TAKE COMMAND HEALTH

December 27, 2018

Room 5205, Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Submitted electronically to regulations.gov

**RE: Health Reimbursement Arrangements and Other Account-Based Group Health Plans [REG-136724-17]**

Dear Sir or Madam:

We are pleased to comment on the Proposed Rule regarding the availability of Health Reimbursement Arrangements and Other Account-Based Group Health Plans ("**HRA**"). We support your efforts to bolster competition and choice and provide employers with more healthcare options.

Our company, Take Command Health, provides cloud-based administration software for Qualified Small Employer Health Reimbursement Arrangements ("**QSEHRA**") and an online individual health plan shopping service to small employers and their employees. We are one of the only QSEHRA Administrators that is also licensed as an individual health brokerage firm (NPN: 18054712). Since QSEHRA became available in early 2017, we have helped over 800 small employers setup and administer a QSEHRA and over 2500 employees find and enroll in health insurance coverage under these arrangements. We are pleased to share our unique experience as a practitioner of HRA + individual insurance to help accelerate the adoption of Individual Coverage HRAs.

We believe the proposed rules, if finalized, present a great opportunity to provide employers additional flexibility to assist employees with health coverage. We have seen first-hand how the HRA approach promotes consumer choice and market competition and we believe these proposed rules will also help return healthy risk to the individual market. However, we've also seen first-hand how some employers that genuinely want to help their employees hit unexpected roadblocks and how others try to game the rules to discriminate unfairly. We want to share our experience, data, and case studies with you to assist as you formulate and consider the final rules.

Our comments will address:

- **Lessons learned from QSEHRA and opportunities to boost Individual Coverage HRA adoption:** Data and case studies on factors we've seen as a QSEHRA + Individual Insurance practitioner we believe can be addressed in the final rules to boost adoption of Individual Coverage HRAs in the broader market;

- **Requested Comments:** Our thoughts on select areas of proposed rules you requested; and
- **Other Practical Ideas to boost Individual Coverage HRA adoption.**

In summary, there are two critical areas we believe must be addressed in the finalized rules to spur Individual Coverage HRA adoption:

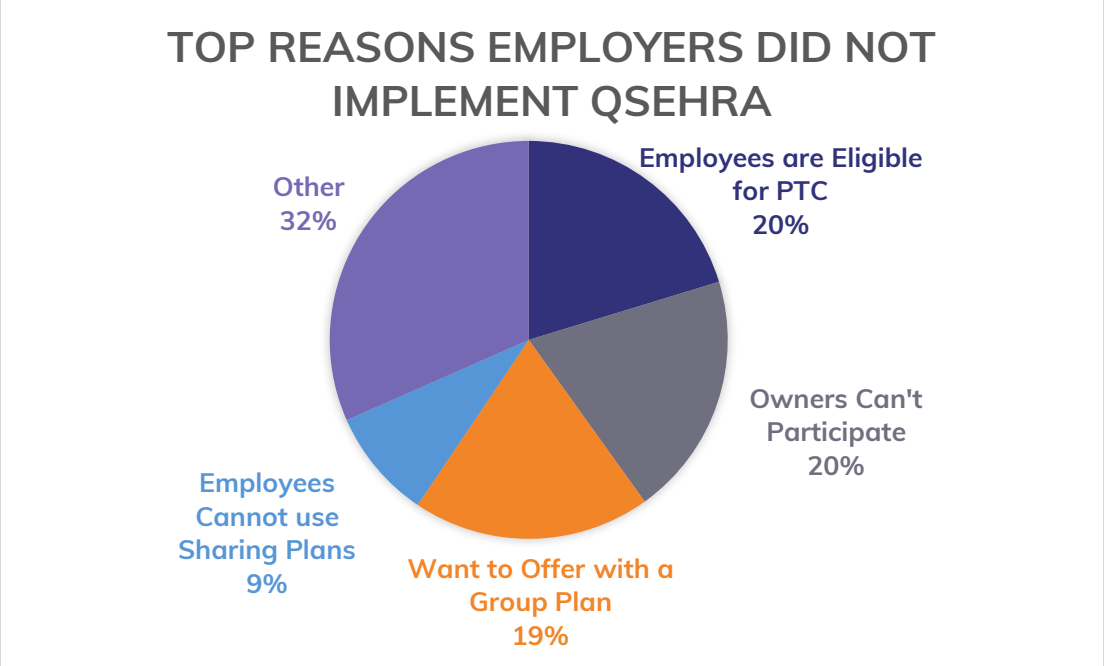
1. Employees otherwise eligible for a Premium Tax Credit (PTC) must be allowed to opt-out of the HRA *regardless of whether or not* the HRA is "affordable";
2. Additional "classes" of employees will need to be allowed to meet the practical needs of employers—including classes based on employee "title" or "role".

We share more on these ideas and provide data and supporting case studies in the sections below.

## Lessons Learned from QSEHRA: Opportunities to Boost Individual Coverage HRA Adoption

QSEHRA has been an effective solution for many small employers, but its rules made it too restrictive to service a broad range of employers. In addition to the 800 employers we've helped with QSEHRA, we've also spoken with over 2,000 well qualified employers that were drawn to the idea of tax-advantaged reimbursement for individual insurance but ultimately determined QSEHRA's rules or the regulatory language made QSEHRA impractical or unworkable.

We've tracked the reasons these employers were not able to implement a QSEHRA and want to share some of their stories with you. The chart below provides a summary of the reasons otherwise qualified employers were not able to implement a QSEHRA:



In the following pages, we'll discuss these categories and provide case studies and examples from Take Command Health clients that sought to provides the benefits of a an QSEHRA but ultimately determined it would not benefit the company or its employees.

## Employees are Eligible for Premium Tax Credits

Under the 21st Century Cures Act and implementing regulations, an employer that merely offers a QSEHRA reduces available premium tax credits ("**PTC**") for employees eligible to receive a PTC. QSEHRA rules and regulations also prohibit employees from "opting out" from QSEHRA. As a result, we've found in practice QSEHRA only works for employers that employ high-income professionals only.

In our opinion, this "offsetting" design between QSEHRA contributions and PTC severely curtailed the applicability of QSEHRA to many small employers, especially ones that employ even a few middle-class or low-income employees. For example, we were working with a small architecture firm to setup a QSEHRA to reimburse $400/mo for the 3 architects and 1 assistant. The 3 architects made too much income to receive PTC, but their assistant (a single mom with dependents) was likely to receive a very large tax credit, offsetting the full value of the $400 the employer was willing to offer. The employer was discouraged he was not actually helping his assistant and as a result, decided to not offer the QSEHRA.

This example represents a common roadblock—a business owner eager to help his or her employees becomes disincentivized when he or she realizes they are just replacing PTCs that would be available if they offered nothing.

The "opt-out" provisions provided in the proposed rules are a step in the right direction, ***but do not go far enough to help employees, especially middle-class and lower-income ones, that really would benefit from their company's contributions.*** We worry this will severely curtail adoption of Individual Coverage HRAs if not addressed. We suggest several solutions below.

Employers also express frustration that their contributions cannot be used separately for medical expenses by employees receiving PTCs without offsetting the PTC. Many employees receiving PTCs through an Exchange could still use help to pay for medical expenses, especially with plan deductibles getting higher and higher each year.

Finally, we are often asked by employers if they can offer employees likely to receive PTC a taxable reimbursement that's conditioned on the employee purchasing health insurance. Our understanding is this would trigger an Employer Payment Plan ("**EPP**") under IRS Notice 2013-54 and be disallowed. In our experience, employers will forgo offering any type of benefit to employees or will proceed with the taxable reimbursement as a practical work-around.

**To help Individual Coverage HRAs gain traction and be a viable solution for more employers, we *strongly suggest* that you consider permitting PTCs and HRA contributions be allowed to "stack" and for employees to be able to accept both on a pre-tax basis.**

If the above is impermissible, we would suggest the following three ideas:

1. **Allow employees to opt-out of the HRA and receive PTC even if the HRA is deemed "affordable".** Consider the following example: A single mom with two dependent children whose employer offers an Individual Coverage HRA. Based on the "affordability" calculations provided by the IRS in Notice 2018-88 which is based on employee-only coverage, the employer offers a $250/mo HRA contribution that is deemed "affordable" based on the safe harbors provided by the IRS. However, because the single mom employee has two eligible dependents, she would otherwise qualify for a much larger PTC and would be much better off purchasing coverage on the individual market for her and her children. As the proposed rules are written though, the employee would not be able to opt-out because the HRA is "affordable" even though she would be better off if her employer offered nothing. ***This would be a great opportunity to help close the "family loophole" that has been problematic with the ACA.***

2. **Allow Individual Coverage HRA contributions to help cover "qualified medical expenses only" or "excepted benefits only" for employees also receiving a PTC.** For example, consider the same single mom employee mentioned above. Assume based on her income and family size, she would qualify for a $600/month PTC to purchase coverage through an Exchange. Her employer offers an Individual Coverage HRA of $250/month. If the $250/mo is deemed "affordable" under the IRS Notice 2018-88 calculations, she'll be forced to choose the HRA, and would likely be worse off than if her employer provided nothing. If the $250/mo is "unaffordable" she will choose to purchase coverage through the Exchange. However, her employer would not be providing any support. If she can use the $600/month PTC to help pay for her premium and separately elect to access her employer's $250/month HRA allowance for medical expenses or excepted benefits only, she would greatly benefit. ***This would also provide a consistent and parallel offering for Individual Coverage HRAs to what will soon be available for traditional group plans with the proposed Excepted Benefit HRAs.***

3. **Allow employees receiving a PTC to accept an HRA contribution from an employer on a *taxable* basis allowed by the employer in the HRA's plan documents**. In our experience, this is happening frequently and would help more small employers operate more compliantly. ***This approach would also be consistent with employees that are covered by their spouse's group plan being eligible to receive taxable reimbursements under QSEHRA and Individual Coverage HRAs to help pay for unreimbursed premiums.***

The PTC issues described above must be addressed for Individual Coverage HRAs to gain traction outside of employers that only have high-income employees (the current QSERHA market). Well-meaning employers will be heavily disincentivized from offering an Individual Coverage HRA if they perceive their contributions could potentially hurt their employees (as in the single mother described above) or will merely replace PTCs.

## Owner Participation

The next biggest hurdle we have witnessed with QSEHRA adoption is the issue of owner participation. We would like to see this addressed in the final version of the HRA rules so that this same hurdle does impede HRA adoption.

As an example and case study, consider a small dental practice with 2 dental partners and 6 employees. The practice is setup as an S-Corporation (very typical) and the owners currently offer a traditional small group health plan in which they both participate. However, the firm is having trouble maintaining the minimum required participation rates as several employees have better coverage options available through their spouses. Moving to a QSEHRA or Individual Coverage HRA makes sense from a benefits perspective, however, under the current QSEHRA rules the two partners would be unable to participate since they are S-Corp owners. Although they could take a self-employment tax deduction, it's not as tax-efficient and a significant barrier to adoption to tell the partners they cannot participate in their new benefits plan.

It has been our experience that many small business owners read the regulations themselves as they don't have attorneys or human resource specialists on staff. For example, IRS Notice 2015-17 that governs S-Corp owners on group plans feels inclusive and includes language about how S-Corp owners can participate even if they have different reporting requirements. Conversely, IRS Notice 2017-67 that governs QSEHRA strictly prohibits participation from S-Corp owners.

We strongly suggest the finalized rules provide inclusion language regarding owner participation—particularly for S-Corp Owners, Partners in a Partnership, and others. This is justifiable because S-Corp owners and Partnership Partners can currently participate under group health insurance and even HRAs under Section 105 and just report their HRA contributions differently on their personal tax-forms. These same participation rules need to be explicitly extended to the new Individual Coverage HRAs and Excepted Benefit HRAs.

If there is concern about tax issues with S-Corp Owners, Partnership Partners, and sole proprietors, language could be included that owners can participate if they employ "at least one non-related W-2 employee that is also eligible for HRA contributions" or a standard similar to what health underwriters require for group health coverage.

## Small Employers that Wish to Maintain a Group Plan and Offer QSEHRA to some employees

This hurdle usually appears when a small business had different classes of employees or when an employer owned multiple businesses.

For example, we had a 25-person private Day School for children that had a popular group plan for the 12-person full-time staff. The administration wanted to extend benefit coverage to the remaining 13 part-time employees although they could not afford to bring them onto the group plan. As a result, they sought out a QSEHRA to reimburse part-time employees $200/mo. However,

because QSEHRA does not allow employers to maintain small group coverage for any employees, it quickly fell apart. This was unfortunate because the employer genuinely wanted to extend benefits to more of their employees, but there was not a vehicle available for them to do so and the result was the part-time employees received no benefits.

We believe the new employee classes proposed in the new rules will solve some of these issues. As we understand in the new rules, this employer will be able to create new employee classes (full-time and part-time, for example) and implement the strategy they wanted to offer. **We advocate the final rules also allow for additional employee classes (see comments in the next section).** We recognize employers could use additional classes for discrimination, but the lack of additional classes could also prevent well meaning employers from being able to extend benefits.

## Inability for Employees to use Healthcare Sharing Ministries or other Alternative Plan Types

While health care sharing ministries ("**sharing plans**") make up a small percentage of the overall insurance market, they are pervasive in the small employer space. For example, when we meet an employer with 10 employees interested in setting up a QSEHRA, it's highly likely at least 1-2 employees are using a sharing plan.

We need explicit guidance and rules on how to handle these plan types or it's likely to trip up many employers considering Individual Coverage HRAs. Current guidelines on QSEHRA require that employees maintain Minimum Essential Coverage (MEC) in order to receive QSEHRA reimbursements. Sharing plans do not meet the MEC requirement but do exempt members from having to meet the MEC requirements.

We believe for practical purposes, sharing plans represent a different issue from STLDI and other alternative insurance-based solutions because sharing plans typically represent an individual's primary and enduring form of "health coverage". They are already exempt and unlikely to cause risk-pool issues based on their belief requirements. We believe they can be cleanly sectioned off in the finalized rules by adjusting the language in the final rules to allow plans that "meet the requirements of Public Health Service Act sections 2711 and 2713 *or* are members and considered exempt from the shared responsibility provision under Section 5000A(d) of the Affordable Care Act."

We believe other plan types, including STLDI, Direct Primary Care (DPC), and others will also need specific guidance as these plans grow in popularity in the individual marketplace. We provide more comments on these plans as requested below, but ***highly recommend the finalized rules allow as much flexibility as possible for innovative plan designs that can still meet minimum protection thresholds.***

## Requested Comment Areas:

We applaud the proposed rules ingenuity in advancing the opportunity provided by HRAs, but we are concerned they may not go far enough and may leave significant hurdles in place for small employers. We share data, experience, and case studies in a few select areas below:

On how an HRA could substantiate whether individual health coverage is subject to and compliant with PHS Act sections 2711 and 2713 (p.36):

- For the sake of individual employees who will be shopping on their own to purchase plans that qualify for their employer's HRA, we support efforts to make compliant plans easy to identify
- The proxy method of assuming "all marketplace" plans make sense
- We also support the suggested idea that issuers of non-marketplace plans be able to provide employees with information upon request that their plans are "Individual HRA Compliant"

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 (p.38; Section II.A.2.a):

- While in general we'd advocate for as much flexibility as possible; however, it's difficult to see how this would practically work if employees in the same employee class could choose between a traditional group health plan and an HRA with individual coverage
    - Traditional group plan issuers would have trouble with participation estimates
    - This could also lead to adverse selection issues in an employee pool
- We support the employee class approach as described; offering one option to each employee class but providing as much flexibility to the classes as possible.

On whether employer size or employee class size should be considered in determining permissible classes of employees (p 41-42; Section II.A.2.b):

- No, we think employer size and employee class size should not be considered
- We see many very small employers where 1-person class sizes would be completely appropriate if the classes are derived from the criteria suggested in the rules.
    - For example, consider a small professional services office like an accounting firm with two accountants and a part-time administrative assistant.
    - In many cases with QSEHRA, we see the assistant completely left out of a reimbursement plan because QSEHRA requires all employees to be eligible for same amount.
    - Giving employers more flexibility to control classes and establish different reimbursement rates for those classes will likely lead to *more* instances where employees like the administrative assistant are included even if at a lower reimbursement rate.

Regarding the proposed employee classifications (p. 45; Section II.A.2.b):

- **In our opinion, more employee classes will be needed in order to make Individual Coverage HRAs a viable option for many employers, especially Applicable Large Employers ("ALE")**
- The classes suggested in the draft rule are, in our opinion and based on our experience, probably safe from adverse selection and discrimination concerns without having to consider employer or class size. Additional class definitions could contain language to help mitigate abusive practices. We provide some ideas below.
- **We *strongly advocate* for <u>classes based on employee role or title</u> to be added:**
    - This will be extremely important for ALEs to consider Individual Coverage HRAs as a viable solution. For example, consider an ALE with 100 employees that provides home health care. You have two distinct types of workers that employers are trying to recruit and retain with benefits: office staff and field staff. Currently, they are likely offering a group health plan with two plans with one tailored for the office and one for the field. This type of ALE would be a perfect candidate for Individual Coverage HRAs, but the ability to only have one "class" of employee based on profession would severely curtail adoption.
    - In addition, traditional group health plans often allow for management "carve-outs" that allow employers to pay a greater portion of a manager's insurance costs; not having something equivalent for HRAs would make them less viable for many employers.
    - ***Adverse Selection or Discrimination Mitigation Ideas:***
        - Limit the total number of classes that can be used based on title or role: For example, limiting to 2-3 classes would solve most practical needs but reduce opportunities for abusive scenarios.
        - Set a limit on minimum class size: For example, at least 2 people must be in a single class or class size must cover 10% of employees, etc.
- **We recommend the department add <u>classes based on gradations of part-time employees and employee tenure</u>:**
    - We see many cases of employers wanting to incentivize greater hours or tenure by offering a higher benefit level
    - ***Adverse Selection or Discrimination Mitigation Ideas:***
        - Define Hourly Ranges: Don't let employers arbitrarily set ranges, but instead offer fixed categories. For example, allow ranges of 1-10, 11-20, 21-30, or 30-35 hours per week. This would prevent a person being singled out based on hours.
        - Define tenure increments: Like above, define the increments for employers so it can't be abused. For example, only allow increments of 1, 2, or 3 years.
        - The above ideas would prevent managers from implementing an unfair "sliding scale" to continually keep some employees from being able to participate but could provide helpful benchmarks for employers to incentivize employees and reward tenure.
- We support allowing classifications based on more specific geographic locations such as address or zip code:
    - Consider an employer with office and warehouse locations or a franchise owner that has multiple franchise locations in a single rating area.

    - It's unlikely an employer would manipulate employee locations to abuse this type of classification
- To your requested comment, we think a combination of classes should be allowed as proposed. One potential abuse mitigation idea would be to limit combination classes to no more than three of the defined classes.

Regarding integration with STLDI and other plan types (p. 57; Section II.A.8):

- **We *strongly advocate* that "Health Care Sharing Ministries" ("Share Plans") and other non-group coverage that qualifies for a Section 5000A exemption from the Minimum Essential Coverage (MEC) requirements be eligible to integrate with HRAs.**
    - These plans have been sought by individuals that have religious or moral exceptions to ACA provisions
    - These plans are considered by these individuals to be their primary form of coverage for healthcare
    - Although these plans make up a small percentage of the overall market, they are pervasive in the individual market. Not allowing them to work with HRAs could dampen adoption of Individual Coverage HRAs.
    - Allowing these plans to integrate is unlikely to have an impact on the health of the individual insurance market as these individuals are already non-participants.
- **We strongly advocate that other non-group plans that meet the requirements of PHS Act Sections 2711 and 2713, including STLDI, be eligible to integrate with the HRA.**
    - Creative plan designs that meet Section 2711 and 2713 requirements will protect consumers and allow for greater flexibility and adoption

Regarding the proposed Excepted Benefit HRA maximum of $1,800 per year (p. 63; Section II.B.2):

- **We *strongly advocate* that the maximum limit be higher if the HRA covers dependents**
    - Almost all the major "excepted benefit" types—dental, vision, etc. are tied to family size. It would be unfair and impractical to have one limit all without considering number of dependents
    - For simplicity, the proposed rules could include a 2x limit for employees with dependents.

Regarding QSEHRA and Individual Coverage HRAs triggering a Special Enrollment Event (p. 85; Section V.)

- **We *strongly support* the proposed rules allowing for Special Enrollment for new HRAs or QSEHRAs or material changes to an HRA or QSEHRA.**
    - We believe these rules will be important for Individual Coverage HRAs to gain traction as a viable alternative to traditional group plans
    - In our experience, we have seen employers setup QSEHRA but employees remain uncovered for months as they do not have a qualifying event
    - Employers that need to modify or change their HRAs should not be able to do it without employees also being able to make changes to their coverage during the year

Regarding the Applicability Date of January 1, 2020 (p. 85; Section IV.)

- We support this applicability date but would encourage you to consider an earlier implementation date as we believe our clients would benefit from the expansion of HRAs.
- Allowing the Special Enrollment Rules sooner would be helpful to employers currently using QSEHRA. A few states have already allowed this on State-based exchanges.

## Other Practical Matters that Can Encourage HRA Adoption

We wanted to share a few practical ideas that will help improve adoption of Individual Coverage HRAs by more employers.

- **The "90 Day" notice needs to be adjusted to realities of individual market**
  - ***This notice requirement is a challenge in the individual insurance market.***
  - For example: We help our QSEHRA clients provide 90-day notices to employees before their QSEHRA renews on the calendar year. Employees are always confused why they are getting a random notice in late September or early October.
  - For employees, especially ones that will be shopping for individual plans, they think about this during Open Enrollment in November and December. A 90-day notice is long forgotten by the time they need it.
  - While the information provided in the proposed rules to be shared with employees is good content-wise, we strongly suggest the "90 day" requirement be scrapped and instead adjusted to coincide with the annual Open Enrollment period.
  - The rules should be clarified that a new Individual Coverage HRA can start anytime—why should an employer have to wait 90 days to make the benefit available to employees?

- **Create a catchy name or acronym to describe the HRAs**
  - The proposed rules refer routinely to "HRA Integrated with Individual Health Insurance Coverage"
  - This is not something that can be easily searched or understood by employers or their advisors. Even professional bloggers that released comments after the proposed rules were released had no way to consistently to refer to this "thing".
  - We strongly suggest you include in the final rules a memorable acronym or short-hand way to refer to these types of plans
  - The IRS Notice called them "Individual Coverage HRAs" which is a great start. Please consider using that language or similar in the final rules.

- **Direct Primary Care ("DPC") Integration**
  - Large, self-insured employers have more flexibility than small and medium size employers to take advantage of innovative models like direct primary care (a subscription for primary care services).
  - DPC should be allowed to integrate with an Individual Coverage HRA if it is part of a combined offering that satisfies PHS Act sections 2711 and 2713.

- **Transition from QSEHRA to Individual Coverage HRA**
    - Many employers currently using QSEHRA will want to transition to Individual Coverage HRAs or Excepted Benefit HRAs
    - The final rules need to include information about the transition process and potential issues such as carry-over amounts, etc.

We appreciate your diligent work on these rules! We would welcome the opportunity to discuss the expansion of HRAs and to share additional insights about our data and experience with you if helpful. If you have questions, please contact me at Jack@TakeCommandHealth.com.

Sincerely,

Jack Hooper
*CEO*
*Take Command Health*