ERIC
The ERISA Industry Committee
Driven By and For Large Employers
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RE: Comments on Proposed Regulations to Expand and Facilitate Access to Health Reimbursement Arrangements and Other Account-Based Group Health Plans

To Whom It May Concern:

The ERISA Industry Committee ("ERIC") is pleased to submit the following comments in response to the Notice of Proposed Rulemaking ("NPRM"), providing expanded opportunities for employers to help their employees pay for (1) the cost of health insurance coverage and (2) medical expenses associated with benefits covered under a health plan through a Health Reimbursement Arrangement ("HRA") or other "account-based group health plans."

ERIC'S INTEREST IN THE NPRM

ERIC is the only national trade association that advocates exclusively on behalf of large employers on health, retirement, and compensation public policies on the federal, state, and local levels. ERIC's member companies offer comprehensive group health benefits to their employees in compliance with the myriad federal laws including the Internal Revenue Code ("Code"), the Employee Retirement Income Security Act ("ERISA"), and the Public Health Service ("PHSA"). ERIC supports the ability of its large employer members to tailor retirement, health, and compensation benefits to meet the unique needs of their workforce, providing benefits to millions of workers, retirees, and their families across the country.

Please note that ERIC strongly disagrees with the Departments' "integration" theory. In our opinion, an HRA is an accounting mechanism, more akin to a bank account, than to an actual health insurance plan or policy. It would make little sense to expect that a bank account would have "no annual limits" or provide "1st-dollar coverage of preventive services"; after all, an HRA is a bank account – not an insurance policy. Rather, an HRA provides resources that a beneficiary can use – at both their discretion, and their peril with the IRS – to obtain needed health care and health insurance coverage. Additionally, the idea that because an account or arrangement contains a sum of money that is not unlimited, it therefore somehow limits an individual's annual coverage for various health care services, is likewise inappropriate. For the

purposes of these comments, ERIC will assume the validity of the "integration" requirement. However, a cleaner and more efficient, effective means of increasing health insurance options for individuals and restoring some measure of flexibility in the offering of health benefits, would be to simply eliminate the "integration" rules.

Further, while the option to provide a defined contribution health benefit to certain "classes" of employee will be attractive in limited circumstances, we do not expect major employers to consider ending their comprehensive group health plans in order to move wholesale toward HRAs. Instead, this rule creates an opportunity to fill limited gaps where specific "classes" of employees who either would be unlikely to elect coverage in a comprehensive (and thus more expensive) group health plan, or for whom an employer generally does not currently offer benefits. The exposure of a large employer to employer mandate requirements related to a "class" of employee likely to be considered for the HRA-individual market plan option is likely to be extremely limited. Employers have made too many great strides in plan design, cost-control, quality improvement, and the like, to simply disengage and cede all responsibility to insurance companies. So while we applaud this additional option, and hope that it leads to more coverage for individuals who currently don't have an offer of employer-sponsored health benefits, we do not believe that large employers are likely to trend toward disengagement and a shift to fully defined contribution benefits.

COMMENTS

A. An HRA Must Be Integrated With a "Non-Grandfathered" ACA-Compliant Individual Market Plan; Not a "Grandfathered" Plan or a "Short-Term Limited Duration Plan"

In 2013, the Department of Treasury, the Department of Labor, and the Department of Health and Human Services (collectively, "the Departments") developed the "integration" theory governing the rules under which HRAs could continue to be utilized by employers. Specifically, while the Departments believed that an HRA standing on its own (i.e., a "stand-alone HRA") would violate certain health plan requirements enacted under the Affordable Care Act ("ACA") – specifically newly enacted PHSA sections 2711[1] and 2713[2] – the Departments believed that if an HRA was paired with a "group health plan" that itself satisfied PHSA sections 2711 and 2713, the HRA would also be deemed to comply with these ACA requirements.[3] The Departments are now proposing to extend this same "integration" theory to HRAs and "individual market" plans, and by doing so, to consider HRAs to fully comply with the ACA so long as the HRA is paired with an individual market plan.

[1] For plan years beginning on or after January 1, 2014, no annual limits may be imposed on the dollar value of "essential health benefits" covered under an individual health insurance policy or a group health plan.
[2] For plan years beginning on or after January 1, 2014, a "non-grandfathered" individual market or group health plan is prohibited from imposing deductibles, co-payments, or co-insurance for the following preventive health services: (1) Evidence-based items or services recommended by the United State Preventive Services Task Force, (2) Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention, and (3) Evidence-informed preventive care and screenings supported by the Health Resources and Services Administration for infants, children, adolescents, and women.
[3] *See* Notice 2013-54.

We support the interpretation of the "integration" theory to allow HRAs to be paired with an individual market plan (hereinafter referred to as an "HRA-individual market plan arrangement"). However, we believe that the individual market plan to which the HRA is integrated with must specifically comply with PHSA sections 2711 and 2713. For consistency with the "group" integration theory (discussed above), this seems to us to be the most appropriate approach.

In the case of an HRA-individual market plan arrangement, however, the proposed regulations seem to assume that determining whether an individual market plan actually complies with PHSA sections 2711 and 2713 is too difficult of a determination to make. So, the Departments propose an approach that would "deem" an individual market plan to be compliant with PHSA sections 2711 and 2713 by virtue of the fact that the plan is sold in the individual market (even in cases where the plan is not fully ACA-compliant).

For example, the Departments acknowledge that adopting this "proxy approach" could result in employees purchasing a "grandfathered" individual market plan. The Departments further acknowledge that a "grandfathered" plan is not compliant with PHSA sections 2711 and 2713. While the Departments went to great lengths explaining that the number of "grandfathered" individual market plans that could be purchased with an HRA would be very limited, this approach still risks subjecting employees to plans that do not provide the level of coverage and security that ERIC members' own plans offer.

Instead, the Departments should consider whether the only individual market plan that can be purchased with an HRA should be a "non-grandfathered" ACA-compliant individual market plan that meets all of the consumer protections and coverage requirements enacted under the ACA, including PHSA sections 2711 and 2713. ERIC members do not believe that an HRA should be allowed to be integrated with a "short-term limited duration" plan, because these plans by definition to do not comply with PHSA section 2711 and 2713 – and as such, could resemble the "mini-med" plans which the ACA sought to prevent from being used as substitutes from comprehensive medical/surgical benefits.[4]

B. The Employer Should Not Be Required to Substantiate That an Employee Purchased an ACA-Compliant Individual Market Plan; The Insurance Company Selling the Plan Must Communicate Compliance with PHSA Sections 2711 and 2713

1. *Substantiation That the Individual Market Plan Complies with PHSA Sections 2711 and 2713*

The Departments solicited comments on the methods by which an employer sponsoring an HRA-individual market plan arrangement could substantiate whether an individual market plan is fully ACA-compliant. It makes little sense for an employer to be responsible for collecting employee attestations of such; once the employer funds the HRA, giving the employee

[4] In order to improve the current state of the individual market – and also to limit market segmentation – the Departments should require that the only individual market plan that can be purchased by an HRA must be an ACA-compliant "non-grandfathered" individual market plan. This will ensure that all of the employees purchasing an individual market plan through an HRA will be entering the same, single risk pool.

the ability to go elsewhere for coverage, the employer's involvement in that individual's health insurance ends.

Instead, the insurance company selling the individual market plan could specify – or certify – that the plan sold by the insurance company is compliant with PHSA sections 2711 and 2713. This specification – or certification – can be demonstrated through a specified "approval seal" or "compliance demarcation" that the consumer would acknowledge seeing through the course of purchasing the individual market plan. When in doubt, the Departments could seek confirmation through electronic means from an Exchange or insurer that the plan is indeed compliant with PHSA sections 2711 and 2713 – however this should be largely unnecessary, and the Departments should avoid creating any additional administrative burdens on plans or plan sponsors, as both would be likely to increase health care costs for consumers.

Employer sponsors should not be responsible for confirming which insurance plan an employee uses HRA funds to purchase, much less the specific benefits and coverage of said plan. Certainly, in the case of misrepresentation by an insurance company about the terms and conditions of a plan, the employer and employee should not be held liable for the insurance company's failure to ensure that the individual market plan purchased through an HRA is compliant with PHSA sections 2711 and 2713, or other "integration" rules determined by the Departments.

In addition, the Departments should confirm that providing an employee with an HRA-individual market plan arrangement in no way jeopardizes the beneficiary's ability to enroll in a qualified high-deductible health plan paired with a Health Savings Account (HSA), and to fund said HSA.

2. *Verification That an Employee Is Covered By an ACA-Compliant Individual Market Plan That Complies with PHSA Sections 2711 and 2713*

As stated above, once the employer funds the HRA, giving the employee the ability to go elsewhere for coverage, the employer's involvement in that individual's health insurance ends. Requiring the employer to request, collect, and maintain records of attestation relating to employees' individual market health insurance plans would be unnecessary, overly burdensome to the employer, and intrusive upon the privacy of the employee.

The Departments propose that an employer offering an HRA-individual market plan arrangement must implement, and comply with, reasonable procedures to verify that an employee (or their dependent) is enrolled in an ACA-compliant plan before any tax-free reimbursements can be made. We understand that before any expenses can be reimbursed on a tax-free basis through an HRA, the expenses must be substantiated to prove that the expenses are permissible medical expenses under Code section 213(d). However, an employer cannot reasonably be expected to police the terms and conditions of individual market plans. Instead, we believe that this verification process should be as simple as possible to reduce any administrative burdens placed on the employer.

To satisfy this "verification" requirement, an employer should be held responsible only for determining that the expense incurred (in this case, the paying of individual market health insurance premiums) was in fact an allowable expense – which the Departments have intimated, individual market health insurance premiums will be. This auto-adjudication of a premium charge, paid to an approved vendor of individual market plans, should in and of itself serve as sufficient record that the individual is covered by an appropriate plan, and no further verification should be needed. Regardless, any and all verification, attestation, or other information needed for compliance with rules related to HRA-individual market plan arrangements should be entirely conducted in electronic format.

The Departments also suggest that an employer can rely on the employee's attestation that they are – or will be – enrolled in an individual market plan. We support this proposal because it limits the administrative burden on employers – so long as the employer is not responsible for collecting, keeping records of, or verifying the veracity of said attestations. And we urge the Departments to ensure that the process be conducted entirely electronically.

3. *Ongoing Substantiation of Coverage Under an Individual Market Plan Prior to Reimbursing Medical Expenses Associated with Benefits Covered Under the Plan*

Once the initial substantiation of coverage occurs, the Departments require that – with each and every request for reimbursement for medical expenses associated with benefits covered under the plan – the employer must substantiate that the employee (and their dependents) are enrolled in an individual market plan. The Departments explain that the employee may provide substantiation through a written attestation, or alternatively, as a part of a form used for requesting reimbursement. The Departments further explain that an employer may rely on the documentation or attestation, provided the employer does not have actual knowledge that the employee (and/or their dependents) are not covered by an individual market plan.

We are generally supportive of this approach, as the employer can rely on the employee's attestation or the form used for requesting reimbursement. The employee may also provide to the employer the insurance policy or membership card that includes an "approval seal" or "compliance demarcation" from the insurance company indicating that the plan complies with PHSA sections 2711 and 2713, along with an attestation that the employee (and their dependents) remain covered under the plan. It may be unnecessary that the employee attest along with every single use of HRA funds – instead, it may be sufficient that an employee acknowledges on an annual or plan-year basis that they understand and will comply with the Departments' HRA "integration" rules.

C. Notice Requirements to Employees Should Be Modified; The Departments Should Issue a Model Notice; Notices Should Be Consolidated

We understand the Departments' concern that employees offered an HRA-individual market plan arrangement may not fully understand their potential eligibility – or ineligibility – for a premium tax credit. And, we respect that employees should be informed in an advance of their decision to enroll or opt-out of an HRA-individual market plan arrangement. However, we question the proposed timing for delivery of the notice. We also request that the Departments

develop a model notice, similar to the model "Exchange Notice" the Department of Labor ("DOL") prepared for employers to comply with section 18B of the Fair Labor Standards Act, which was added to the law through the ACA. Further, the Departments should review the various notices and disclosures plan sponsors are required to furnish to employees, and to the extent possible, consolidate, combine, and eliminate excess notices and requirements.

With respect to the timing for delivery of the notice, we believe the notice (when practicable) should be sent on the first day of an employer's "open enrollment" period. The Departments should consider that in some circumstances, such as when an employer decide mid-year to fund an integrated HRA for some classes of employees, that flexibility will be needed in order maximize the benefits to consumers. But generally, furnishing the notice at any time other than the first day of "open enrollment" (which will typically include the first day an employee is eligible to enroll in an HRA-individual market plan arrangement) could result in the employee failing to even read, understand, or act upon the information that is being communicated through the notice (which is contrary to the intent of providing the notice in the first place).

As the Departments know, "open enrollment" varies employer-by-employer. Some employers choose to begin their "open enrollment" period on October 1st, October 15th, or November 1st of the year prior to the beginning of the coverage year. For those employers that begin their "open enrollment" period on October 1st, the proposed 90-day timing deadline makes sense. But, for those employers that begin their "open enrollment" on November 1st, furnishing a notice to employees 30 days prior to the start of "open enrollment" will lead to confusion and employees failing to fully understand their potential eligibility – or ineligibility – for a premium tax credit. As noted above, the first day an employee is eligible to enroll in an HRA-individual market plan arrangement typically represents their first day of "open enrollment."

We suggest that the Departments instead require employers to furnish the necessary information in an employee's "open enrollment" package provided on or around the first day of the "open enrollment" period. This will ensure that the employee gets timely information that is most relevant to a very important financial decision that must be made by the employee shortly after receiving the notice.

As stated above, with respect to the type of information that must be included in the notice, we request that the Departments develop a model notice which employers may use word-for-word or customize to fit their employees' needs (again, similar to the "Exchange Notice" developed by the DOL). The Departments should ensure that the model notice would be readable by the average American, and the notices should be permitted to be furnished electronically. The notice should inform beneficiaries that if they fail to substantiate their individual market coverage, the HRA-individual market plan arrangement funds could be considered income to the employee, which must be declared and would become subject to taxation or penalties. Further, the notice should inform individuals who are Medicare eligible, or enrolled in Medicare, that they are ineligible to take up an HRA-individual market plan arrangement. This would align with the recently proposed Exchange Program Integrity rule.

Further, the Departments should recognize that the amount of information that plan sponsors are required to furnish to beneficiaries is significant. Often times this information must

be conveyed in a highly specific manner, and there may be information that is repetitive, or would better fit elsewhere, or would make more sense in conjunction with other data. As a result, plan beneficiaries often do not fully review required notices, or do not comprehend the information conveyed. As ERIC has requested previously, the Departments should do a joint review of all required information, notices, and disclosures that plan sponsors must convey to plan beneficiaries. When possible, this information should be simplified, combined, or eliminated, to ensure that employees receive only the most critical information, that it be conveyed in electronic format whenever possible, and that "information overload" may be avoided.

D. We Support Requiring an Employer to Choose Between Offering a Traditional Group Health Plan or an HRA-Individual Market Plan Arrangement to Employees in the Same "Class" of Employees

1. *The "All or Nothing Proposition"*

According to the proposal, if an employer wants to give its employees a tax-free contribution to purchase an ACA-compliant individual market plan through an HRA, the employer cannot also offer a "traditional group health plan" to the same "class" of employees. In other words, an employer must choose whether it wants to offer only a traditional group health plan to a particular "class" of employees, *or* whether the employer will offer only an HRA-individual market plan arrangement to this "class" of employees.

We support this "all or nothing proposition" (i.e., we support that a specific choice must be made between offering a traditional group health plan *or* an HRA-individual market plan arrangement). While we believe that employers should be given the greatest flexibility possible when designing an arrangement to provide health benefits to their employees, we believe that if employers are able to offer a traditional group health plan to a specific set of similarly situated employees, while also offering an HRA-individual market plan arrangement to another set of these same similarly situated employees, this could create a serious adverse selection risk, which could disrupt risks in both the individual market, and in an employer's own plan.

2. *The Proposed "Classes" of Employees*

The proposed "classes" of employees are essentially drawn from the rules set forth under Code section 105(h), although the proposed regulations add an additional "class" for purposes of offering an HRA-individual market plan arrangement. The proposed classes include: (1) Full-Time Employees; (2) Part-Time Employees; (3) Seasonal Employees; (4) Union Employees; (5) Foreign Employees (with no U.S.-based income); (6) Employees In a "Waiting Period"; (7) Employees Under Age 25; (8) Employees Whose Place of Employment Is Located In a Particular "Rating Area."

The Departments have proposed that it is appropriate to permit employer-sponsors of an HRA-individual market plan arrangement to offer different benefits to different "classes" of employees. The Departments justify this position, explaining that many employers have historically offered varying benefit packages to members of the different "classes" of employees

stated above for purposes other than inducing higher risk employees to leave the employer-sponsor's traditional group health plan. We resoundingly agree.

An employer's decision to offer different benefits to different "classes" of employees is based on business factors unique to a specific "class" of employees. In addition, the decision to voluntarily offer health benefits to these "classes" of employees is based on different strategies on how best to attract and retain talented workers, and to keep workers productive. These benefit decisions are not motivated by a pre-conceived strategy to discriminate against particular employees and/or to reduce the health risks covered by the employer-sponsor's traditional group health plan.

We note that ERIC members generally offer the same health benefits to employees regardless of where they live, work, or receive medical care. As such, they are unlikely to be interested in segmenting out specific employee classes based on a rating area. Additionally, ERIC members generally keep health insurance premiums affordable to employees by spreading risk as broadly as possible, and it is unlikely that they would be interested in pulling their youngest employees out of the employer-sponsored plan in order to send them to the individual market.

3. *Consideration of Additional "Classes"*

The Departments request comments on whether additional "classes" should be considered. At this time, we do not have specific suggestions. In determining any additional "classes" of employees to consider, the Departments should consider how different groups of employees might differ in their incomes (and thus the amount of coverage they might be interested in purchasing), desires for robust employer-sponsored plans (most ERIC members' plans are above 80% actuarial value) versus desires for more affordable and less comprehensive plans (available in the individual market), their levels of physical activity, and more.

We also considered suggesting the addition of "independent contractors" who receive a Form 1099 as a "class." We recognize, however, that employers currently cannot by definition offer these independent contractors a traditional group health plan, so the creation of this "class" would not provide an employer the ability to choose whether to offer independent contractors (1) a traditional group health or (2) an HRA-individual market plan arrangement. But, with the continued growth of the "gig economy," we believe the Departments – and Congress – should consider means through which an employer can provide a tax-free benefit to independent contractors for, among other things, the purchase of health coverage. While a statutory change may be required, the Departments may consider privately ruling on an arrangement that facilitates the purchase of an individual market plan through an HRA or another account-based group health plan.

E. We Support the Concept of Offering Different Types of Health Coverage Arrangements to Different "Classes" of Employees

As discussed above, we support the concept of allowing an employer to choose whether to offer (1) a traditional group health plan *or* (2) an HRA-individual market plan arrangement to

the same "class" of employees. We believe this eliminates any risks of discrimination or adverse risk. We also believe that this proposal – coupled with the proposed "classes" of employees – provides certain planning opportunities for employers wanting to offer some type of health benefits to non-traditional employees.

1. *Offering a Tax-Preferred Benefit to Part-Time, Seasonal, and Temporary Employees to Obtain Health Coverage*

To ensure compliance with the "employer mandate" requirements, large employers offer traditional group health plan coverage to their "full-time employees." But, some applicable large employers choose to exercise the option not to offer health coverage to their part-time or seasonal/temporary employees. However, employers may have an interest in offering some type of tax-preferred health benefit to help part-time and seasonal/temporary employees obtain some form of health coverage.

Under current law, large employers have no opportunity to provide a tax-preferred benefit for health coverage other than through offering health coverage under a traditional group health plan. But, under the proposed regulations, employers will now be afforded the flexibility to offer a tax-free benefit so their non-traditional employees can purchase an individual market plan. This means employers will have the flexibility to offer an HRA-individual market plan arrangement to these non-traditional employees, while continuing to offer traditional group health plan coverage to their "full-time employees." We believe this is a win-win because in many cases, the non-traditional employees who may be offered an HRA-individual market plan arrangement will be receiving – for the first time – some sort of financial assistance from their employer to obtain health insurance.

2. *Offering a Tax-Preferred Benefit to Employees In a "Waiting Period" to Obtain Health Coverage*

In addition, we support giving employers the opportunity to provide some sort of tax-preferred benefit to employees in a "waiting period." Employers often times adopt a 30, 60, or even a 90-day waiting period (in accordance with the ACA). Employees in a "waiting period" are often times forced to go without health insurance in the absence of an employer contribution for health coverage – or to pay the full freight of the costs of an individual market plan. In some cases, these employees may fill their "gap" in coverage through purchasing a subsidized health plan sold through an ACA Exchange. However, in many cases, an employee in a "waiting period" may earn income that exceeds 400% of the Federal Poverty Level ("FPL"). While these employees could purchase a "short-term limited duration health plan" to provide coverage during the "waiting period," health coverage provided under an ACA-compliant individual market plan will provide more comprehensive coverage, and thus, benefit the employee to a greater degree, which is something an employer may choose to promote by offering an HRA-individual market plan arrangement.

3. *Offering Different Health Coverage Arrangements to Employees In Different Geographic Locations and Foreign Employees*

Consistent with common practice, we support an employer's ability to offer different health benefits to different employees located in different geographic locations. As the Departments know, Code section 105(h) already allows an employer to offer different health benefits to different "classes" of employees in different parts of the country. In recognition of current law – and in recognition of the different business factors unique to each set of employees in different parts of the country – employers should be allowed to choose whether to offer (1) a traditional group health plan or (2) an HRA-individual market plan arrangement to employees located in different geographic locations. This is also true for foreign employees with no U.S.-based income. In cases where an employer chooses not to offer traditional group health plan coverage to foreign employees with no U.S.-based income, an employer may still want to attract and retain talented foreign workers by offering them access to health insurance through an HRA-individual market plan arrangement.

F. We Support the Use of the Definitions Under Code Section 4980H for Determining Whether an Employee Is Full-Time, Part-Time, or Seasonal

For purposes of determining whether an employee falls within a particular "class," the proposed regulations allow an employer to use definitions under Code section 105(h) *or* Code section 4980H. Regardless of which definitions an employer adopts, the definitions must be applied consistently within each "class."

The Departments seem to prefer the definitions under Code section 105(h) (because an HRA is a self-insured arrangement, and thus, subject to Code section 105(h) regardless of the size of the employer). However, we support the use of the definitions under Code section 4980H for purposes of determining whether an employee is full-time, part-time, or seasonal. Therefore, we support the flexibility provided for in the proposed regulations to adopt the Code section 4980H definitions for these purposes, while adhering to the definitions set forth under Code section 105(h) for determining whether an employee falls within one of the other "classes" of employees discussed above.

In the case of the "class" of employees whose worksite is located in different "rating areas," we support relying on the definition of a "rating area" as set forth under PHSA section 2701(a) of and 45 C.F.R. section 147.102(b), which is the geographic area established by a State that indicates where an insurance company may adjust the premium in accordance with the ACA and State law. An argument can be made that a "service area" – which typically reflects the geographic area(s) that an insurance company intends a particular health plan to serve, based in part upon its provider network – could be an alternative definition to rely on for purposes of defining a "class" of employees located in different geographic areas. But, because the "affordability" test for purposes of satisfying the employer mandate (discussed more fully below) relies on the cost of the lowest cost self-only "silver" plan offered in the "rating area" where the employee's worksite is located (as explained in Notice 2018-88), determining a "class" based on the "rating area" of the employee's worksite is the most appropriate definition.

G. We Support the Ability to Vary HRA Contributions By "Class" of Employees, Age, and Family Size

1. *HRA Contribution Amounts Within "Classes" and Among Different "Classes"*

According to the proposed regulations, there is no limitation placed on the amount an employer may set aside in an HRA for the purchase of an ACA-compliant individual market plan. We support this approach, as we believe that employers should be afforded the greatest amount of flexibility so they can design their HRA-individual market plan arrangement(s) in a way that best fits their employees' needs.

The proposed regulations also set forth a general rule, requiring that the terms and conditions of an HRA-individual market plan arrangement must be the same for all of the employees in a particular "class" of employees. This means that regardless of the dollar amount an employer chooses to provide to its employees, an employer must offer the same contribution amount to all employees within the same "class."

We support this proposal, as we believe this eliminates appearances of discrimination or possibilities of adverse risk selection among similarly situated employees (by prohibiting employers from giving a specific set of employees a higher HRA contribution amount, while providing a lower contribution amount to another set of employees in the same "class"). We also support this proposal because it means that – similar to the proposal to allow an employer to offer different health benefit arrangements to different "classes" of employees – an employer may give different HRA contribution amounts to different "classes" of employees, so long as the contribution amounts within the same "class" of employees is the same amount.

2. *HRA Contribution Amounts That Vary by Age and Family Size*

Notwithstanding this general rule, the proposed regulations set forth various exceptions. Specifically, an employer is permitted to vary their HRA contribution amounts (1) by the age of an employee and (2) by the number of dependents covered under the HRA-individual market plan arrangement (i.e., the employee's "family size"). However, in cases where an employer varies their HRA contributions by age and/or family size, the employer is still required to provide the same contribution amount to those employees within the same "class" who are the same age or who have the same family size.

In our opinion, this is the right policy. Generally, age is not taken into account when determining how much an employee is responsible for, in terms of their share of the premium for a self-insured plan sponsored by a large employer. However, individual market health insurance plans are more expensive for older individuals, and recognizing this fact – and allowing an employer to compensate their employee accordingly – is a win-win.

However, many large employers do vary employees' share of the premium based upon family size – the more dependents an employee has, the greater the amount they may be required to shoulder. This dynamic is directly mirrored in the individual market, and as such, employees with larger families may have vastly higher costs there. Allowing an employer to help an

employee with one or multiple dependents better afford health coverage is something employers currently do – and will continue to do – even in cases where the employer sponsors an HRA-individual market plan arrangement.

H. We Support the Ability to Establish a Code Section 125 Cafeteria Plan so Employees Can Pay the Employee Portion of their Individual Market Plan Premiums on a Pre-Tax Basis

In the case of an HRA-individual market plan arrangement, the employer's contributions are tax-free, but the only way the employee's portion of the individual market plan premiums can be tax-free is if the employer establishes for its employees a Code section 125 cafeteria plan (hereinafter referred to as a "cafeteria plan"). In recognition of cases where the employer's HRA contributions may not cover the entire premium amount, the proposed regulations allow an employer to establish a cafeteria plan so employees can pay their portion of the individual market plan premiums on a pre-tax basis.

However, the proposed regulations indicate that the Departments are limited by the statute, and therefore, these proposed regulations do not allow an employee to utilize a cafeteria plan to purchase an individual market plan sold through an ACA Exchange.[5] The proposed rules do permit an employee to use a cafeteria plan to purchase an ACA-compliant individual market plan sold *outside* of the ACA Exchange (because the statute does not prohibit the purchase of an off-Exchange individual market plan with a cafeteria plan).

We recognize that the Departments cannot change the statute, but we do want to point out the odd inconsistency that the statute and the proposed regulations create. For this reason, we urge the Departments to work with Congress to recognize this inconsistency and amend the statute to allow an employee to purchase an ACA Exchange individual market plan with a cafeteria plan. We also urge the Departments to find an alternative interpretation, perhaps by clarifying that the ACA was referring to individuals in a situation different than someone offered an HRA-individual market plan arrangement combined with a cafeteria plan through which the individual can pay their own portion of the individual market plan premium.

It is important to point out that the underlying reason why employees are prohibited from using a cafeteria plan to purchase an ACA Exchange plan is because the drafters of the ACA were concerned about "double-dipping" (i.e., there was concern that the employee would access a premium tax credit while also paying for premiums on a pre-tax basis through a cafeteria plan). However, the concern over "double-dipping" should no longer be present in the case of an HRA-individual market plan arrangement because (as discussed more fully below) if an employee enrolls in the HRA-individual market plan arrangement, an employee is ineligible to receive a premium tax credit. As a result, if an employee purchases an ACA Exchange plan through an HRA-individual market plan arrangement, this employee will by definition be ineligible for a premium tax credit, which means the employee cannot access a premium tax while also paying for the ACA Exchange plan on a pre-tax basis through a cafeteria plan. Again, we believe Congress should amend the law in this area, or the Departments should develop a workaround.

[5] The Affordable Care Act ("ACA") added section 125(f)(3)(A) of the Internal Revenue Code, providing that an individual *cannot* use a cafeteria plan to purchase an individual market plan *inside* the ACA Exchange.

I. We Support Allowing a Cafeteria Plan Premium Arrangement to Be Integrated with an Individual Market Plan

We support a cafeteria plan – standing on its own – to be integrated with an individual market plan. Therefore, we support including a cafeteria plan premium arrangement in the definition of an "account-based group health plan" that can be integrated with an individual market plan. In our opinion, some employers may not want to contribute any employer dollars toward an employee's purchase of an individual market plan. However, an employer may still want to provide its employees with a tax-free way to purchase an individual market plan through a cafeteria plan (with the employees' own money). Allowing employers to establish a cafeteria plan premium arrangement on a stand-alone basis would provide for this much needed flexibility. In addition, some employers may prefer to run their employer contributions through a cafeteria plan for the purchase of an individual market plan – instead of utilizing an HRA – and these employers should have the flexibility to do so.

J. We Support an Employee's Ability to Opt-Out of the HRA-Individual Market Plan Arrangement If the Individual Market Plan Coverage Is "Unaffordable"

Importantly, the proposed regulations treat the offer of an HRA-individual market plan arrangement as an offer of "employer-sponsored coverage" for purposes of determining whether an employee is eligible for a premium tax credit. As such, if an employee chooses to accept reimbursements from the HRA for the purchase of an individual market plan (i.e., the employee opts-in to the arrangement), the employee will be ineligible for a premium tax credit regardless of whether the individual market plan is "unaffordable" or not. However, if the HRA-individual market plan arrangement turns out to be "unaffordable" to the employee, the proposed regulations allow the employee to opt-out of the HRA-individual market plan arrangement and purchase a subsidized individual market plan through an ACA Exchange (assuming the employee is eligible for a premium tax credit based on their income).

We support this proposal. In our opinion, if an employer chooses to limit the HRA contribution amounts made available to employees such that the contribution amount is too low to make the individual market plan "affordable" for an employee, the employee should be given the right to forego receiving the HRA contribution, especially if the employee will be better off purchasing a subsidized individual market plan through an ACA Exchange (again, assuming the employee is eligible for a premium tax credit based on their income).

K. We Support the "Affordability" Test for Determining Whether an Employee May Be Considered Eligible for a Premium Tax Credit

For purposes of determining whether an employee enrolled in an HRA-individual market plan arrangement is eligible for a premium tax credit, the proposed regulations establish an "affordability" test that is based on the cost of the lowest cost "silver" self-only plan in the employee's rating area. The proposed regulations also base the "affordability" test on the HRA contribution amount for self-only coverage that is newly made available for the year. Thus, according to the proposal, if the HRA contribution amount that is newly made available for the

year for self-only coverage is too little such that the employee's cost for purchasing the lowest cost "silver" self-only plan in the employee's rating area exceeds 9.56% of the employee's household income, the arrangement will be deemed "unaffordable," which means an employee will be eligible for a premium tax credit if they opt-out of the HRA-individual market plan arrangement and purchase an individual market plan through an ACA Exchange (assuming the employee is eligible for a premium tax credit based on their income).

We support this "affordability" test because it is consistent with the rules that apply to an offer of a traditional group health plan. According to the existing eligibility rules for a premium tax credit, a traditional group health plan is "unaffordable" if the employee's cost of the lowest cost self-only group health plan that provides "minimum value" (i.e., 60% actuarial value) exceeds 9.56% of the employee's household income.

An argument can be made that the proposed "affordability" test should be based on the second lowest cost "silver" self-only plan in an employee's rating area. After all, the second lowest cost "silver" self-only plan is the current benchmark under rules that apply to a Qualified Small Employer HRA ("QSEHRA"). In addition, the second lowest cost "silver" plan is used as the benchmark to determine the amount of the premium tax credit an eligible consumer may access.

However, as the Departments explain, the lowest cost "silver" self-only plan is a more appropriate benchmark because the lowest cost "silver" self-only plan is the lowest costing individual market plan that provides "minimum value." At a minimum, the lowest cost "silver" plan will cover at least 66% of the cost of the benefits covered under the plan. Again, this is consistent with the benchmark plan for a traditional group health plan, which is the lowest cost self-only plan that provides "minimum value" (i.e., which requires the plan to cover at least 60% of the cost of the benefits covered under the plan).

L. We Support the "Affordability" Test for Determining Liability Under the Employer Mandate, along with the Location Safe Harbor as Explained in Notice 2018-88

Because the offer of an HRA-individual market plan arrangement is treated as an offer of employer-sponsored coverage, an employer employing 50 or more full-time equivalent employees ("FTEs") will avoid the penalty set forth under Code section 4980H(a) if the HRA-individual market plan arrangement is offered to at least 95% of the employer's "full-time employees" and their dependents. Similarly, an employer employing 50 or more FTEs will avoid the penalty set forth under Code section 4980H(b) if the HRA-individual market plan arrangement is "affordable" and provides "minimum value."

Similar to the rules for determining whether an employee is eligible for a premium tax credit (as discussed above), the proposed regulations provide that for purposes of complying with the employer mandate, the "affordability" test will also be benchmarked to the lowest cost "silver" self-only plan in an employee's rating area. However, in Notice 2018-88, the Department of Treasury ("Treasury") and the Internal Revenue Service ("IRS") acknowledge the administrative burdens associated with an employer determining "affordability" if an employer has to look at the cost of the lowest cost "silver" self-only plan in each rating area where each

employee resides. Thus, to reduce the administrative burden of determining "affordability" on an employee-by-employee basis, Treasury and the IRS proposed to allow an employer to look to the lowest cost "silver" self-only plan made available in the rating area where the employee's worksite is located, rather than where the employee resides (referred to as the "location safe harbor").

This proposal aligns to some degree with the employer mandate rules that apply in the case of a traditional group health plan; in cases where an employer offers a traditional group health plan, the employer is only required to look to one, single health plan to determine whether the employer satisfies the "affordability" test (i.e., the employer looks to its lowest cost traditional self-only group health plan that provides "minimum value"). As a result, in the case of an HRA-individual market plan arrangement, an employer should only be required to look to one, single health plan to determine whether the employer satisfies the "affordability" test. Here, the employer only needs to look at the cost of the lowest cost "silver" self-only plan in the rating area of the employee's worksite.

Note, as discussed above, the lowest cost "silver" self-only individual market plan will by definition provide "minimum value" because the plan will cover at least 66% of the cost of the benefits covered under the plan (which is greater than the 60% threshold under the "minimum value" test). As a result, the "minimum value" test will always be satisfied.

This would be an incredibly burdensome requirement for national employers. First, even determining the "worksite" for an employee could be a challenge, consider employees who work in multiple states or jurisdictions, or who are not affixed to a specific work location (or perhaps even within the gig economy). Second, a large, national employer is unlikely to consider offering HRA-individual market plan arrangements if, in order to do so, they must track and align their plans with every single rating area in the nation. ERIC is interested in working with the Departments to find an equitable benchmark that is less burdensome. One possibility could be a national average cost for plans, perhaps averaged over multiple years. If this is too unfair due to price variation throughout the country, perhaps HHS could assist by allowing employers to align with averages (that CMS could publicly post) across regions. If the goal is to encourage companies to increase the offering of HRA-individual market plan arrangements, it is imperative that administering said plans not be overly burdensome.

M. Additional Safe Harbors in Notice 2018-88

1. *Calendar Year Safe Harbor*

In Notice 2018-88, Treasury and the IRS also identified an issue relating to determining "affordability" when the cost of the lowest cost "silver" self-only plan is not available until the Fall of year prior to the year the HRA-individual market plan arrangement is made available. In this case, Treasury and the IRS recognize that employers determine their health benefit offerings months in advance of the employer's "open enrollment" period (which for calendar years is the Fall), and therefore, looking to the cost of the lowest cost "silver" self-only plan this late in the year may be problematic.

In recognition of these difficulties, Treasury and the IRS will allow an employer to determine "affordability" based on the prior year cost of the lowest cost "silver" self-only plan in the rating area of the employee's worksite. In reality, an employer will look to the cost of the lowest cost "silver" self-only plan in the "current year" when planning their HRA contribution amounts for the following year (and whether their contribution is sufficient to satisfy the "affordability" test in the following year).

We fully support this proposal because it provides the greatest amount of flexibility to an employer to the extent permitted under the law. Treasury and the IRS already know the problems associated with announcing annual updates of the various health benefit limits in the Fall time frame (e.g., updates to the Flexible Spending Arrangement contribution limit were not updated until November of this year, which caused disruption for employers' 2018 "open enrollment" period). The least Treasury and the IRS can do is provide this type of flexibility to employers so they can plan their health benefit offerings accordingly.

Treasury and IRS also requested comments on whether an "adjustment" to the cost of the prior year lowest cost "silver" self-only plan is necessary to reflect changes in the cost of health coverage year-to-year. On the one hand, we recognize that the cost of health care increases year-over-year, so an argument can be made that developing some sort of benchmark for increasing the cost of the lowest cost "silver" self-only plan to better reflect the realities of the market makes sense. However, the volatility of health care costs makes it extremely difficult to develop a benchmark that is representative of market realities, especially when trying to guess what the cost of health coverage may be in future years.

If Treasury and IRS are dead-set on requiring an adjustment – which we believe would further reduce the incentive for employers to offer HRA-individual market plan arrangements – an adjustment similar to the ACA's "premium adjustment percentage" may be considered. After all, the ACA premium adjustment percentage is intended to reflect the increase in premiums over a period of years, based on a benchmark year (e.g., 2013) compared to the national average cost of coverage in a particular year. However, we are concerned that relying on a premium adjustment percentage may not accurately represent the true increase in cost (if any) in the rating area of the employee's worksite.

As the Departments know, premium increases in the individual market have varied widely. In some State markets, premiums have increased by double-digits, while premiums in other State markets actually went down. Any adjustment based on a nationwide average would disadvantage employers with worksites in those areas where premiums went down. It appears that the Departments recognize this scenario, as the Departments have indicated that no liability under Code section 4980H(b) will arise if an HRA-individual market plan arrangement is "unaffordable" based on the cost of the lowest cost "silver" self-only plan in the prior year, but is "affordable" in the following year due to the premiums for the lowest cost "silver" self-only plan going down.

Based on the foregoing, we recommend that the Departments opt against developing any adjustment, and simply allow employers to rely on the current year cost for the lowest cost

"silver" self-only plan in rating area of the employee's worksite for purposes of satisfying the employer mandate's "affordability" test in the following year.

It should further be noted that requiring an automatic inflation adjustment, no matter the size, could contribute to rising health care costs, by locking in an assumption that costs will rise every year. The Departments should avoid contributing to the unsustainable rise in health care costs.

2. *Age Safe Harbor*

The premiums for an individual market plan can vary by age, but only by a 3 to 1 ratio. Unlike individual market plans, traditional group health plan premiums typically vary by age by a 5 to 1 ratio, and premium rates are developed for the entire group of employees based on this age rating factor, as opposed to on an employee-by-employee basis. More importantly, once the premium rates are developed, all employees – regardless of age – are typically charged the same premium amount. Thus, for purposes of determining "affordability" for a traditional group health plan, the cost of the group health plan does not vary by age from employee-to-employee. In the individual market, however, costs do vary by age, which may require the employer to make the "affordability" determination on an employee-by-employee basis by their age.

Treasury and the IRS acknowledge that such a determination may be difficult for an employer. As a result, Treasury and the IRS requested comments on the administrative issues and burdens that would arise for employers in determining the employee's contribution for the lowest cost "silver" self-only plan based on each employees' age. Treasury and the IRS further requested suggestions as to any safe harbors or other alternatives that would ease the burdens of determining an employee's required contribution based on age. For example, Treasury and the IRS ask whether the ability to use age bands or other assumptions concerning employee age would lower an employer's administrative burden without disadvantaging employees.

We believe that requiring an employer to determine "affordability" on an employee-by-employee basis by age is extremely burdensome, and imposing such a requirement would actually be prohibitive (i.e., employers subject to the employer mandate would be discouraged from offering an HRA-individual market plan arrangement on account of such a requirement). As a result, we support the development of some sort of safe harbor for determining an employee's required contribution based on age.

We recommend a safe harbor that allows an employer to adopt a "composite rate" for all of its employees at a minimum at particular worksite, and preferably regionally or nationally. Developing this composite rate can be accomplished by taking the average cost of the lowest cost "silver" self-only plan in the rating area of the employee's worksite, and using this average cost for determining "affordability" for all of its employees at the worksite. Alternatively, a composite rate can be based on the cost of an individual market plan at a specified age (e.g., the lowest cost "silver" self-only plan for a 40-year-old in the rating area of the worksite), where the employer can use this cost for determining "affordability" for all of its employees at the particular worksite. The over-arching goal is to allow an employer to use a benchmark plan that yields one, single uniform cost so the employer does not have to determine "affordability" on an

employee-by-employee basis. Using age bands or other assumptions might result in too much variation.

3. *Non-Calendar Year Plan Safe Harbor*

Despite the fact that the cost of an individual market plan is determined on a calendar year basis, an employer may still choose to offer an HRA-individual market plan arrangement on a non-calendar year basis. This would result in an apples-to-oranges mismatch during some portion of the 12 months in the non-calendar plan year (which would span two calendar years).

In recognition of the fact that the cost of an individual market plan that spans two calendar years will differ, Treasury and the IRS propose to allow an employer to determine "affordability" based on the cost of the lowest cost "silver" self-only plan in the rating area of the employee's worksite for the first month of the plan year for *all* of the months in the plan year. This is an example where Treasury and the IRS recognize that an employer needs to rely on the cost of one, single benchmark plan to determine "affordability" for all of its employees at a particular worksite.

4. *Existing "Affordability" Safe Harbors Available to Traditional Group Health Plans Are Available to HRA-Individual Market Plan Arrangements*

In Notice 2018-88, Treasury and the IRS confirm that an employer offering an HRA-individual market plan arrangement may rely on the employer mandate's affordability "safe harbors" available to employers offering a traditional group health plan as set forth under Treas. Reg. section 54.4980H-5(e)(2). For example, an employer offering an HRA-individual market plan arrangement may rely on an employee's W-2 income or hourly rate of pay to determine if the HRA contribution is "affordable." We fully support the availability of these safe harbors for the "affordability" determination.

5. *Employer Reporting Under Code Section 6056*

Lastly, Treasury and the IRS confirm that employers with 50 or more FTEs that offer an HRA-individual market plan arrangement must comply with the employer "reporting" requirements under Code section 6056. Treasury and IRS state their intention to issue guidance on how an employer offering an HRA-individual market plan arrangement should determine an employee's required contribution, which is information that must be reported on the Form 1095-C. At a minimum, Treasury and IRS indicate that an employer offering an HRA-individual market plan arrangement is permitted to report the employee's required contribution based on the safe harbors discussed in Notice 2018-88. As stated above, it is imperative that Treasury and IRS allow an employer to rely on one, single benchmark plan that can be used to determine "affordability" for all of the employer's full-time employees, instead of requiring an employer to determine "affordability" on an employee-by-employee basis at a particular worksite. We look forward to commenting on the forthcoming guidance. Additionally, in the wake of the repeal of the penalty for individuals who do not maintain health coverage (pursuant to the Tax Cuts and Jobs Act), we urge the Departments to err on the side of less 1095-reporting, and explore ways that this reporting can be simplified, digitized, and ultimately eliminated.

N. We Support the Concept That an HRA-Individual Market Plan Arrangement Will Not Be Considered an ERISA-Covered Plan If Certain Requirements Are Met

1. *The Proposal Will Keep Employer Dollars In the "Health Care Game"*

The proposed regulations provide that – if certain requirements are met – an HRA-individual market plan arrangement will not be subject to ERISA's requirements. This is an important feature because those employers that are disinterested in many of the administrative complexities associated with offering a traditional group health plan to certain classes of employees – and instead, are interested in giving those employees a defined contribution to purchase health insurance – can now do so without triggering ERISA's requirements, such as ERISA's notice and disclosure rules, fiduciary duties, COBRA, and more. We note that under no circumstances should a properly constructed and administered HRA-individual market plan arrangement constitute a COBRA-covered benefit, and the Departments should clarify as such.

In our opinion, most employers that may choose to offer an HRA-individual market plan arrangement to some "classes" of employees – instead of a traditional group health plan – are doing so because sponsoring a group health plan has become too expensive and/or too administratively burdensome. But, many of these employers still want to provide some sort of financial assistance to help their employees better afford health insurance.

We believe it is good public policy to ensure that employers have an ability to provide some sort of financial assistance so their employees have the ability to obtain some form of health insurance, especially in situations where an employer is not offering a traditional group health plan. Encouraging employers to serve as the "financier" of health insurance – even though the employer is not actually sponsoring a traditional group health plan – achieves this policy goal, which we believe the proposed HRA-individual market plan arrangement promotes. If an employer that prefers to simply act as the "financier" of health insurance is subject to ERISA's requirements, however, the Departments will likely see a smaller number of employers offering an HRA-individual market plan arrangement, which is counter to the policy of keeping employer dollars in the "health care game."

2. *The Conditions That Must Be Met So an HRA-Individual Market Plan Arrangement Is Not Considered an ERISA-Covered Plan*

An HRA-individual market plan arrangement will not be considered an ERISA-covered arrangement if: (1) The purchase of the individual market plan is voluntary for employees (e.g., enrollment in a plan cannot be a condition employment), (2) The employer does not select or endorse any particular insurance company or individual market plan (e.g., providing general contact information for an ACA Exchange or allowing a Web-Broker Entity (WBE) to assist employee enrollment is permitted), (3) The reimbursement for premiums is limited solely to premiums for an individual market plan (i.e., the employee must use the HRA to purchase an individual market plan), (4) The employer does not receive any compensation in connection with the employee's purchase of an individual market plan (i.e., the employer cannot get a commission or some other in-kind benefit), and (5) The employee receives annual notice that the

individual market plan is not subject to ERISA (which will by definition be met by furnishing a notice to employees in the manner discussed above).

In our opinion, the requirements described above are relatively straight-forward, with the exception of the requirement that an employer not select or endorse any particular insurance company or individual market plan. While there is some existing guidance[6] – as well as court precedent[7] – describing what would and would not constitute "endorsement" of a particular insurance company or a particular individual market plan, we believe it is critically important that the DOL issue detailed guidance on how an employer may satisfy this particular condition. For example, an argument can be made that allowing a WBE or a traditional agent/broker to assist employee enrollment in individual market plans would not constitute "endorsement" – and ERIC members believe it is appropriate that the Departments allow an employer to coordinate with a WBE, vendor, navigator, or other appropriate 3rd party to assist employees in selecting a plan, and this should not be consider an endorsement. However, developing specific guidelines and parameters on the level of involvement that is permissible between the employer and the WBE or traditional agent/broker or other service provider is advisable.

The proposed regulations note that the DOL has issued guidance describing certain types of employee communications that would not constitute "endorsement" of, for example, a payroll-deduction IRA. We believe that it would be helpful if the DOL issued similar regulatory or interpretive guidance with respect to employee communications about an HRA-individual market plan arrangement and the reimbursement of premiums for an individual market plan. We believe such regulatory or interpretive guidance should also speak to the administrative fees that an employer may or may not pay to, for example, a WBE or traditional agent/broker or other service provider.

The proposed regulations indicate that the limitation on an employer receiving consideration in connection with an employee's purchase of an individual market plan was not intended to change any of ERISA's requirements governing the circumstances under which an employer may be reimbursed for certain expenses associated with the administration of the arrangement. Guidance that describes the amount and type of reasonable compensation an employer may receive for services actually rendered in connection with HRA and/or the HRA-individual market plan arrangement (if any) would also be helpful.

We also note that this condition should not be interpreted as limiting the ability to pay for out-of-pocket medical expenses associated with benefits covered under the plan. An HRA-individual market plan arrangement should still offer the financial security inherent in most HRA plans, shielding beneficiaries when possible from some of the plan deductible costs.

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[6] *See, e.g.,* DOL Adv. Op. 94-23A (July 1, 1994); DOL Adv. Op. 80-21A (Apr. 17, 1980); DOL Adv. Op. 77-54A (Aug. 8, 1977); DOL Adv. Op. 75-06A (Nov. 3, 1975).

[7] *See, e.g.*, *Crabtree v. Life Care Ctrs. Of Am., Inc.,* 2009 WL 734726 (S.D. Ind. 2009); *Chase v. Prudential Ins. Co. of Am*., 2008 WL 697301 (E.D.N.Y. 2008); *Booth v. Life Ins. Co. of N. Am.*, 2006 WL 3306846 (W.D. Ky 2006); *Zavora v. Paul Revere Life Ins. Co*., 145 F.3d 1118 (9th Cir. 1998); *du Mortier v. Mass. Gen. Life Ins. Co*., 805 F. Supp. 816 (C.D. Cal. 1992); *Hansen v. Cont'l Ins. Co*., 940 F.2d 971 (5th Cir. 1991).

3. *The Application of ERISA to the HRA Itself*

The Departments recognize that although the HRA-individual market plan arrangement may not be subject to ERISA, the HRA itself – as a self-insured group health plan – remains subject to ERISA's requirements. The proposed regulations request comments on whether it would be helpful for the DOL to issue additional guidance addressing the application of ERISA to the HRA.

We believe that it would be helpful for the DOL to issue guidance detailing the specific ERISA requirements that the HRA must comply with. Among other things, such guidance should discuss the employee communications that are appropriate, and whether, for example, furnishing an employee with a Summary Plan Description ("SPD") that describes the HRA-individual market plan arrangement – which is an ERISA requirement – constitutes "endorsement." We recommend that the DOL develop model language to be included in the SPD that satisfies ERISA's requirements, but language that does not constitute "endorsement."

The guidance should also detail the employer's fiduciary duties as they relate to the HRA, along with the rights of an employee. For example, because the HRA-individual market plan arrangement is not subject to ERISA, an employee should not have a private right of action against the employer for any issues associated with the individual market plan on account of the fiduciary duties that apply to the employer as sponsor of the HRA. Similarly, the guidance should clarify that in no event does the employer's fiduciary duties as sponsor of the HRA extend to the HRA-individual market plan arrangement. While it might seem self-evident that the employer-sponsor of the HRA is not subject to fiduciary liability in cases where the HRA-individual market plan arrangement is not subject to ERISA, specific confirmation that no such liability will arise is critically important.

4. *Forms of Payment Treated as Reimbursement*

The payment of an employee's individual market plan premiums on a one-time basis or on a scheduled/recurring basis should be promoted for administrative simplicity. These payment methods could also stream-line the substantiation process discussed above. Automatic substantiation can be accomplished through the use of an HRA debit card, provided that a merchant category code has been assigned to the insurance company. The use of an HRA debit card can also serve as the means through which a one-time payment or scheduled/recurring payments of the employee's individual market plan premiums may be processed.

At this time, we do not believe that additional guidance is necessary describing how employees can receive reimbursements for individual market plan premiums and Code section 213(d) expenses covered under the plan through an HRA debit card. However, if the Departments – or public commenters – feel that additional guidance in this area in needed, we are open to working with the Departments on the development of any clarifying guidance.

We will note, reimbursements for individual market plan premiums made through an HRA debit card – or otherwise – would be made on an individual (as opposed to an aggregate) basis. As a result, we believe there is no compelling reason to require an employer to serve as a

"premium aggregator" and provide payment to the various insurance companies under-writing the various individual market plans purchased by the employer's employees. If, however, an employer voluntarily chooses to pay the premiums on behalf of its employees directly to each of the insurance companies under-writing it employees' plans (in the aggregate), an employer should be permitted to do so.

O. We Generally Support the Creation of the "Excepted Benefit HRA"

1. *Limitations Placed on the "Excepted Benefit HRA"*

In order to permit a "stand-alone HRA" that is not otherwise integrated with a group health plan to be offered, the Departments needed to develop an HRA that they considered something other than a group health plan. To accomplish this, the Departments drew upon their discretion to develop an additional "excepted benefit" (because an "excepted benefit" is not a group health plan under the law). Thus, the newly created "excepted benefit HRA" is not a group health plan, and therefore, this "stand-alone HRA" cannot violate PHSA sections 2711 and 2713 (because these requirements do not apply to "excepted benefits").

While we commend the Departments for their creativity to allow employers to offer a "stand-alone HRA" (which was a common practice prior to the enactment of the ACA), developing a new "excepted benefit" unfortunately led the Departments to restrict, for example, the amount of employer dollars that may be contributed to this "stand-alone HRA." We hold the position that employers should be afforded the greatest flexibility possible when it comes to (1) providing health benefits to their employees and (2) helping their employees pay for medical expenses on a tax-free basis. Developing an arbitrary dollar limit is contrary to that position.

However, if the Departments insist that the statute requires a dollar limit on these benefits, we recommend that the Departments adopt the highest "excepted benefit HRA" limit based on the methodologies the Departments considered for determining the limit in the first place. According to the proposed regulations, it would appear that this upper limit is $2,850 (although the proposed regulations do not seem to indicate which methodology the Departments considered to produce the $2,850 amount). Regardless, in the interest of affording employers the greatest flexibility possible, we recommend that the Departments adopt the highest limit possible.

2. *With the Addition of the "Excepted Benefit" HRA, the Departments Must Confirm the Continued Ability to Integrate a "Spousal Stand-Alone HRA" With a Group Health Plan*

We interpret the proposed regulations as preserving a "spousal stand-alone" HRA (often times referred to as a "family HRA"). Specifically, under previous guidance, the Departments confirmed that a "stand-alone HRA" offered to an employee may be integrated with a group health plan offered by the employee's spouse's employer – which may then be used to reimburse medical expenses of the employee-spouse and their dependents – provided certain requirements are met.[8] Among other requirements, the employee-spouse and their dependents must be

[8] https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-37.pdf.

enrolled in the employee's spouse's group health plan.[9] In addition, in order for the HRA to pay for any Code section 213(d) medical expenses (including premiums), the group health plan in which the employee-spouse and their dependents are enrolled must provide "minimum value" (the "MV Integration Method").[10]

We request that the Departments specifically confirm that a "spousal stand-alone HRA" (or "family HRA") may indeed continue to be offered by an employer. Such a clarification is recommended to distinguish the "spousal stand-alone HRA" (or "family HRA") from the newly created "excepted benefit HRA." More specifically, as discussed above, for a "spousal stand-alone HRA" (or "family HRA") to be permissibly integrated with a group health plan, the employee-spouse and their dependents must actually be enrolled in the employee's spouse's employer-sponsored group health plan. In the case of an "excepted benefit HRA," on the other hand, an employee (e.g., an employee-spouse) is not required to enroll in any other group health plan to be able to pay for medical expenses through the "excepted benefit HRA."

In essence, the Departments would be clarifying that there are two different ways a "stand-alone HRA" could be utilized. In the case of the "spousal stand-alone HRA" (or "family HRA"), the employee-spouse and their dependents must be enrolled in a group health plan that provides "minimum value." In the case of the "excepted benefit HRA," the employee-spouse is not required to enroll in any group health plan coverage to be able to use the HRA to reimburse medical expenses incurred by the employee-spouse and/or their dependents (although the employer offering the "excepted benefit HRA" must at least offer traditional group health plan coverage to which the employee-spouse may decline).

P. Various Integration-Related Issues

The Departments request comments on whether an HRA integrated with an individual market plan should *also* be able to be integrated with an employee's spouse's group health plan. We interpret this to mean that an employee would utilize an HRA-individual market plan arrangement to purchase an individual market plan, yet the HRA used under this arrangement would also be integrated with a group health plan offered by the employer of the employee's spouse. We see no reason why the Department's should develop such a proposal, as we see little value in the idea (because if the HRA is being used to pay for individual market plan premiums, as well as the medical expenses incurred for benefits covered under the individual market plan, there likely will be limited HRA dollars left over to pay for the group health plan's premiums and/or the medical expenses incurred for benefits covered under the group health plan).

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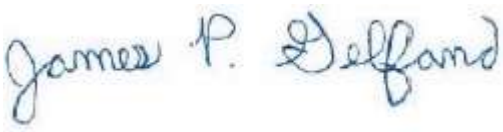
[9] *Id.*
[10] Notice 2013-54, Q&A-6.

Thank you in advance for considering these comments. Please do not hesitate to contact me with any questions, or if I can serve as a resource on these very important issues.

Sincerely,



James P. Gelfand
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