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Requirements for Group Health Plans and Health Insurance Issuers under the Patient Protect on and Affordable Care Act

Comment On: IRS-2010-0015-0002
Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and PatientProtections

Document: IRS-2010-0015-0020
Comment on FR Doc # 2010-15278

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Government Agency: IRS

General Comment

See attached file(s)

Attachments

IRS-2010-0015-0020.1: Comment on FR Doc # 2010-15278

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August 27, 2010

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VIA RULEMAKING PORTAL
CC:PA:LPD:PR (REG-120399-10)
Room 5205
Internal Revenue Service
PO Box 7604
Ben Franklin Station
Washington, DC 20044
Regarding: Notice 2010-44

Dear Sir/Madam:

We have been asked to submit comments regarding Reg-120399-10 as reprinted in the Federal Register, Vol. 75, No. 123 (Monday, June 28, 2010) (the Interim Final Rule). More specifically, we have been asked by Meritain Health, Inc. ("Meritain") to address the treatment of health reimbursement arrangements (HRAs) under Section 2711 of the Public Health Service Act (PHSA) which generally prohibits annual or lifetime limitations under a medical plan that is subject to PPACA's provisions. This provision was added to the PHSA by the Patient Protection and Affordable Care Act (Public Law 11-148 or "PPACA") and incorporated into the Internal Revenue Code (Code) by Code Section 9815(a)(1) and into the Employee Retirement Income Security Act (ERISA) by ERISA Section 715(a)(1).

Meritain is a third party administrator that provides claims processing services for a variety HRA plan sponsors, including governmental, religious, and non-profit plan sponsors. Meritain services over 4 million members nationwide, across all industry sectors.

As discussed more fully herein, we believe that the agencies' exclusion of most HRA arrangements (i.e., because they are flexible spending arrangements as described in Section 106 of the Code) from the prohibition on annual caps is a step in the right direction. However, we believe that HRAs do not violate the annual cap prohibition in the first instance because HRAs (whether stand-alone or integrated with other coverage) do not have an annual cap on benefits. Thus, HRAs should be excluded in all cases. Moreover, given the nature of HRA benefits as employer-funded supplemental benefits,

all HRAs should be exempt, as such arrangements are not the type of comprehensive health care intended to be regulated under PPACA.

Alternatively, if the agencies do not exclude all HRAs from PPACA, we believe that it is critical that the agencies:

i) codify the exceptions recognized in the preamble to the Interim Final Rule (i.e., for retiree only, excepted benefit, and integrated HRAs) ;
ii) further clarify that an HRA is exempt from PPACA's annual benefit maximum prohibition whenever it is offered in conjunction with primary medical coverage that complies with PPACA – regardless of whether the HRA is formally part of the same plan as the underlying PPACA compliant coverage.
iii) Clarify that, for purposes of the Code Section 106 flexible spending arrangement exception (the "5 Times Rule"), the HRA should be analyzed on an aggregate (plan-wide) basis rather than on a participant by participant basis. [This is consistent with guidance provided by IRS in Notice 2002-45, 2002 IRB 93, Part VII.]

Finally, for any HRA arrangements that are not found to be exempt from PPACA's annual maximum prohibition, we believe that transition relief should be allowed for currently covered individuals. Such an approach would ensure that existing HRA accruals can be applied toward eligible expenses rather than forfeited (jeopardizing participant interests) as a result of this new PPACA provision.

Background on HRAs

A health reimbursement arrangement (or HRA) is an employer-funded arrangement that reimburses employees for certain medical care expenses incurred by employees and their eligible dependents.[1]. Typically, an employer creates a notional (i.e., unfunded) HRA account for each participating employee and then reimburses the employee for substantiated, qualified medical expenses up to the employee's HRA account balance at the time a claim is submitted. Under applicable tax rules, an HRA must be paid for solely by the employer and may not be funded by employees through salary reduction under a cafeteria plan. IRS authority recognizes that HRAs can be flexible spending arrangements (or FSAs) as defined in Section 106(c)(2) of the Code,[2] and indeed most HRA arrangements qualify as FSAs.

HRAs have been recognized as an important tool in encouraging efficient utilization of health care resources. Many major employers (including the federal government) have

[1] While HRAs are governed by several Code Sections (e.g., IRC 105, 106), HRAs are a creation of IRS agency guidance. Specifically, IRS Revenue Ruling 2002-41, 2001-28 I.R.B. 75 (July 15, 2002) and IRS Notice 2002-45, 2002-38 I.R.B. 93 (July 15, 2002) define and provide the operating rules for HRAs.
[2] See IRS Notice 2002-45, 2002-38 I.R.B. 93 (July 15, 2002), part II.

implemented an HRA arrangement for their employees. Indeed, a recent GAO Report recognizes that:

> On average, enrollees in the HRA groups of both employers GAO reviewed spent less and generally used fewer health care services before they switched into the HRA in 2003 than those who remained in the PPO, suggesting that the HRA groups were healthier. Average annual spending per enrollee for the public employer's HRA group was $1,505 lower than the PPO group for the 2-year period prior to switching. (Spending for the public employer was based on analysis of both medical and pharmacy claims.) Likewise, the private employer's HRA group spent $566 less per enrollee for the 2-year period prior to switching than the PPO group (we were not able to examine pharmacy claims for the private employer). Similarly, of the 21 studies GAO reviewed that assessed the health status of HRA and other CDHP enrollees, 18 found they were healthier than traditional plan enrollees based on utilization of health care services, self-reported health status, or the prevalence of certain diseases or disease indicators.[3]

HRAs are most often offered as an additional employer-funded benefit to employees who have primary health coverage from another plan. In many cases, the HRA operates essentially as a "deductible reducer", reducing employee exposure to out-of-pocket costs while simultaneously encouraging prudent health care expenditures through fostering a sense of employee "ownership" in the account. HRA coverage is often made available to retirees and, in some cases, employers (both public and private) pre-fund future HRA benefits by contributing an amount to a trust (e.g., a VEBA or Section 115 governmental trust) account.

Treatment of HRAs Under Interim Final Rule

The Interim Final Rule addresses HRAs in the preamble as follows:

> When HRAs are integrated with other coverage as part of a group health plan and the other coverage alone would comply with the requirements of PHS Act section 2711, the fact that benefits under the HRA by itself are limited does not violate PHS Act section 2711 because the combined benefit satisfies the requirements. Also, in the case of a stand-alone HRA that is limited to retirees, the exemption from the requirements of ERISA and the Code relating to the Affordable Care Act for plans with fewer than two current employees means that the retiree-only HRA is generally not subject to the rules in PHS Act section 2711 relating to annual limits. The Departments request comments regarding the application of PHS Act section 2711 to stand-alone HRAs that are not retiree-only plans.

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[3] Consumer-Directed Health Plans: Health Status, Spending, and Utilization of Enrollees in Plans Based on Health Reimbursement Arrangements, GAO-10-616 July 16, 2010, at http://www.gao.gov/products/GAO-10-616

Thus, based on this discussion, and prior guidance included in the grandfather regulations, it seems clear that the following HRAs are exempt from the PPACA annual maximum prohibition:

i) HRAs that are "integrated" with other coverage that complies with PPACA requirements;
ii) HRAs that are limited to certain excepted benefit (e.g., vision or dental) coverage; and
iii) HRAs that are restricted to retirees.

It would help to specifically codify these exceptions in the regulations (rather than merely addressing the exceptions in the preamble).

Perhaps more importantly, the Interim Final Rule specifically provides that arrangements that are flexible spending arrangements (FSAs) as defined in Code Section 106 are exempt from PPACA's annual maximum prohibition. See 54.9815-2711T(a)(2)(ii). A "flexible spending arrangement" is defined in Code § 106(c)(2) as follows:

> A flexible spending arrangement is a benefit program which provides employees with coverage under which— (A) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and
>
> (B) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage.

As recognized by the IRS in its 2002 HRA guidance, this FSA definition is not restricted to traditional salary reduction funded "use it or lose it" FSAs, but rather also includes many health reimbursement arrangements (HRAs). We discus below helpful clarification with regard to how this "5 Times Rule" should be applied on an HRA plan-wide basis – rather than on an individual account basis.

Specific Requests/Comments

i) HRAs Should be Exempt From the PPACA's Annual Limit Prohibition

As noted above, HRAs are funded 100% by employers and are most often offered to supplement primary coverage that an individual has through employment, a spouse's employment, or another source. HRAs, by plan design, provide benefits based on the individual employee's "account level" at the time a claim is incurred. This account level varies from participant to participant based upon a number of factors such as historical claims and accruals, length of participation in the arrangement, and the presence of any

additional employer contributions through wellness or other health incentive programs. This plan design feature is distinguishable from an annual cap (e.g., "No more than $1,000 in claims may be paid per year") since the additional accruals (whether pre-scheduled monthly accruals or wellness incentives) can at any time provide additional coverage under the Plan. As a result, we believe that the HRA account balance (as distinguished from an annual cap) is not the type of annual financial limitation intended to be addressed by PPACA.

Moreover, in most cases, after 2014, neither employers nor individuals will seek to satisfy their minimum essential benefit coverage obligation through an HRA. Rather, the HRA will serve as an additional supplemental benefit (which incidentally is 100% employer funded) that will help the employee satisfy their out-of-pocket financial obligations. Making HRAs subject to the annual limitation prohibition will discourage many employers from offering such benefits to employees. At a minimum, the agencies should implement a "waiver program" similar to that established for other limited medical benefit programs to allow employer-funded HRAs to proliferate and ensure that enforcement of the annual limit prohibition does not cause employers to reduce or eliminate HRA benefits.

ii) Agencies Should Codify the Exceptions Recognized in the Preamble

The preamble to the Interim Final Rule recognizes that certain HRAs (i.e., for retiree only, excepted benefit, and integrated HRAs) would be exempt from the annual limit prohibition. To ensure that these exceptions are properly recognized, they should be codified into the final rule.

iii) Agencies Should Further Clarify that an HRA is Exempt from PPACA's Annual Benefit Maximum Prohibition Whenever Offered in Conjunction With Any PPACA-Compliant Primary Medical Coverage

As noted above, HRAs are most often offered in conjunction with primary coverage. In some cases this coverage may be through the same plan of the employer, in other cases it may be a separate stand-alone plan sponsored by the same employer or another employer (e.g., a spouse's employer). The critical factor here is that the individual has primary coverage from some other source, and that the HRA operates effectively as an employer-provided supplement to that other coverage. The preamble to the Interim Final Rule provides that an HRA that is integrated with another PPACA compliant plan would not violate PPACA's annual limit requirement. However, if "integration" is interpreted to require that the HRA be part of the same ERISA plan as the primary coverage, the approach would overlook the fairly common practice of offering an HRA as a coverage supplement regardless of where the primary coverage is obtained. We think that a better rule would be to find that an HRA is considered compliant with the annual limitation prohibition whenever an individual has other primary coverage that satisfies the essential benefit requirement from any source, or has access to such coverage through their

employer (regardless of whether they elect such coverage). This change would enable employers to continue to offer HRAs to their eligible employees without requiring that the HRA be part of the same plan as the primary coverage or that the employee select (potentially inferior or duplicative) coverage under the employer's plan merely to preserve HRA eligibility.

iv) ***Agencies Should Clarify That An HRA Qualifies as an FSA Plan on a Plan-Wide Basis Rather than on a Participant by Participant Basis.***

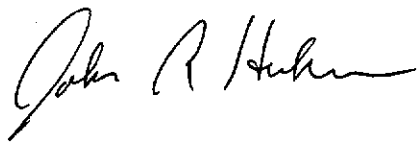
As noted above, HRAs that qualify as FSAs under Code Section 106 are exempt from the annual limitation prohibition. For purposes of the Code Section 106 FSA definition, an arrangement will qualify as an FSA if "the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage" (i.e., "5 Times Rule"). Unfortunately, very little guidance exists as to how to calculate the cost of coverage for an HRA. What little guidance there is indicates that the annual cost of coverage for an HRA arrangement (and compliance with the 5 Times Rule) should be based on the experience of the HRA arrangement as a whole, rather than on an individual account by account basis. [See IRS Notice 2002-45, 2002 IRB 93, Part VII.]. Under this rule, the HRA should be exempt whenever the aggregate projected claims (under the actuarial method for determining COBRA rates) or past claims for the preceding year (under the past cost method) exceed 20% of the aggregate maximum HRA benefit available under the arrangement. Incorporation of this type of "blended" approach (as allowed under existing IRS guidance for COBRA purposes) would enable employer/plan sponsors to determine on an HRA plan wide basis whether the arrangement is subject to PPACA's annual limitation prohibition.

v) ***Need for Transition Relief***

Finally, for any HRA arrangements that are not found to be exempt from PPACA's annual maximum prohibition we believe that transition relief should be allowed for currently covered individuals. Such an approach would ensure that existing HRA accruals can be applied toward eligible expenses rather than forfeited (jeopardizing participant interests) as a result of this new PPACA provision.

If we can be of further assistance with regard to any of the issues discussed herein, please contact the undersigned.

Sincerely,



John R. Hickman

JRH:rps
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