



December 28, 2018

Internal Revenue Service
U.S. Department of the Treasury
Room 5205
P.O. Box 7604
Ben Franklin Station
Washington, D.C. 20004

Re: REG 136724-17, Health Reimbursement Arrangements (HRAs) and Other Account-Based Group Health Plans

To Whom It May Concern:

The District of Columbia Health Benefit Exchange Authority (HBX) appreciates your consideration of our comments on Notice of Proposed Rulemaking (NPRM) REG 136724-17, issued by the U.S. Department of the Treasury, U.S. Department of Labor, and U.S. Department of Health and Human Services (Departments).

By way of background, HBX is a private-public partnership established by the District of Columbia (District) to develop and operate the District's on-line health insurance marketplace, DC Health Link (DCHealthLink.com). We cover approximately 100,000 people -- District residents and people who work for District small businesses. DC Health Link fosters competition and transparency in the private health insurance market, enabling individuals and small businesses to compare health insurance prices and benefits and to purchase affordable, quality health insurance. Since we opened for business, we have cut the uninsured rate by 50% and now more than 96% of District residents have health coverage.

HBX appreciates efforts to expand use of pre-tax dollars to help pay for quality health insurance. However, HBX is concerned that as proposed the rule will have unintended negative consequences on workers, will increase the number of people without health insurance, and will raise premiums for people with individual market coverage. Below are recommendations to improve the rule for your consideration.

Excepted Benefit HRAs

The Departments propose to create an "excepted benefit" HRA with a \$1,800 limit that employees can use to pay for short-term limited-duration (STLD) plans or excepted benefits – both of which are exempt from the Affordable Care Act's consumer protections and insurance market reforms.

HBX strongly opposes use of taxpayer dollars to subsidize the purchase of junk plans such as STLD plans. The Internal Revenue Code does not permit the preferential tax treatment of premiums for STLD plans. The Departments are exceeding their authority when they create an HRA to allow pre-tax dollars to pay for premiums of STLD plans. Furthermore, as a policy matter, HBX recommends that the federal government not encourage the growth of junk insurance because such plans discriminate against people with preexisting conditions, do not cover essential benefits like maternity or mental health services, and



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limit benefits through annual and lifetime caps. Proliferation of junk plans hurt ACA comprehensive coverage. According to Oliver Wyman actuaries studying the District's private market, if STLD plans proliferate in the District, claims costs would increase by 21.4% for people with ACA individual market coverage.¹ HBX recommends that the final rule not allow excepted benefit HRAs from including premiums for STLD plans as allowable expenses.

We appreciate and strongly support the requirement that in order to offer an excepted benefit HRA, an employer would also have to offer a group health plan. However, this requirement is not sufficient to guard against two negative consequences: adverse selection in group health plans and more uninsured people.

Adverse selection will occur within an employer's plan if healthier or younger employees decline group coverage in favor of only the excepted benefit HRA.² When young and healthy employees leave, premiums increase for workers who remain covered, which is also bad for employers. By requiring enrollment in a group health plan, the Administration could avoid causing premiums to increase.

Additionally, the proposal would increase the number of uninsured Americans. Excepted benefits include accident-only insurance and non-coordinated benefits like indemnity or disease-specific plans. These products are not designed as a substitute for group health plan coverage. Dropping or not enrolling in group health plan coverage and instead signing up only for excepted benefits means that people will be uninsured.

Also, some people may forego group health plan coverage not realizing that excepted benefits are not the same as quality health insurance. There is a long history of problems with some excepted benefits being bundled to look like major medical health insurance. Unscrupulous promoters market bundled products made to look like major medical as a cheaper substitute for major medical health insurance. For example, just last month (November 2018), the Federal Trade Commission (FTC) successfully shut down a nationwide scheme that collected more than \$100 million in premiums from consumers who needed major medical insurance. Promoters fraudulently marketed bundled hospital indemnity and other limited benefit plans as major medical insurance.³ A federal judge ordered the operations to halt, froze assets, and appointed a receiver. According to court documents, there are tens of thousands of victims and unpaid medical claims. Although states and federal regulators work hard to find and shut down misleading and fraudulent marketing practices, many consumers get hurt.⁴ As proposed, an inadvertent consequence of

¹ Oliver Wyman, *Potential Impact of Short-Term Limited Duration Plans*, April 11, 2018, <https://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/OWReview%20of%20Impact%20of%20Short%20Term%20Duration%20Plans%204.11.2018%20%28002%29.pdf>. Note this analysis also assumes repeal of the individual mandate. DC enacted a local responsibility requirement. According to the Oliver Wyman analysis having a local requirement mitigates the negative impact of STLD plans to increased claims cost of 3.1%.

² See Young, C.L., Levitis, J. and Fiedler, M., *Evaluating the Administration's Health Reimbursement Arrangement Proposal*, Brookings Center for Health Policy, Dec. 2018, https://www.brookings.edu/wp-content/uploads/2018/12/Linke-Young_Levitis_Fiedler_HRA-paper_12.11.18.pdf.

³ *Fed. Trade Comm'n v. Simple Health Plans, LLC, et al.*, Case No. 18-CV-62593 (S.D. FL. 2018). See also FTC Press Release, *FTC Halts Purveyors of Sham Health Insurance Plans*, Nov. 2, 2018, <https://www.ftc.gov/news-events/press-releases/2018/11/ftc-halts-purveyors-sham-health-insurance-plans>.

⁴ *Fed. Trade Comm'n v. Simple Health Plans, LLC, et al.*, Case No. 18-CV-62593 (S.D. FL. 2018). See also FTC Press Release, *FTC Halts Purveyors of Sham Health Insurance Plans*, Nov. 2, 2018, <https://www.ftc.gov/news-events/press-releases/2018/11/ftc-halts-purveyors-sham-health-insurance-plans>; Connecticut Dept. of Insur., "Health Discount Plans: Fact or Fraud?" http://www.ct.gov/cid/lib/cid/discount_plan.pdf; Pennsylvania Dept. of Insur., *Consumer Alert: Health Insurance Plans with Limited Benefits*, Oct. 2016, <https://www.insurance.pa.gov/Pages/Consumer%20Alerts/Limited-Benefits-Consumer-Alert.aspx>; Virginia State

the rule will be more victims. Requiring enrollment in a group health plan will prevent unsuspecting people from becoming victims.

Taxpayer dollars should not be used to subsidize excepted benefits. Without a requirement to enroll in a group health plan, the proposal would create a new population of uninsured people who forego their group health plan coverage to enroll in either bundled or stand-alone excepted benefits. To address these problems, HBX recommends that in the final rule, the Departments require enrollment in a group health plan to qualify for an excepted benefit HRA.

HRAs Integrated with Individual Market Coverage

The Departments propose allowing employers to provide an HRA for employees to purchase individual market coverage (“integrated individual market HRA”) including qualified health plan coverage through state-based and the federal marketplaces. HBX supports additional funding for individual market premiums, but is concerned about unintended negative consequences of the proposed rule.

Harm to Consumers with an Integrated HRA from an Employer

There may be unintended consequences. The proposed rule allows a consumer offered an HRA to access APTC only if the HRA amount makes coverage unaffordable. This proposal would create a hardship especially for moderate income people who can afford to stay covered only because their monthly premiums are reduced through APTC. If lower and moderate income people are forced to pay 100% of the monthly premium upfront and wait for HRA reimbursement, such taxpayers may lose or forgo their individual marketplace coverage and become uninsured.

HBX recommends that individuals be able to receive APTC without regard to the offer of an HRA. Importantly, making both APTC and an HRA available will help make individual health insurance premiums more affordable and will minimize the risk of people losing coverage because they cannot pay 100% of premium upfront.

If the final rule does not allow for an HRA to be available in addition to APTC, then HBX recommends making the standard for affordability consistent with the Qualified Small Employer HRA that is in current law. As proposed, the rule creates a new and different affordability test, which will leave consumers worse off than using the existing affordability standards.

The proposed standard to determine affordability is whether the applicant, given the HRA, could purchase the lowest-cost silver plan for self-only coverage for less than a specific percent of his or her household income (9.86% in 2019).⁵ This proposed standard is different from the affordability standard used for the Qualified Small Employer HRA option. Under the Qualified Small Employer HRA, the APTC eligibility calculation applies the *second* lowest cost silver plan. Tying affordability to the lowest cost silver plan leaves consumers worse off than using the second lowest silver plan. For example, assuming the lowest cost silver plan is \$500 and the second lowest cost silver plan is \$550, a person with income of \$28,000 (approximately 250% of the federal poverty level) with an HRA of \$3,600 would not be eligible for APTC using the lowest cost silver affordability standard.⁶ However, if the second lowest cost silver plan

Corp. Comm’n, *SCC Bureau of Insur. Advises Virginians Regarding Short-term or Limited Benefit Health Insurance Policies*, Nov. 30, 2017, https://www.scc.virginia.gov/newsrel/i_aca_17.aspx.

⁵ I.R.S. Rev. Proc. 2018-34.

⁶ Using a similar scenario from the Departments’ proposed rule. 83 Fed. Reg. 54420 at 54460.

<https://www.federalregister.gov/documents/2018/10/29/2018-23183/health-reimbursement-arrangements-and-other-account-based-group-health-plans>.

affordability standard is used, then that person would be eligible for APTC in the amount of \$4,260, which is \$660 more than the \$3,600 HRA.

HBX recommends the second lowest cost silver plan be used as the benchmark for affordability determinations, rather than the current proposal to use the lowest cost silver plan. This change would be better for consumers and would ensure a consistent standard for both Qualified Small Employer HRAs and integrated individual market HRAs.

Harm to individual markets

The Departments estimate that 6.8 million people will shift out of the employer group markets into the individual market and a total of 10.7 million people will be added to the individual market by 2028 using the integrated individual market HRA. Recognizing that the new HRA could result in negative impact if employers design HRA offerings to shed their costs for older and sicker employees, the proposal sets standards to prevent dumping of sicker workers into the individual market. The proposed rule seeks to prevent dumping of bad risk by requiring employers to establish classes for eligibility based on the following: (1) full-time employment; (2) part-time employment; (3) seasonal employment; (4) membership in a collective bargaining unit; (5) not having satisfied a waiting period for coverage eligibility; (6) not having attained age 25; (7) being a non-resident alien; and (8) rating area of employment.

We strongly support the effort to prevent dumping of sicker employees. However, even if finalized, these standards would not be sufficient to prevent dumping. For example, an employer could shift workers to the individual market for any high cost geographic area. The proposed standard allows eligibility to be based on geographic area.⁷ Sicker workers will likely buy individual coverage because they need insurance, while healthier workers would not. The employer would no longer have the cost of providing coverage in a high cost geographic area and would no longer have to pay for sicker workers in such areas. Consequently, premiums would increase for people in the individual markets.

Even a relatively minor shift of higher-cost people to state individual markets including the District's individual market will negatively impact claim costs and will increase premiums for individuals. In the District, if merely 100 people who are high cost leave job-based coverage and enroll in individual health insurance, claims costs will increase by 8.9% and **by 24.4%** if approximately 800 high cost people enroll.⁸

Adding close to 11 million people to an existing individual market of approximately 15 million people could destroy the individual markets everywhere if employers dump their sickest people.⁹ Even assuming that the final rule will have strong safeguards against dumping and the IRS will have strong enforcement of those safeguards, there is still a risk that some employers will decide to stop offering group health

⁷ See Young, C.L., Levitis, J. and Fiedler, M, *Evaluating the Administration's Health Reimbursement Arrangement Proposal*, Brookings Center for Health Policy, Dec. 2018, https://www.brookings.edu/wp-content/uploads/2018/12/Linke-Young_Levitis_Fiedler_HRA-paper_12.11.18.pdf.

⁸ Oliver Wyman, *Potential Impact of ACA Enrollees Moving From Other States to the District of Columbia*, Nov, 9, 2018, https://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/DC_HBX_Comment_CMS-9936-NC%20Attachment%20A.pdf.

⁹ See Kaiser Family Foundation, *Data Note: Changes in Enrollment in the Individual Health Insurance Market*, July 31, 2018, https://www.kff.org/health-reform/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market/?utm_campaign=KFF-2018-July-Health-Reform-Individual-Insurance-Market-Enrollment%20-%20clone&utm_source=hs_email&utm_medium=email&utm_content=2&hsenc=p2ANqtz-_KVZesGa14vLV_ORYDI_kiFxoHkTbafw1j_o6Y9jvEuF00UOvKTDODBFTEgpCBNoCB9IO5A13WkGu7wofa9cDEwRLRbw&hsmi=2.

plans altogether and instead offer integrated HRAs to all their workers. According to researchers at Brookings, the risk is greatest in states with relatively young and healthy individual market risk pools.¹⁰ Employers with older and sicker employees could discontinue their group health plans for all workers. And if enough sicker firms are part of the 11 million new participants in the individual market, then individual markets everywhere will collapse.

Given the potential for this new HRA option to shift higher cost individuals to the individual market, HBX urges the Departments to delay finalizing the proposed rule until the Departments conduct more analysis on the risk mix of the estimated 11 million people that would come in (or be dumped) into individual markets. Additional analysis would also enable proper standards to be put in place to address this unintended consequence.

Major Exchange Operational Effort and Cost

The proposed rule allows a consumer to keep APTC only if the HRA amount makes coverage unaffordable. The proposal requires state-based marketplaces (SBMs) and the Federally Facilitated Marketplace (FFM) to determine whether a QHP would be unaffordable. The proposal also creates a new special enrollment period (SEP), which SBMs would have to administer.

To implement these new responsibilities, SBMs including HBX would have to change IT systems, which adds new cost and also takes time to implement. Changing IT requires, at a minimum, developing specifications for IT vendors for a new APTC eligibility calculation and a new SEP, and developing and testing functionality for the new APTC eligibility calculation and SEP. The IT design is not as simple as asking whether a person qualifies for an integrated individual market HRA, which is not a term that most people would understand. The IT design would require adding new questions to the application for APTC and new “help text” explaining terms in the application. It is a challenge to draft user-friendly questions about HRAs that consumers understand and that prompt accurate responses. Through user testing, questions can be refined and tailored, but user testing also takes time and is an expense. The IT design also includes adding additional affordability calculation logic, adding a new table of lowest cost silver plan data since this is not used in any other calculation, adding logic to check if the employee-only lowest cost silver plan less the value of the integrated individual market HRA is above or below the expected contribution percent, calculating and denying eligibility based on new rules, and creating and adding new notices within the IT system for this new class of denials.

In addition to implementing complex new eligibility rules, the proposal also requires adjusting the IT roadmap and delaying other new functionality and automation already planned, finding funding (this is not currently budgeted by HBX for FY2019 or the FY2020 proposed budget), paying for estimates for development cost (level of effort), and negotiating cost.

The proposal also adds new operational costs. HBX will need to increase staffing levels for administration, training, and oversight. For example, contact center staff currently do not answer questions related to employer-healthcare accounts. Also, most customers are unlikely to understand the differences between the various types of healthcare accounts that their employer may offer. When a customer calls to ask about how to answer questions about HRAs in the application for APTC, call center representatives will have to assist. Call center customer service representatives will have to be trained to understand different types of tax accounts including health savings accounts, health flexible savings accounts, traditional health reimbursement arrangements, Qualified Small Employer HRAs, the new

¹⁰ Young, C.L., Levitis, J. and Fiedler, M, *Evaluating the Administration’s Health Reimbursement Arrangement Proposal*, Brookings Center for Health Policy, Dec. 2018, available at https://www.brookings.edu/wp-content/uploads/2018/12/Linke-Young_Levitis_Fiedler_HRA-paper_12.11.18.pdf

integrated individual market HRAs and the new excepted benefit HRAs in order to assist potential customers. HBX will incur costs for tax consultants to develop and administer training. Also, costs for the call center may increase because higher skilled customer service representatives may be needed to answer accurately questions about various tax preferred healthcare accounts. HBX will also need to develop and provide training for business partners, navigators and assisters, and brokers on the HRAs and rules around each type. There will also be a need for additional staff to handle more complex cases; for example, working with a consumer and reviewing an employer's plan documents to figure out whether the consumer being offered an HRA is eligible to purchase marketplace coverage. Handling internal appeals related to the new SEP may also require additional staff. For APTC eligibility appeals, HBX will need to develop and provide training to administrative law judges responsible for appeals from agency decisions.

The proposed rule requires SBMs to make IT and operational changes by November 2019 when open enrollment for plan year 2020 begins. HBX is continuing to calculate costs, but estimates a significant expense given the scope and complexity of the proposal. Additionally, given the complexity of the integrated individual market HRA rules around APTC eligibility, any changes would need to be thoroughly tested with consumers. Considering the timeframe and the complexity of the policies, the implementation timeframe in the proposal is not reasonable. Also, none of these new requirements are budgeted for by HBX or other SBMs.

HBX requests an effective date of at least 2021 to allow time for IT changes and implementation. HBX also recommends that the Departments conduct a cost benefit analysis. The analysis should compare costs for marketplaces for IT changes and operational implementation and administration to cost to the IRS if the IRS administered. The Departments should also compare IT and operational costs for states to an approach recommended above, which is to allow both APTC and HRAs to make individual market coverage more affordable.

Conclusion

HBX supports efforts to increase options for employers to provide affordable, quality health insurance to workers. However, we are concerned with the unintended negative consequences on workers and consumers in the individual market. Thank you for considering our recommendations.

Sincerely,



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