTC if the coverage is either unaffordable or does not provide minimum value.

Employers Must Provide a Detailed Notice to Employees – Plan sponsors of ICHRAs must provide written notices to each participant at least 90 days before the beginning of each plan year under the Proposed Rule. The notice can include additional information, but, at a

minimum, must include eight specific pieces of information. Examples of required information include the maximum dollar amount for each participant, that participants must enroll in individual coverage (and that this coverage cannot be STLDI or excepted benefits), and an explanation of the implications of the HRA on eligibility (or not) for PTCs through the exchanges. It is important to educate individuals about the promises and the limitations of ICHRAs in order to help make sure that the rules are implemented as intended and to prevent market segmentation, instability, and increasing costs in the individual market.

II. A Traditional Group Health Plan May Not Be Offered With an ICHRA (Proposed 26 C.F.R. § 54.9802-4(c)(2), 29 C.F.R. § 2590.702-2(c)(2), 45 C.F.R. § 146.123(c)(2))

Issue: Allowing Enrollment in a Traditional Group Health Plan or an ICHRA (But Not Both)

The Proposed Rule prohibits offering employees in a class the option to enroll in either a traditional group health plan or an ICHRA. This restriction is intended to reduce the risk of market segmentation between the individual and group markets as well as the potential for discrimination against individuals based on health status. The Agencies solicit comments on 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.

Recommendation:

The prohibition against offering employees in the same class the option to enroll in either a traditional group health plan or an ICHRA must be retained as proposed.

Rationale:

The Agencies correctly assess the potential for adverse selection and health status discrimination that could occur if employers were given the option to offer an ICHRA and a traditional group health plan to the same individual. As explained above, this type of market segmentation could have a significant impact on premiums in the individual market given the relatively small size of the individual market when compared to the much larger employer group market. As demonstrated by the American Academy of Actuaries analysis above, the risk remains significant even if only a small number of employers adopted this practice. The prohibition on offering an ICHRA and a traditional group plan to employees in the same class, when coupled with the other proposed requirements, meaningfully reduces the potential for market segmentation and discrimination based on health status (such as demonstrated by the ACP discussed previously).

III. Permitted Classes (Proposed 26 C.F.R. § 54.9802-4(d), 29 C.F.R. § 2590.702-2(d), 45 C.F.R. § 146.123(d))

Issue #1: The Proposed Classes of Employees Should Not be Expanded

Under the Proposed Rule, if an ICHRA is offered to any class of employees, it must be offered on the same terms and conditions to all employees within that class, subject to certain exceptions. The employee classes include: full-time employees, part-time employees, seasonal employees, collectively bargained employees, those who are in a waiting period, employees under 25 years old, foreign employees without U.S. income, and employees who work in the same geographic rating area. The Agencies request comments related to the proposed classes including whether additional classes of employees should be provided (*e.g.*, classifications based on form of compensation such as hourly versus salaried) and whether additional classifications within the proposed classes of employees should be allowed.

Recommendation #1:

The classes of employees should not be expanded beyond those in the Proposed Rule, and no new classes or subsets of classes should be added. In addition, as discussed later, the class for employees under 25 should be eliminated.

Rationale #1:

The Agencies have done an excellent job of defining the classes to which an ICHRA may or may not be offered, including variation in the terms of the ICHRA. The proposed classes strike an appropriate balance between providing employers with the flexibility to vary terms between certain classes of employees where the potential for market segmentation would be more limited, and restricting flexibility where there is a real potential for abuse. For example, while some employers might want to vary the benefits between salaried and hourly workers, the Agencies correctly identify that this would have much more potential to be manipulated for risk selection purposes than the proposed classes. Given that impermissible classifications would likely only be identified in an audit, some employers might view it as worth the risk given the magnitude of potential savings that can be achieved by selectively moving high-cost individuals from a group health plan to the individual market.

While some may criticize this limitation on flexibility as inhibiting the growth potential of ICHRAs, because ICHRAs will only be successful on a broad scale if they offer affordable options for a large number of employers and their employees, the potential for this market segmentation must be addressed in order for the proposal to succeed.

Finally, while BCBSA is not concerned with allowing the proposed classifications to be used in combination with each other to create a new class, we do not support allowing more granular subdivision of classes. If the Agencies do allow further subdivision of classes, such as distinctions between the numbers of hours worked by part-timers, the parameters should be included in regulations and not allowed to be determined by individual employers as this would increase the potential for adverse consequences and game playing.

Issue #2: Collective Bargaining Agreements

The Proposed Rule establishes a separate class for employees who are included in a unit of employees covered by a collective bargaining agreement ("CBA") in which the plan sponsor participates; however, it is not clear if the employer may differentiate between classes covered by different CBAs.

Recommendation #2:

The Agencies should clarify that employers may differentiate between classes covered by different CBAs and not just between employees who are covered by a CBA and those who are not.

Rationale #2:

The Preamble to the Proposed Rule notes that "unions typically bargain with employers over health benefits provided to employees who are members of that union, and the health benefits than an employer provides pursuant to a CBA are often different than those that it provides to its employees who are not covered by the CBA." 83 Fed. Reg. 209, 54431. This rationale is as true for employees covered by different CBAs as it is for employees covered by a CBA and those who are not covered by a CBA. Because each CBA is bargained for separately, health benefits will often differ between CBAs. Further, the health benefits under the different CBAs will differ for reasons other than inducing higher-risk employees to leave the employer's traditional group health plan, and it would be burdensome, and perhaps not even possible, for employers to shift employees from one CBA unit to another merely for the purpose of offering different types of health benefits. The Agencies should, therefore, clarify that an employer may separate employees covered by different CBAs into different classes just like an employer may distinguish between employees covered by a CBA and employees who are not covered by a CBA.

Issue #3: Separate Class for Employees Under Age 25

The Proposed Rule establishes a separate class for employees under age 25.

Recommendation #3:

The separate class for employees under age 25 should be eliminated.

Rationale #3:

The Proposed Rule establishes a separate class for employees under age 25; however, it does not provide a policy rationale for why this separate class is necessary. Based on our experience, being under age 25 is not a criterion that is widely adopted by employers for eligibility for health insurance. In fact, doing so would actually disadvantage employers who want to attract recent graduates. Many employers look at ways they can design their health insurance offerings to make it attractive to younger persons as having them in the risk pool helps bring down the average cost of coverage. Nevertheless, BCBSA is concerned that any class that allows for segmentation by age has the potential to lead to negative results.

We assume the class for employees under age 25 was included as it is a class that is allowed to be excluded under Code section 105(h) related to the discrimination test for self-insured medical reimbursement plans. However, we do not believe that the class is necessary for ICHRAs.

Issue #4: Minimum Class Size

The Agencies did not propose a minimum employer size or employee class size for purposes of applying the proposed integration rules. The Agencies recognize that very small employers could manipulate these classes (for example, a very small employer could put someone who is a higher-risk employee in a separate class on his or her own), but note that other economic incentives related to attracting and retaining talent would discourage employers from doing so. The Agencies invite comments on whether employer size or employee class size should be considered in determining permissible classes of employees.

Recommendation #4:

The Agencies should include a minimum class size of twenty employees in any class before they can offer an ICHRA to a class on different terms and conditions.

Rationale #4:

In the Proposed Rule, the Agencies do not provide a minimum employer size or employee class size for purposes of applying the integration rules. The Agencies themselves recognize that "very small employers could manipulate these classes (for example, a very small employer could put someone who is a higher-risk employee in a separate class on his or her own), but note that other economic incentives related to attracting and retaining talent would discourage employers from doing so." The Agencies do not discuss the potential for abuse by larger employees that use very small class sizes. BCBSA is concerned that using the flexibility provided by the proposed classes, an employer could manage to place high-cost employees into a separate class or classes and offer them high dollar benefits through an ICHRA coupled with individual market coverage while saving tens of thousands of dollars per employee through reduced premiums in their group plan. Including a minimum class size of at least twenty employees would go a long way towards protect against this type of manipulation.

IV. Benign Discrimination (Proposed 26 C.F.R. § 54.9802-4(c)(3), 29 C.F.R. § 2590.702-2(c)(3), 45 C.F.R. § 146.123(c)(3))

Issue: Clarification of Benign Discrimination

One of the ways the Proposed Rule prohibits discrimination based on health factors is by requiring that an ICHRA be offered on the same terms to all participants within a class of employees. This rule applies both to offering less and more generous benefits under an ICHRA. This rule differs from some other discrimination provisions, such as those for wellness programs, where offering more generous benefits based on health factors is allowed.

Recommendation:

The clarification that discrimination includes offering more generous benefits through an ICHRA should be maintained. In addition, the Agencies should clarify that while contributions may vary for the various classes or combination of classes, the amount of the employer's contribution must have a reasonable relationship to the cost of the coverage for those classes and not be related to the health of one or more members of the class.

Rationale:

The addition of the prohibition against offering more generous benefits is an important protection against risk segmentation that would allow an employer to incent higher-cost employees to enroll in individual market coverage, as illustrated by the example of the ACP referenced earlier in this letter. It is critical that this protection be retained, and the Agencies should include the additional protection of requiring the employer's contribution to have a reasonable relationship to the cost of coverage. This latter protection would help protect against the practice of developing a unique class or classes for one or more high-cost individuals within the bounds of the other seemingly permissible requirements and sending that class to the individual market. Selectively moving only a small number of employees from the group medical plan into the individual market has the potential to offer an employer considerable savings while also having a significant adverse impact on the individual market.

V. Same Terms and Conditions – Place Limits on Maximum Dollar Amounts Based on Age (Proposed 26 C.F.R. § 54.9802-4(c)(3), 29 C.F.R. § 2590.702-2(c)(3), 45 C.F.R. § 146.123(c)(3))

Issue: No Limits on Variations for Age

The Proposed Rule generally requires that a plan sponsor that offers an ICHRA to a class of employees must offer the ICHRA on the same terms (that is, both in the same amount and, otherwise, on the same terms and conditions) to all employees within the class, but allows variations for participants' age. However, the Proposed Rule does not put any parameters on the maximum amounts by which ICHRAs may vary based on age.

In Notice 2018-88, for which we are providing comments under separate cover, the IRS has proposed that to meet the requirements of the self-insured plan nondiscrimination rules (Code sec. 105(h)) the ICHRA would have to provide that the maximum dollar amount made available to employees who are members of a particular class increases in accordance with the increases in the price of an individual health insurance coverage policy in the relevant individual insurance market based on the ages of the employees who are members of that class, provided that the same maximum dollar amount attributable to the increase in age is made available to all employees who are members of that class who are the same age.

Recommendation:

The proposed safe harbor, including limits on variations by age proposed under Notice 2018-88, should be allowed for situations where the group health plan varies contributions to the ICHRA by age, but should be reasonably related to the cost of individual coverage.

Rationale:

The exception for age in the Proposed Rule is logical and justified since the cost of coverage in the individual markets is based in part on age. However, there is the potential for market segmentation and health factor discrimination if the contributions by age are not directly related to the increase in the cost of coverage by age. As discussed earlier in this letter, BCBSA is concerned about any permitted variations that are based on age because of the relationship between age and health factors and the incentives for employers to try to send older individuals out of their group health plans and into the individual market. For employers that opt to vary contributions by age, tying the contribution to the increase in price of individual health insurance coverage policies in the relevant individual health insurance market is appropriate, nondiscriminatory, and is unlikely to cause market segmentation.

VI. Integration of an ICHRA with Short-Term Limited Duration Insurance Coverage

Issue: **ICHRA Integration with STLDI**

The Proposed Rule allows for integration of an ICHRA with all individual market coverage, but does not include STLDI, in part, because it is not considered individual market coverage and, in part, because it does not satisfy the policy rationale for permitting integration with an individual health plan. Under current federal requirements, STLDI is not required to comply with the requirements of PHSA Sections 2711 and 2713 (42 U.S.C. §§ 300gg-11 and 300gg-13) that prohibit annual or lifetime dollar limits and requires the coverage of preventive care with no cost-sharing. The Agencies request comments on whether integration with STLDI should be permitted, including whether integration should be permitted with any other type of coverage that satisfies PHSA Sections 2711 and 2713 and how such integration rules should be structured, as well as comments on what, if any, potential benefits and problems might arise from allowing these types of ICHRA integration.

Recommendation:

The Agencies should not allow an ICHRA to be integrated with STLDI.

Rationale:

In the Proposed Rule, the Agencies explain that the proposed integration requirements are designed to ensure compliance with the ACA's annual and lifetime limits and preventive services requirements. The Agencies also considered the possibility that expanding access to HRAs could lead to employers offering coverage options to their employees in a manner that discriminates based on health status. Specifically, the Agencies are concerned with how to

avoid permitting discrimination based on health status or similar employer practices with respect to offering HRAs to employees that might have destabilizing effects on the individual market or lead to higher premiums in that market.[6]

Our analysis of the products currently being sold in the STLDI market indicates that all STLDI coverage that is currently being sold (and that has ever been sold) has both annual and lifetime limits. In addition, most STLDI coverage does not have any benefits for preventive care, and if it does, it is limited and does not comply with the requirements of PHSA section 2713.

The Agencies' reason for allowing an ICHRA to be offered is the fact that the HRA, which cannot by itself satisfy the requirements of PHSA sections 2711 and 2713, is being integrated with individual market coverage that complies with PHSA Sections 2711 and 2713.[7] Given that STLDI products are not required to meet these requirements, and that it appears that none ever have, allowing integration without significant additional requirements for verification is inconsistent with prior HRA guidance, inconsistent with the integration requirements proposed in this very rule, and inconsistent with "Congress's overall intent in enacting HIPAA and PPACA."[8]

> "[I]n expounding a statute, we are not guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy.' " *Massachusetts v. Morash*, 490 U.S. 107, 115, 109 S.Ct. 1668, 1673, 104 L.Ed.2d 98 (1989), *quoting Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 51, 107 S.Ct. 1549, 1555, 95 L.Ed.2d 39 (1987). *See also K mart Corp. v. Cartier, Inc.*, 486 U.S. 281, 291, 108 S.Ct. 1811, 1818, 100 L.Ed.2d 313 (1988) (same).[9]

Here, when drafting the HRA rules, the Agencies considered the object and policy of HIPAA and the ACA and concluded that an HRA, as a group health plan, must provide the same level of protections and must be subject to the same anti-discrimination provisions as other group health plans. Thus, the Agencies require HRAs to "integrate" with plans that comply with sections 2711 and 2713 of the PHSA. In that way, the Agencies can ensure that HRAs do not impose impermissible annual or lifetime limits and provide the statutorily mandated preventive services. Permitting an HRA to integrate with STLDI would ignore the object and policy of HIPAA and the ACA as recognized by the Agencies in this very preamble.

Finally, STLDI is not part of the single risk pool and, therefore, does not participate in risk adjustment. It is essential to preventing market segmentation that all products that are sold in conjunction with an ICHRA be part of the single risk pool and participate in risk adjustment (other than grandfathered plans since they are no longer sold to new enrollees and represent an extremely small segment of the market). Not doing so runs the risk of upending the individual market and dramatically increasing costs.

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[6] 83 Fed. Reg. 54420, 54427-28 (Oct. 29, 2018).
[7] 83 Fed. Reg. 54420, 54427 (Oct. 29, 2018).
[8] 83 Fed. Reg. 54420, 54428 (Oct. 29, 2018).
[9] *Doel v. United Steel Workers,* 494 U.S. 26, 35 (1990).

VII. Excepted Benefits HRA ("EBHRA")

Issue #1: Offering an EBHRA That can be Used to Purchase STLDI Simultaneously with a Traditional Group Health Plan

The Proposed Rule requires that an employer offer a traditional group health plan if it offers an EBHRA but does not require than an employee actually enroll in the group health plan in order to use the EBHRA to purchase qualified coverage. One of the options under the EBHRA is that it may be used to purchase STLDI insurance which typically:

- Requires a person to pass medical underwriting;
- Does not provide coverage for pre-existing conditions, even if an applicant passes medical underwriting;
- Has annual limits on some benefits; and
- Does not provide comprehensive coverage, including limited or no coverage for prescription drugs, maternity, mental health, and preventive care.

Allowing an employee the option to use an EBHRA to fund STLDI insurance while at the same time having the option to enroll in traditional group health insurance, but not requiring such enrollment will result in market segmentation resulting in increased cost for the traditional group health plan.

Recommendation #1:

STLDI should not be included as a product for which EBHRA funds are allowed to be used.

Rationale #1:

While BCBSA supports the EBHRA for excepted benefits products such as dental and vision, we are concerned about the market segmentation that could result if STLDI is also an option under an EBHRA. Both STLDI and traditional group health insurance provide coverage for medical benefits, but traditional group health coverage is available without regard to health and has comprehensive benefits while STLDI is medically underwritten, imposes pre-existing condition waiting periods, and has limited or no coverage of several important benefits.

Allowing the same employee or class of employees the choice between these two options will result in market segmentation causing increased costs for the traditional group health plan. Healthier, lower-cost persons who can pass medical underwriting, do not have pre-existing conditions, and believe they do not need comprehensive benefits may to enroll in STLDI rather than in group coverage. This type of market segmentation is much more likely to occur in the small group insured market where premiums do not vary based on an individual employer's claims experience. Large employers, whose plans are experience-rated or self-insured, likely will not offer the EBHRA with the option to purchase STLDI as this would have direct financial consequences on the cost of their more comprehensive traditional group health plans.

Additionally, while STLDI policies typically have numerous annual or per visit dollar limits on some services, they often have lifetime limits of $1,000,000 or more and, therefore, are not really limited benefits in the way that excepted benefits are. As the Agencies state in the preamble to the Proposed Rule, "[u]nder the statute, limited benefits may include limited scope vision or dental benefits, benefits for long-term care, nursing home care, home healthcare, or community-based care, or any combination thereof and may include ''such other similar, limited benefits as are specified in regulation."[10] Coverage that provides lifetime benefits of $1,000,000 or more for medical expenses is not "similar, limited benefits" when compared to dental plans that typically have a $1,500 annual limit[11] or vision plans that provides an annual eye exam and either a pair of glasses or contacts which typically has a value of less than $1,000. In this respect, STLDI coverage is more similar to traditional individual or group coverage (whose premiums may not be reimbursed by an EBHRA) than it is to excepted benefit health coverage (which may be paid for by an EBHRA).

Finally, as the Agencies know, although Congress did not include STLDI as individual health insurance coverage,[12] it also did not include it as an excepted benefit.[13] This indicates that while Congress did not intend STLDI policies to be subject to all of the individual market requirements, it similarly did not intend STLDI to be excepted from all of the market requirements, or to be treated as if it were excepted. Rather, as the Agencies have repeatedly recognized, most recently in the new STLDI rule,[14] STLDI "was primarily designed to fill temporary gaps in coverage that may occur when an individual is transitioning from one plan or coverage to another plan or coverage."[15] The preamble further noted commenters who suggested that STLDI provides an option for individuals between jobs and for those that may go without coverage at all. Allowing employers to subsidize STLDI through an excepted benefit HRA furthers none of these goals—STLDI is designed to fill gaps between traditional group health insurance coverage, not be offered alongside such benefits. Such a policy would effectively transform STLDI into an excepted benefit—a step that Congress did not take.

Issue #2: $1,800 limit for amounts newly made available in an EBHRA annually

The Agencies propose that the amounts newly made available for a plan year in an EBHRA may not exceed $1,800, indexed for inflation for plan years beginning after Dec. 31, 2020. In determining the amount of this dollar limit, the Agencies considered a number of different justifications, and the $1,800 limit approximates the midpoint amount yielded by the various methodologies considered. The Agencies seek comment on the amount of the proposed dollar limit.

Recommendation #2:

The Agencies should adopt a dollar limit of $1,800 or less for the EBHRA.

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[10] 83 Fed. Reg. 54420, 54437 (Oct. 29, 2018).
[11] https://www.bankrate.com/finance/insurance/dental-insurance-1.aspx
[12] PHSA § 2791(b)(5)("INDIVIDUAL HEALTH INSURANCE COVERAGE.—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.")
[13] PHSA § 2971(c).
[14] 83 Fed. Reg. 38212 (Aug. 3, 2018).
[15] 83 Fed. Reg. at 38213.

Rationale #2:

The Agencies' justification of picking the midpoint of various possible methodologies is reasonable and rational. Further, given the relatively low cost of coverage under excepted benefit plans, there is no need for a higher amount. Finally, a higher dollar limit makes the EBHRA more difficult to categorize as a "limited benefit" similar to other excepted benefits.

Issue #3: Inflation Adjustment

The Agencies propose to use the Chained Consumer Price Index for All Urban Consumers, unadjusted (C–CPI–U), published by the Department of Labor, for inflation adjustment. The Agencies seek comment on whether an alternative inflation adjustment such as the medical care component for CHI-U should be used.

Recommendation #3:

The Agencies should adopt Chained CPI for inflation adjustment of the dollar limit on the EBHRA.

Rationale #3:

While BCBSA believes that the use of the medical care component of CPI-U would be an appropriate inflation adjustment for dollar limits related to comprehensive medical coverage, the EBHRA is associated with limited benefit plans such as dental, vision, and indemnity. These types of coverage typically have relatively low dollar limits on the services that are covered or they pay a fixed amount per day. Because of this, they do not have cost trends (*i.e.*, inflation) similar to products that provide comprehensive medical care and that do not have low annual limits. Therefore, Chained CPI is an appropriate inflation adjustment for an EBHRA.

VIII. Premium Tax Credit

Issue: Lowest Cost Silver Plan to Determine Affordability

The affordability rule in the Proposed Rule uses the lowest cost silver plan for self-only coverage available to the employee through the exchange for the rating area in which the employee resides, without regard to the type of plan in which the employee actually enrolls. The lowest cost silver plan was chosen because, in the individual market, the lowest cost silver plan is the lowest cost exchange plan for which the plan's share of the total allowed costs of benefits provided under the plan is certain to be at least 60 percent of such costs, as required by code Section 36B(c)(2)(C)(ii) for a plan to provide minimum value.

The Treasury Department and the IRS seek comment on whether the silver level plan used for this purpose should be the second lowest cost silver plan, instead of the lowest cost silver plan, for self-only coverage offered in the exchange for the rating area in which the employee resides or whether another plan should be used, and any operational or other issues that the use of the plan proposed or any alternative plan would entail.

Recommendation:

The lowest cost silver plan should be used to determine affordability.

Rationale:

The Treasury Department and the IRS correctly assess that in the individual market, the lowest cost silver plan is the lowest cost exchange plan for which the plan's share of the total allowed costs of benefits provided under the plan is certain to be at least 60 percent of such costs. Allowing bronze plans to be used for affordability would not meet the requirements under code section 36B(c)(2)(C)(ii) for a plan to provide minimum value as bronze plans would often not meet the 60 percent threshold.

Regarding the question of whether the lowest cost silver plan or second lowest cost silver plan should be used to determine affordability, since the lowest cost silver plan is certain to meet the ACA's minimum essential coverage requirements, there does not appear to be a justification to use the second lowest cost silver plan, which is higher cost and, therefore, a more stringent test for employers.

IX. Status as ERISA Plans

Issue #1: Employer Actions Could Unilaterally Result in Individual Market Coverage Being Treated as Subject to ERISA

Individual market health insurance coverage selected by the employee and reimbursed by an HRA would not be treated as part of a group health plan, or as health insurance coverage offered in connection with a group health plan, or as a part of any employee welfare benefit plan for purposes of Title I of ERISA, if it meets a specified set of conditions. However, if the employer is found to not meet the conditions it is unclear what the impact is on the individual health insurance coverage and the issuer of that coverage.

Recommendation #1:

The Agencies should clarify that the specified conditions are safe harbors from ERISA and that noncompliance with the requirements does not automatically subject the arrangements to ERISA.

Rationale #1:

The Department of Labor ("DOL") proposes that an individual market plan purchased with an ICHRA would not be treated as part of a group health plan for purposes of ERISA if: (1) the purchase of coverage is voluntary, (2) the employer does not select or endorse any particular issuer or insurance coverage, (3) reimbursement of premiums is limited solely to individual health insurance coverage, (4) the employer receives no consideration in connection with the employee's selection or renewal of coverage, and (5) the employer provides the required notice.

Many of these conditions are virtually identical to the DOL's "voluntary plan" safe harbor. The majority of cases that have addressed this issue have concluded that a program failing the "voluntary plan" safe harbor is not automatically deemed to be an ERISA plan. *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).

The DOL's advisory opinions are not as clear on this point, however, with some advisory opinions suggesting that noncompliance with the "voluntary plan" safe harbor does automatically subject the arrangements to ERISA. In at least three advisory opinions, the DOL has found that the arrangements do not meet the "voluntary plan" safe harbor, and in the next sentence concluded that they were ERISA plans. DOL Adv. Op. 77-54; DOL Adv. Op. 94-23A; DOL Adv. Op. 94-26A.

Given that the Proposed Rule does not clearly state whether the conditions are a safe harbor or whether noncompliance automatically subjects the arrangements to ERISA, and given that the authority addressing the similar "voluntary plan" safe harbor is mixed on this question, BCBSA asks that the Agencies clarify that the conditions are merely a safe harbor.

Issue #2: Individual Market Coverage Issuer Responsibility if an Arrangement Becomes a Group Health Plan

Recommendation #2:

In the event that an employer group health plan is found to be noncompliant with the ICHRA requirements, the employer's group health plan should be responsible for any obligations needed to comply with ERISA.

Rationale #2:

Under the Proposed Rule, an employer group health plan might be out of compliance due to actions of an employer – and the issuer of the individual health insurance coverage would not know that the plan had become subject to ERISA. In addition, it would be impossible for an individual market issuer to make modifications to the coverage to comply with ERISA because the policies are filed with, and approved by, state insurance regulators under state insurance laws governing individual health insurance prior to being sold.

To enable issuers to offer individual coverage to employees of employers in a compliant manner, DOL should clarify that an employer's failure to meet the Proposed Rule's requirements will not result in an issuer's noncompliance with the ACA's market reforms and other related requirements. Issuers should be able to rely upon the representations of the employer that it has complied with all applicable ERISA requirements—whether to offer an ICHRA, EBHRA, retiree-only HRA, or other account-based group health plan—and should be held harmless in the event the employer does not properly comply with the requirements applicable to the account-based group health plan it offers.

The Agencies have previously recognized that issuers have limited knowledge and control of employer group health plan design and compliance. For example, one of the requirements to maintain grandfathered status is that the employer not decrease its contributions below specified levels. Because an issuer may not know when an employer decreases its contribution, the Agencies provided that a plan would not lose grandfathered status based on a change in the contribution rate unless the issuer knew or should have known of the change.[16] Similarly, the ACA prohibits waiting periods of longer than 90 days for group health plans, including for insured group health plans. The Agencies recognized that an issuer would not have the information necessary to determine whether the employee had been eligible for coverage for 90 days or longer. To address this, the Agencies provided that "the issuer is permitted to rely on the eligibility information reported to it by the employer (or other plan sponsor) and will not be considered to violate the requirements of this section with respect to its administration of any waiting period" provided certain conditions are met.[17]

Here, an issuer's knowledge of the group health plan is a further step removed. In both the grandfathered and waiting period examples, the employer or plan sponsor has a contract with the issuer. In the case of an ICHRA, the issuer will not even interact with the employer because the employee will select and purchase the individual coverage independently. The issuer will likely not even know whether the employer has offered an account-based plan to reimburse for the cost of coverage or, if it did, whether the employee has or will be reimbursed.

As a result, BCBSA asks that the Agencies clarify that, whether an employer successfully complies with ICHRA, EBHRA, retiree-only HRA, or other account-based group health plan requirements, the individual health insurance coverage will not be subject to group market requirements, the issuer of the individual health insurance coverage will not be subject to any group health plan compliance requirements, and the issuer will be held harmless from any failure by the employer to satisfy the account-based plan group health plan requirements.

Issue #3: Medicare Secondary Payer Requirements

Recommendation #3:

The Agencies should clarify that a health insurance issuer providing individual market health coverage purchased with an ICHRA need not comply with Medicare Secondary Payer reporting requirements or pay for benefits primary to Medicare in situations where Medicare Secondary Payer rules might technically apply to an individual's group health plan. Specifically, the Agencies should state that an employer's failure to meet the Proposed Rule's ERISA safe harbor requirements will have no effect on an individual market health plan's Medicare Secondary Payer status.

Rationale #3:

It is well settled that HRAs are generally considered group health plans under the Medicare Secondary Payer rules and, thus, must usually pay benefits primary to Medicare when an

[16] 45 C.F.R. § 147.140(g)(1)(v)(C); 29 CFR § 2590.715-1251(g)(1)(v)(C).
[17] 45 C.F.R. § 147.116(g); 29 CFR § 2590.715-2708(g).

individual has both an HRA and Medicare coverage. The Proposed Rule provides that an ICHRA may be used to purchase coverage on the individual market. In that situation, the ICHRA would be used to purchase coverage, with the individual market plan actually paying for benefits. Thus, the individual market plan would be obligated to make payments pursuant to the individual's policy, as filed with state regulators, and would not necessarily know that the individual was part of an employer-sponsored group health plan. Under these circumstances, it would be exceedingly difficult for the individual market plan to comply with the Medicare Secondary Payer rules insofar as they require both reporting and payment primary to Medicare.

The Agencies should follow the same general approach regarding Medicare Secondary Payer rules as they have with ERISA and clarify that individual coverage purchased through an ICHRA is not group health coverage subject to the Medicare Secondary Payer rules. As noted above, this approach alleviates the practical difficulties inherent in requiring individual health plans to follow the Medicare Secondary Payer rules. Furthermore, this approach comports with the plain language of the Medicare Secondary Payer statute and its implementing regulations, which require only that group health plans "not take into account" Medicare availability when making "benefits" determinations. *See* 42 U.S.C. § 1395y(b)(1)(A)(i); 42 C.F.R. § 411.172(a).

Where an employee uses an ICHRA to purchase individual insurance, the ICHRA, as a group health plan, would not be taking Medicare availability into account when making benefits determinations, since the ICHRA is merely being used to purchase insurance and itself makes no benefits determinations. Likewise, the individual market health plan actually making benefits determinations should not be considered a group health plan, since it is not sponsored or contributed to by an employer, and therefore should not be subject to the Medicare Secondary Payer requirements. Thus, for reasons both practical and legal, the agencies should make clear that the Medicare Secondary Payer statute does not apply to these individual market plans.

Moreover, even where individual coverage purchased with an ICHRA could be construed as a group health plan under ERISA pursuant to the Proposed Rule, the Agencies should not treat that individual coverage as subject to the Medicare Secondary Payer rules. The definition of group health plan applicable to the Medicare Secondary Payer statute, 42 U.S.C. § 1395y(b)(1)(A)(v), is different from that used in the ERISA context. Furthermore, as noted above, under the plain language of the Medicare Secondary Payer statute and its implementing regulations, individual market coverage purchased with an ICHRA should not be considered group health coverage subject to the Medicare Secondary Payer rules at all. Therefore, rather than falling into a regulatory safe harbor, the individual market coverage simply falls outside the reach of the Secondary Payer Rules entirely. The agencies should make this approach explicit, however, to provide guidance and certainty to individual market issuers.

Issue #4: Private Exchanges

The Proposed Rule includes a requirement that the employer does not select or endorse any particular issuer or insurance coverage for an ICHRA. Employers that decide to offer an HRA may wish to offer their employees coverage through a private exchange that makes coverage of a selected group of issuers available and it is not clear whether such an arrangement would be allowed under the requirements of the Proposed Rule.

Recommendation #4:

The Agencies have adopted many protections that ensure that the individual market risk pool is protected. Here too, the Agencies must ensure that private exchanges are not used in a manner that harms the risk pools or are anti-competitive and promotes one issuer over another. The Agencies can do this by specifying that an employer cannot use an ICHRA in conjunction with a plan purchased through a private exchange unless the private exchange is designed in such a way as not to constitute selection or endorsement by the employer. The Agencies should provide a design based safe harbor that would permit an employer to use private exchanges under appropriate circumstances, such as when an employer purchases a private exchange product from a third party and such product contains plans offered by multiple unaffiliated insurers that are available in the rating area(s) in which eligible employees reside (or such other area as may be specified by the Agencies) and these products are part of the single risk pool and thus subject to risk adjustment.

Rationale #4:

The Proposed Rule makes clear that the individual policies purchased with HRA funds shall not be part of the employer's group health plan if the employer does not select or endorse any particular issuer or any particular insurance coverage. Prop. Reg. 29 C.F.R. § 2510.3-1(l)(2). This anti-endorsement requirement is drawn from the existing ERISA exception for "voluntary" plans, whereby employers that meet certain regulatory conditions, including no endorsement, are not considered to have established or maintained an ERISA-covered plan.[18]

The Department of Labor has made clear that, to avoid an endorsement issue, the employer must remain "neutral" as to which insurance plans are offered to employees. This neutrality concept should apply to individual coverage offered via private exchanges. *See*, *e.g.*, 40 Fed. Reg. 34,526 (1975) ("employer neutrality is the key to the rationale for not treating such a program…as an employee benefit plan....").[19] In this context, employer neutrality would require that the employer not select the plans (or a subset thereof) offered on the private exchange, but instead works with a third party to purchase an exchange product that offers a choice of coverage from several issuers to employees. The third party should be independent of the issuers and the issuers should offer a range of products (such as HMO and PPO) to employees. *See generally* Dep't of Labor Op. No. 94–26A (1994).[20]

Finally, if the Agencies allow private exchanges, any products offered through them must be part of the single risk pool and thus subject to risk adjustment to protect against the potential for adverse selection.

[18] 29 C.F.R. § 2510.3-1(j)(3).
[19] *Thompson v. Am. Home Assur. Co.*, 95 F.3d 429, 436 (6th Cir. 1996).
[20] *Johnson v. Watts Regulator Co.*, 63 F.3d 1129, 1134 (1st Cir. 1995)

X. Enforcement

Issue: Enforcement Needs to be Adequate

As stated earlier, BCBSA appreciates the efforts of the Agencies in constructing appropriate guardrails in the Proposed Rule with respect to whom and under what conditions an ICHRA may be offered. The proposed guardrails are critical to preventing market segmentation. But these guardrails will only prevent market segmentation if there is effective oversight by the Agencies.

Recommendation:

The Agencies should clarify that the employer group health plan sponsor alone is responsible for compliance with the Proposed Rule, and that enforcement is subject to the normal enforcement scheme that governs Part VII of ERISA (including DOL audits, private litigation, and self-reporting on Form 8928).

Rationale:

As explained earlier in this letter, issuers are far removed from the employers who offer the ICHRAs and EBHRAs. In fact, the issuer will not even interact with the employer, because the employee will select and purchase the coverage independently. The issuer may not even know whether the employer has offered an account-based plan to reimburse for the cost of coverage, or if it did, whether the employee has been or will be reimbursed. As a result, BCBSA asks that the Agencies clarify that the employer group health plan sponsor alone – and not the issuer – is responsible for compliance with the Proposed Rule.

In addition, the Agencies have included all of the ICHRA and EBHRA requirements in Part VII of ERISA, which falls under the DOL's jurisdiction. The Agencies should provide a simple statement making clear that enforcement of the Proposed Rule is subject to the entire enforcement scheme that governs Part VII of ERISA. This includes DOL audits, private litigation, and self-reporting on Form 8928.

XI. Notice Requirements

Issue #1: Notice Does Not Address Issues Related to Persons Enrolled in Medicare

ICHRAs must provide written notices to each participant at least 90 days before the beginning of each plan year. The notice can include additional information but, at a minimum, must include eight specific pieces of information. Examples of required information include the maximum dollar amount for each participant, that participants must enroll in individual coverage (and that this coverage cannot be STLDI or excepted benefits), and explain the implications of the HRA on eligibility (or not) for premium tax credits through the exchanges. However, the notice does not discuss the fact that persons enrolled in Medicare, either the employee or a dependent, are not eligible to enroll in individual healthcare coverage and therefore cannot meet the requirements to benefit from an ICHRA.

Recommendation #1:

A disclosure should be added to the notice that persons who are enrolled in Medicare are not eligible to enroll in individual healthcare coverage and therefore cannot meet the requirements to benefit from an ICHRA.

Rationale #1:

Without a disclosure specific to persons enrolled in Medicare not being eligible for individual health insurance coverage these persons could mistakenly enroll in an ICHRA. In addition, they may forgo other coverage options, such as coverage under a spouse's coverage, which would better meet their needs.

Issue #2: Providing the Notice Along with Other Benefits Information.

The Preamble to the Proposed Rule suggests that some ICHRAs will provide the notice along with other benefits information, rather than separately, but does not explicitly state that this is permissible. Specifically, the Economic Impact and Paperwork Burden section states: "It is assumed that these notices would be provided along with other benefits information with no additional mailing cost." 83 Fed. Reg. 54454.

Recommendation #2:

The Agencies should clarify that it is permissible to provide the notice along with other benefits information, including disclosures required under ERISA and other federal laws. The best way to approach this would be to provide that electronic delivery is the default for providing notices.

Rationale #2:

ERISA, the ACA, and other federal laws impose numerous disclosure requirements on employers and group health plans, including requirements to provide summary plan descriptions, summary annual reports, and summaries of benefits and coverage (to name a few). To save on mailing costs, employers and group health plans often provide these notices together, often along with other benefits information (such as annual enrollment information). Permitting an ICHRA to provide the notice required under the Proposed Rule along with other benefits information would be consistent with current employer and group health plan practice and would be cost-effective for such plans.

This approach is consistent with executive orders directing the Agencies to reduce the burdens of regulatory requirements. Exec. Order No. 13765, relating to minimizing the economic burdens of the ACA, requires the heads of all executive departments and agencies with responsibilities under the ACA to "…minimize the unwarranted economic and regulatory burdens of the [ACA]…." 82 Fed. Reg. 8351 (January 24, 2017). This approach was echoed in a subsequent Executive Order stating that "…it is essential to manage the costs associated with the governmental imposition of private expenditures required to comply with Federal regulations." Exec. Order No. 13771, 82 Fed. Reg. 9339 (February 3, 2017).

Issue #3: Attestation Should Include Language Regarding Consequences of Not Having Individual Health Insurance Coverage

An employer providing an ICHRA must implement and comply with reasonable procedures to verify that individuals whose medical care expenses are reimbursable by the HRA are, or will be, enrolled in individual health insurance coverage during the plan year. This verification can be done by requiring the participant to provide:

- A document from a third party showing the participant and any dependents covered by the HRA are, or will be, enrolled in individual health insurance coverage; or

- An attestation that states that the participant and any dependents covered by the HRA are, or will be, enrolled in individual health insurance coverage, the date coverage began or will begin, and the name of the provider of the coverage.

However, the required attestation does not include the consequences to the participant if they are not enrolled in individual health insurance coverage.

Recommendation #3:

Any self-attestation should include language stating that for any month the person receives HRA funds and does not have individual market coverage the funds received from the HRA become taxable income and that falsely attesting to coverage is a tax violation that may be subject to additional penalties.

Rationale #3:

BCBSA recommends including potential consequences as a means of encouraging voluntarily cooperation with the ICHRA requirements Consumer education, coupled with adequate verification, will help decrease the potential for false reporting and will help ensure program integrity.

XII. New Special Enrollment Period

Issue: New Special Enrollment Period Related to HRAs and QSEHRAs

The Agencies propose a new Special Enrollment Period ("SEP") for individuals gaining access to an HRA or QSEHRA. Under the proposal, employees would be able to enroll in or change Qualified Health Plans ("QHPs") up to 60 days before or after gaining access to an HRA. Coverage would be effective the first of the month following plan selection or the first of the month following access to the HRA, depending on when the employee selects their plan. The Department of Health and Human Services ("HHS") seeks comments on these proposals.

HHS also specifically seeks comments on whether the proposed new SEP should be available to employees who are enrolled in an HRA or are provided a QSEHRA each year at the time their new health plan year starts if their health plan year does not align with the calendar year.

HHS notes that an annual SEP for these employees would allow them to enroll in or change to a new plan in response to updated information about their HRA or QSEHRA benefit.

Recommendation:

We agree with the Agencies that a new SEP will be necessary for employees gaining initial access to an HRA. For program integrity, we recommend that employees applying for the new SEP on ACA exchanges be required to provide documentation demonstrating when they gained or will gain access to an HRA or QSEHRA.

We do not support a recurring annual SEP for employees with non-calendar year benefits, as suggested in the Preamble to the Proposed Rule. Changes to an already-established HRA or QSEHRA should not trigger an SEP. However, if the SEP is expanded to allow QHP enrollments or plan changes in response to annual employer contribution changes, we urge the Agencies to limit triggering the SEP to contribution increases or decreases of greater than a *de minimis* amount (*e.g.*, $100 or more). In addition, enrollees using this SEP to change QHP coverage mid-year should be notified in their employer's open enrollment materials that their plan's accumulators, such as their deductible and out-of-pocket maximums, will restart on reenrollment.

Rationale:

The new SEP will be important so that employees can enroll in or change coverage in the individual market when they gain access to an HRA or QSEHRA. However, adding any SEP opportunity increases the risk of adverse selection, and so it will be important to verify eligibility for the new SEP, consistent with existing SEPs on the federal exchange. Likewise, expanding the SEP to allow enrollment and plan changes following mid-year HRA or QSEHRA contribution changes further increases the risk that employees will enroll in or upgrade their coverage in response to a diagnosis or need for care, driving up costs for everyone. Between their initial HRA or QSEHRA enrollment opportunity and the individual market's annual open enrollment, employees with non-calendar year benefits will have ample opportunities to enroll in or change coverage.

If HHS does opt to expand the SEP, it will be important to establish guardrails so that employees are not enrolling or changing plans every time their employer increases, for example, HRA contributions by $5 annually. A threshold of $100 for contribution changes is a reasonable amount to trigger a mid-year SEP. Exchanges would need to verify mid-year HRA contribution changes to ensure program integrity.

Regardless of whether the SEP is expanded, consumers considering changing their QHP coverage mid-year should be made aware that their deductibles and maximum-out-of-pocket accumulators would restart. A notice in their employer enrollment materials would help prevent consumers from being surprised by cost-sharing following a plan change.

XIII. Monitoring the Impact of the New HRAs

Issue: Impact of the Changes in the Final Rule on Prices in the Individual Market will be Uncertain

While the Proposed Rule has carefully constructed guardrails to protect the individual market from adverse selection, the ultimate impact is unknown both in terms of enrollment and the impact on the affordability of individual market coverage. As noted earlier, it is essential that the changes allowing ICHRA not harm the individual market.

Recommendation:

The Agencies should carefully monitor enrollment in the new HRAs, including tracking this by firm size, and the impact that ICHRA enrollees have on the affordability of individual market coverage. If ICHRAs are having a material negative impact on individual market pricing, modifications should be made to the ICHRA requirements.

Rationale:

As noted earlier, individual market coverage is only attractive as an option to group coverage if it is affordable. It will be important to understand how many persons are enrolling in ICHRAS and the impact these enrollees are having on the affordability of individual market pricing in order to make any necessary changes to the requirements.

XIV. Applicability Date

Issue: Applicability Date Is Jan. 1, 2020

The proposed applicability date is for plan years beginning Jan. 1, 2020, or later, but the finalized rule may not be published in time for issuers to include the impact in their 2020 pricing, particularly if changes are made to the guardrails.

Recommendation:

If the rule is not finalized and not published by April 2019 it should become effective no earlier than Jan. 1, 2021.

Rationale:

The proposed applicability date will not allow enough time to include an accurate impact of the HRA finalized rule in the rates for 2020 individual market coverage if such rules are not published by April 2019. Issuers need to understand the final details of the rule, including the final guardrails, so the impact can be reflected in pricing for individual market coverage.

If the rule is not finalized and published by April 2019 the effective date should be for plan years beginning on or after Jan. 1, 2021.