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Requirements for Group Health Plans and Health Insurance Issuers under the Patient Protection 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-2010-0015-0023
Comment on FR Doc # 2010-15278

Submitter Information

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General Comment

Dear Sir or Madam: Please find attached comment letter regarding the referenced Interim Final Rule, submitted on behalf of HRA Administrator, LLC, a wholly-owned subsidiary of The Variable Annuity Life Insurance Company (VALIC).

Attachments

IRS-2010-0015-0023.1: Comment on FR Doc # 2010-15278

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CC:PA:LPD:PR (REG-120399-10)
Room 5205, Internal Revenue Service
P.O. Box 7604
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Washington, D.C. 20044

Re: REG-120399-10

Dear Sir or Madam:

On behalf of HRA Administrator, LLC, a wholly-owned subsidiary of The Variable Annuity Life Insurance Company, we offer our comments on the above-referenced interim final regulations, published in the Federal Register on June 28, 2010 and implementing the rules for group health plans and issuers under the Patient Protection and Affordable Care Act (PPACA) regarding preexisting condition exclusions, lifetime and annual dollar limits on benefits, rescissions, and patient protections (the "Interim Final Rule").

As specifically requested in the preamble to the Interim Final Rule, our comments relate to the applicability of the lifetime and annual dollar limits on Health Reimbursement Arrangements (HRAs), a type of account-based health plan that typically consists of a contribution by an employer to reimburse medical expenses for the year up to a certain amount.

Introduction

HRAs may be either funded or unfunded by an employer. Unfunded HRAs consist of a promise by the employer to reimburse medical expenses for the year up to a certain amount. Funded HRAs typically consist of an employer contribution, or a mandatory, employee contribution made into the HRA account, which contribution amount is made available either immediately or upon the satisfaction of certain conditions (vesting requirements, for example) to be withdrawn by the employee to reimburse medical expenses for the year.

The definition of HRAs as set forth in applicable IRS guidance limits the overall available benefit to the aggregate funded or notional amount contributed and allows unused amounts to be carried forward to future coverage periods.[1] Thus, the total amount available for reimbursement at any time is capped based upon the aggregate amounts promised year-to-year (less the total amounts claimed) - in the case of unfunded HRAs - or the actual funded balance in the HRA account - in the case of funded HRAs. Also, both funded and unfunded HRAs allow unused amounts for each year to carry over for reimbursement of medical expenses in future years. Many non-retiree HRAs (or HRAs offered to active employees) apply annual reimbursement limits in order to encourage savings of carry-over amounts and to increase the maximum coverage amount available to participants for future health care needs upon retirement.

In pertinent part, the Interim Final Rule implements Section 2711 of the Public Health Service Act (PHSA) which, as added by PPACA, prohibits group health plans from imposing lifetime or annual limits on the dollar value of health benefits (the "Financial Cap Prohibition"). The Financial Cap Prohibition is designed for the vast majority of traditional group health plans, which promise coverage for specified defined benefits (e.g., hospital benefits, outpatient benefits, preventive services benefits, etc.), often with specified limits on the amount of benefits available under the program (a "DB Health Program").

We respectfully submit that the Service should extend to HRAs the exemption from the Financial Cap Prohibition that is already available under the Interim Final Rule for other, very similar types of non-DB Health Programs such as health flexible spending arrangements (health FSAs), Medical Savings Accounts (MSAs) and Health Savings Accounts (HSAs).

In the event the Service does not extend the exemption from the Financial Cap Prohibition to all HRAs, we believe that the Service must at least provide significant regulatory assurance and elaboration with regard to the partial exemption of HRAs from the Financial Cap Prohibition which is only discussed in the preamble to the Interim Final Rule.[2]

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[1] *See* IRS Notice 2002-45, which states that "[a]n HRA is an arrangement that . . . provides reimbursements up to a *maximum dollar amount* for a coverage period and any unused portion of the *maximum dollar amount* at the end of the coverage period is carried forward to increase *the maximum reimbursement amount* in subsequent coverage periods (emphasis added).
[2] 75 FR 37190-91.

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Annual Reimbursement Limits for In-Service (or Non-retiree Plans) Encourage Savings of Health Care Dollars.

As stated in the introductory paragraphs above, many non-retiree HRAs apply annual limits to in-service reimbursements. This annual limit during active employment years does not work to penalize the participant as with a DB Health Program, because unused amounts are carried forward from year-to-year to increase the maximum reimbursement amount available in subsequent years upon retirement. In addition, the tax-advantaged structure of HRAs that are funded in tax-exempt trusts, such as Section 115 trusts for governmental employers or VEBAs, encourages participants to save unused amounts, investing those dollars on a tax-exempt basis, making available to the participant increased amounts of health care dollars in retirement years. The additional application of annual limits applied for active or in-service employees furthers this goal.

Discussions in Preamble to the Interim Final Rule

In the preamble to the Interim Final Rules, the Service, the Department of Health and Human Services and the Department of Labor provided the following discussion of HRAs:

> 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.

In addition, the preamble to the Interim Final Rules explains that certain other account-based arrangements such as Health Savings Accounts, Medical Savings Accounts and health FSAs are fully exempt from the Financial Cap Prohibition:

> The restriction on annual limits applies differently to certain account-based plans, especially where other rules apply to limit the benefits available. For example, under section 9005 of the Affordable Care Act, salary reduction contributions for health flexible spending arrangements (health FSAs) are specifically limited to $2,500 (indexed for inflation) per year, beginning with taxable years in 2013. These interim final regulations provide that the PHS Act section 2711 annual limit rules do not apply to health FSAs. The restrictions on annual limits also do not apply to Medical Savings Accounts (MSAs) under section 220 of the Code and Health Savings Accounts (HSAs) under section 223 of the Code. Both MSAs and HSAs generally are not treated as group health plans because the amounts available under the plans are available for both medical and nonmedical expenses. Moreover, annual contributions to MSAs and HSAs are subject to specific statutory provisions that require that the contributions be limited.

Requests for Modification of Interim Final Rule

We request that the final regulations extend an exemption from the Financial Cap Prohibition to all HRAs. We believe that a full exemption is warranted because the Financial Cap Prohibition is a solution designed specifically for DB Health Programs and, as such, does not serve the intended purpose when applied to non-DB Health Programs such as HRAs. In addition, HRAs are subject to a regulatory definition that requires that the maximum reimbursement amount be limited, similarly to MSAs and HSAs, which are currently exempted from the Financial Cap Prohibition.

If the Service declines to extend the exemption to all HRAs, we request that the Interim Final Rule be modified to indicate that HRAs qualify as FSAs on a plan-wide basis rather than on a participant-specific basis. The Interim Final Rule specifically states that flexible spending accounts (FSAs) as defined in Section 106 of the Code are exempt from the prohibition on annual limits under PPACA. As recognized by the IRS in its 2002 HRA guidance, this FSA definition is not limited to FSAs funded by salary-reduction, but also includes many HRAs. In specific, Code Section 106(c)(2) provides that 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" (the "5 Times Rule"). Unfortunately, very little guidance is available on calculation of the cost of coverage for an HRA.

What little guidance there is indicates that the annual cost of coverage for an HRA (and compliance with the 5 Times Rule) should be based on the experience of the HRA 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

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maximum HRA benefit available under the arrangement. A specific approval in the regulations 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.

If the Service declines to extend the exemption to all HRAs, we request that the Interim Final Rule be modified to clearly reflect the partial exemption discussed only in the preambles. More specifically, we believe that the preamble discussion quoted above warrants additional provisions in the Interim Final Rules to clearly provide for an exemption from the Financial Cap Prohibition for the following HRAs:

- HRAs that are integrated with a DB Health Program that already complies with the Financial Cap Prohibition;
- HRAs that are limited to certain excepted benefits (e.g., vision or dental) coverage; and
- HRAs that are restricted to retirees;

If the Service declines to extend the exemption to all HRAs, we request that the Interim Final Rule be modified to clarify that, for all HRAs (including stand-alone HRAs that are not retiree-only plans), the Financial Cap Prohibition does not affect the limitation or cap on the maximum reimbursement amount available. Specifically, we request that Interim Final Rule clarify that the maximum reimbursement amount available for funded or unfunded, stand-alone HRAs for non-retired employees, remains limited or capped based upon the aggregate amount of funded or notional amounts contributed by an employer, less the aggregate amount of reimbursements paid to the participant, notwithstanding the application of the Financial Cap Prohibition to annual and lifetime limits.

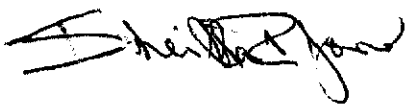
As an example of why this issue requires clarification, please consider the case of a stand-alone HRA account for which the employer funds $1,000 per year for each participant and has previously imposed a $500 per year annual limit on in-service reimbursements. In this plan, one participant has an aggregate funded or notional amount equal to $2,500 (taking into account annual employer contributions and unused, carry-over amounts), but such participant has elected not to enroll in the DB Health Program that would otherwise comply with the Financial Cap Prohibition. If the participant undergoes open-heart surgery during the coverage year with no other insurance coverage, (1) would such participant be entitled to reimbursement for eligible medical expenses in excess of the prior annual $500 limit ***but not more than*** the maximum amount available of $2,500, or (2) would the employer be liable to reimburse the participant for 100% of the eligible medical costs incurred from the surgery?

We respectfully submit that the result described in part (2) of the preceding sentence is not the intended result of the Financial Cap Prohibition and that the Interim Final Rule should be clarified to ensure that aggregate maximum dollar limits under HRAs (*i.e.* the amount equal to the funded account balance, for funded HRAs, or the aggregate notional amount less reimbursements paid out, for unfunded HRAs) are not affected by the Financial Cap Prohibition.

If the Service declines to extend the exemption to all HRAs, we request that the Interim Final Rule be modified to either grandfather HRAs that are not exempted or provide transition relief allowing these HRAs to be converted into retiree-only plans. Contributions into these stand-alone, in-service HRAs with annual limits were often based upon the expectation that most of the funds would used in retirement years, but with a desire on the part of the employer to provide some in-service benefits. A grandfathering of these HRAs or transitional relief allowing them to be converted to retiree-only plans would ensure that the funds remain in HRA accounts to be utilized by retired employees to assist in the increased cost of medical care in later years.

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

Sincerely,



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