



# AMERICAN BENEFITS COUNCIL

December 28, 2018

Submitted electronically at [www.regulations.gov](http://www.regulations.gov)

Internal Revenue Service  
CC:PA:LPD:PR (REG-136724-17)  
Room 5205  
1111 Constitution Avenue, N.W.  
Washington, DC 20044

## **Re: Comments on Proposed Regulations Regarding Health Reimbursement Arrangements and Other Account-Based Group Health Plans and on Notice 2018-88**

Dear Sir or Madam:

The American Benefits Council (the “Council”) appreciates the opportunity to comment on the Notice of Proposed Rulemaking<sup>1</sup> (“Proposed Rule”) issued by the Departments of Labor (“Labor”), Health and Human Services (“HHS”), Treasury (“Treasury”), and the Internal Revenue Service (“IRS”) (collectively, the “Departments”) and on Notice 2018-88 (the “Notice”) issued by Treasury and the IRS.<sup>2</sup>

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council’s members either directly sponsor or provide services to retirement and health plans that cover more than 100 million Americans.

### **SUMMARY OF COMMENTS**

For years, the Council has urged policymakers to make Health Reimbursement Arrangements (“HRAs”) more flexible. We support the Proposed Rule’s goal of expanding the availability of HRAs and permitting their use in combination with policies purchased on the individual insurance market and welcome the increased flexibility it provides for both employees and employers. The Proposed Rule largely

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<sup>1</sup> 83 Fed. Reg. 209, 54429 (Oct. 29, 2018).

<sup>2</sup> IRS Notice 2018-88

aligns with the Council's recommendation for "standalone HRAs" in our long-term strategic plan adopted in 2014, A 2020 Vision: Flexibility and the Future of Employee Benefits. The Proposed Rule will provide employers with an additional tool in designing employer-sponsored health benefit plans, which have been the backbone of America's system of health coverage for generations.

We have also supported measures over the years to help ensure a vibrant individual health insurance market, an essential source of coverage for many Americans. In order for the Proposed Rule to achieve its goals, it is vital that the individual market be stable and well-functioning, otherwise, employers will be unwilling to utilize this expanded flexibility.

The stability of the individual insurance market is particularly important since, under the Proposed Rule, employers cannot also offer group health plan coverage alongside an HRA that may be integrated with a plan purchased on the individual market (referred to in this letter as an "ICHRA"). The Proposed Rule includes a range of safeguards to mitigate any risk of adverse selection in utilizing ICHRAs. For example, these safeguards would prohibit employers from offering new ICHRAs to employees based on their health status or from allowing employees to self-select for an ICHRA. We believe the Proposed Rule will make HRAs more usable and also has the potential to shore up the individual market as more individuals enroll in coverage, while at the same time, providing additional, affordable coverage options for employees and their families.

The Council has the following substantive comments and concerns with respect to the Proposed Rule and Notice, each of which we discuss in further detail below:

### **The Proposed Rules**

- While the Council fully supports the Departments' goal in establishing appropriate protections against anti-selection with respect to the individual insurance market, some adjustments are needed to the permissible classes in order to provide employers with the necessary flexibility to offer an ICHRA.
- To facilitate enrollment and reduce administrative complexity for employers, substantiation of enrollment in the requisite individual insurance coverage should only be required prior to making reimbursements from an ICHRA (rather than also at time of enrollment in the HRA).
- To facilitate compliance, the Departments should issue a model notice for use by employers in satisfying the notice requirements of the Proposed Rule. Additionally, the Departments should make clear as part of their final rulemaking that the required notice may be delivered electronically.

- The Council appreciates the Departments' interest in providing guidance regarding how ERISA and group health plan status applies to the ICHRA as well as when they do not apply to the integrated individual insurance policies. As discussed below, the Council requests that any final rule confirm how employers may utilize a private exchange model with respect to ICHRAs. Employers currently use these models very successfully with regard to retiree HRAs and HRAs integrated with group health coverage.
- The Council strongly supports the provision of the Proposed Rule that makes clear that an employer may make available an Internal Revenue Code ("Code") section 125 "cafeteria plan" for use by employees in paying their share of the premium of the individual insurance policy that is unreimbursed by the ICHRA. This should help ensure that employers and employees are not relatively disadvantaged from a tax perspective when compared to traditional group coverage, and, as such, should facilitate use of the ICHRA model by employers and employees alike. As discussed below, however, the Council requests some clarifications regarding how cafeteria plans can be used to help pay for premiums for individual health insurance coverage.
- Increasing numbers of Americans are enrolled in HSA-qualified high-deductible plans ("HDHPs"). According to the most recent Kaiser Family Foundation study, 19% of covered workers are enrolled in an HSA-qualified HDHP in 2018, a number that has increased over the past five years. *See*, Kaiser Family Foundation, *Employer Health Benefits: 2018 Annual Survey*, 136 (2018). The Proposed Rule provides no guidance regarding how an individual can be offered an ICHRA with individual insurance that is an otherwise qualified HDHP and continue to be HSA-eligible. As set forth below, the Council requests guidance confirming that an individual retains HSA-eligibility to the extent the ICHRA is limited to the reimbursement of post-deductible medical expenses, payment of individual insurance premiums for qualifying individual HDHP insurance and other excepted benefits coverage.
- The Council requests additional guidance regarding how excess funds in an ICHRA may be used by the ICHRA enrollee. For example, there are questions as to the extent that ICHRA funds that are not used to pay for premiums for qualifying individual health insurance coverage, may be used for other expenses. As discussed below, the Council requests that final regulations confirm that such excess funds may be used to pay for all medical expenses, including out of pocket expenses and premiums for other insurance, such as dental and vision, excepted benefits.
- The Council requests certain clarifying guidance regarding how the Medicare anti-duplication and secondary payer rules apply to the ICHRA model.

- With respect to the Excepted Benefit HRA (referred to in this letter as an “EBHRA”), the Proposed Rule sets a maximum contribution amount at \$1,800 (indexed for inflation after 2020). To reduce administrative complexity for employers, as well as to reduce potential confusion for employees, the Council requests that the annual contribution limit be the same as the maximum limit for a Health Flexible Savings Account (“FSA”), and indexed in the same manner.

### **Notice 2018-88**

- The Council appreciates the issuance of Notice 2018-88 and, specifically, potential approaches regarding how an ICHRA can be offered by an employer in compliance with the employer shared responsibility provisions of Code section 4980H. We request, however, that subsequent guidance make clear that an employer will be considered to have made an offer for purposes of Code section 4980H(a) when an ICHRA is offered to a class, regardless of whether an individual employee actually enrolls in individual health insurance coverage or otherwise meets the other requirements for use of an integrated HRA.
- Additionally, for ease of administration, with respect to Code section 4980H(b), the Council requests guidance that would determine “affordability” based on a single silver plan as a nationwide baseline for an employer’s employee population.
- Examples are required to help illustrate how employers can avoid violating the rules of Code section 105(h) when providing higher dollar limits to older employees. Because policies sold on the individual market are age rated, employers must have clarity around how they can make sure that their older employees have ICHRA funds sufficient to actually purchase an appropriate policy without possibly violating Code section 105(h). The Council requests that Treasury and IRS include specific examples in future guidance explaining how the rules work in practice.

## **DISCUSSION**

### **Employer Flexibility to Offer an ICHRA – Proposed Classes**

The Council recognizes that appropriate safeguards will be needed to prevent any adverse risk from being disproportionately shifted from the group market into the individual insurance market as a result of offering new ICHRAs. To address this concern, under the Proposed Rule, employers are permitted to divide their workforce into several specified classes of employees for purposes of offering ICHRAs. If the employer offers an ICHRA to an employee in a given class, it must offer the ICHRA on

the same terms to all employees in that class. We request certain clarifications and expansions with respect to the rules relating to classes.

First, the Proposed Rule provides eight permissible classes but does not specify whether these classes are determined on an employer-by-employer (or, to use the language of the Proposed Rule, a plan-sponsor-by-plan-sponsor) basis, or on a controlled group basis. Because the Departments do not reference Code section 414 in the Proposed Rule, it appears that classes should be determined on an employer-by-employer basis. The Council requests that the Departments clarify as part of final rulemaking that the classes are applied on an employer-by-employer basis. Additionally, the Council requests that employers be permitted to make reasonable determinations for this purpose such as, for example, by determining classes within a particular Employer Identification Number.

Second, the Proposed Rule lists as one of the permitted classes “employees who are included in a unit of employees covered by a collective bargaining agreement (“CBA”) in which the plan sponsor participates.” The Council interprets the Proposed Rule to mean that an employer may divide its employee population into separate classes of employees covered by separate CBAs – such as is permitted under the employer shared responsibility requirements of Code section 4980H – but requests confirmation of this interpretation in any final rule.

Third, the Departments request comments on the proposed classes of employees and whether additional classes of employees should be provided (for example, classifications based on form of compensation (hourly versus salaried)).

The Council recommends that the permissible classes in the Proposed Rule be expanded to include hourly and salaried employees, employees covered under the Davis Bacon and related Acts (“DBRA”), and employees covered under the McNamara-O’Hara Service Contract Act (“SCA”).

In the Preamble to the Proposed Rule the Departments expressed concern that employers could easily change an employee’s status from salaried to hourly with minimal consequences solely for the purpose of ICHRA eligibility. The Council believes such concern is misplaced for several reasons.

To begin with, under longstanding non-discrimination provisions in the Code and the Employee Retirement Income Security Act (“ERISA”), employers are prohibited from re-categorizing employees solely for purposes of diminishing or otherwise interfering with health benefits for which an individual is otherwise eligible. *See*, ERISA section 510.

Additionally, the distinction between salaried versus hourly is one of the categories most often used by employers to classify their workforce for purposes of eligibility for overtime and employee benefits. The Departments assert that “employers might easily be able to change an employee’s status from salaried to hourly (and in

certain circumstances, from hourly to salaried) with seemingly minimal economic or other consequences for either the employer or employees.” To the contrary, employers cannot readily change an employee’s status from salaried to hourly, or vice versa, without wide ranging implications for that employee’s pay and status under existing employment laws (such as running afoul of certain requirements with respect to the Fair Labor Standards Act). The rules governing the status of employees as “non-exempt” or “exempt” from overtime protections of the Fair Labor Standard Act and the risk of employers of violating these requirements serve as a potent backstop against manipulating the classification of employees as hourly versus salaried for purposes of offering an ICHRA. It is precisely because this is such an important and often used way of categorizing employees that the Council requests that it be used for purposes of ICHRA eligibility. We are confident that if this class is added, it will encourage employers to offer an ICHRA who might otherwise decline to do so.

In addition to the above, the DBRA and SCA require that certain government contracts provide that workers employed under the contract are paid no less than the locally prevailing wages and fringe benefits paid in projects of similar character or contained in a predecessor contractor’s collective bargaining agreement. 40 U.S.C. 3141, *et seq*; 41 U.S.C. 6701, *et seq*. As with employees covered by a CBA, employers are bound by different legal requirements with respect to their employees covered by the DBRA and SCA than with respect to their general workforce. And, as with other classifications that the Departments permit in the Proposed Rule, allowing employers to create a separate class for their employees covered by the DBRA and SCA will facilitate the use of the ICHRA as well as compliance with DBRA, SCA, and related contracting requirements, without the potential for employers to switch employees in and out of the class solely for purposes of health coverage. Because of the unique nature of the requirements related to employees covered by the DBRA and SCA, the Council recommends that the Departments permit employers to classify employees based on whether they are subject to the DBRA or SCA.

Finally, the Proposed Rule allows as additional classes, groups of employees described as a combination of two or more of the enumerated classes. Departments request comments on allowing combinations of classes of employees. The Council is supportive of the flexibility afforded to employers by allowing combinations of classes of employees and urges the Departments to include this provision in a final rule.

### **Integration with Individual Health Insurance Coverage Sold in States with 1332 Waivers in Place**

In order for the HRA to be sufficiently integrated with individual health insurance coverage, any participant and dependent who can receive reimbursements from the ICHRA must be enrolled in individual health insurance coverage for each month that they are covered by the ICHRA. For this purpose, the Proposed Rule treats all individual health insurance coverage as subject to, and compliant with, the ACA’s market reforms. Thus, an ICHRA may be integrated with any individual health

insurance coverage policy except for excepted benefits (within the meaning of Code section 9832, ERISA section 733, and Public Health Service Act (“PHSA”) section 2791) and Short Term Limited Duration Insurance (“STLDI”). And, while the Proposed Rule provides some helpful clarity regarding how an ICHRA can be used with certain “grandfather” policies, they are silent regarding if and how ICHRAs can be used to reimburse premiums for individual health insurance coverage policies issued pursuant to a State Innovation Waiver under ACA section 1332. Accordingly, we request the Departments clarify that for purposes of integration with an ICHRA, individual health insurance coverage that is purchased in a state with a State Innovation Waiver may be integrated with an HRA.

### **Substantiation of Coverage in an Individual Health Insurance Coverage Plan**

As discussed above, an individual who can receive reimbursements from an ICHRA must be enrolled in individual market health insurance coverage. Substantiation of enrollment in such health insurance coverage appears to be required under the Proposed Rule both at the time of enrollment in the ICHRA and prior to any expense being reimbursed from the ICHRA. An employer may generally rely on an employee’s self-attestation of coverage. There are, however, special rules when there is actual knowledge that any individual covered by the ICHRA is not, or will not be, enrolled in individual health insurance coverage during the plan year.

To begin with, the Council very much appreciates the provision of the Proposed Rule that allows employers generally to rely on an employee’s self-attestation of coverage. Such a rule makes sense given that in many instances an employer may have little or no information or access to such information regarding whether a given employee is actually enrolled in the qualifying insurance coverage.

The Council also requests that the final rule provide that substantiation is not required at time of enrollment, but solely prior to reimbursement of expenses. Given how HRAs are typically administered in practice, requiring substantiation prior to “enrollment” in an HRA would be unduly cumbersome and, given that substantiation will be required prior to reimbursement of any expense, such substantiation seems unnecessary.

Lastly, the Council requests clarification of how the substantiation requirements can be met with the use of an HRA debit card. Such cards have proven to be an extremely popular and consumer-friendly option for HRA beneficiaries. The Departments could, for example, provide that, if certain conditions are met, an individual’s signature at time of use of the debit card qualifies as self-attestation.

### **Required Notices for ICHRA**

Under the Proposed Rule, an employer sponsoring an ICHRA is required to provide written notice to eligible employees at least 90 days before the beginning of each plan year. For participants who are not eligible for the ICHRA at the beginning of

the plan year, the Proposed Rule provides that the notice must be given no later than the date on which the participant is first eligible to participate in the ICHRA. The notice must include a substantial list of information as specified in the Proposed Rule.

The Council requests that the Departments issue a model notice, as they have done for similar required notices in the past, in order to help ensure compliance, promote uniform provision of information, and ease administrative burden. The Council also requests that the Departments permit the required notice to be delivered to employees electronically provided that employees are given an appropriate opportunity to opt-out of electronic delivery.

### **ERISA Treatment**

The Council appreciates the Departments' efforts, specifically those of the Department of Labor, to provide clarifying guidance regarding when and how ERISA applies with respect to the ICHRA coverage model.

#### *Application to ICHRA-related cafeteria plan*

To begin with, the Council strongly supports the Departments' clarification that ERISA treatment does not apply to an arrangement that allows an employee to use pre-tax dollars through a cafeteria plan to pay for the portion of the premium for individual health insurance coverage that is not covered by the ICHRA. Without this provision, the effective cost of using an ICHRA would be relatively increased and would discourage employers and employees alike from considering use of an ICHRA. We request further clarification that inclusion of coverage as an eligible pre-tax benefit through a cafeteria plan does not, in and of itself, cause a program to fall outside of the current voluntary plan safe harbor or give rise to the plan being subject to ERISA.

#### *Circumstances of application to individual health insurance coverage*

The Council also appreciates the Departments' efforts to clarify that ERISA generally should not apply to the individual health insurance coverage purchased by employees with ICHRA funds. Per the terms of the Proposed Rule, the following criteria must be satisfied:

- The purchase of any individual health insurance coverage is completely voluntary for employees;
- The sponsor must not select or endorse any particular issuer or insurance coverage;
- The reimbursement for premiums must be limited to qualifying individual health insurance coverage;
- The sponsor must receive no consideration in the form of cash or otherwise in connection with the employee's selection or renewal of health insurance coverage; and
- Each plan participant must be notified annually that the individual health insurance coverage is not subject to ERISA.



The Council is concerned that certain of the stated criteria – specifically the second criteria above regarding non-endorsement – could increase risk for employers, as well as carriers, of running afoul of ERISA with respect to the use of typical and/or expected arrangements for providing certain assistance to employees.

For example, many employers may seek to provide a third-party resource for employees in identifying, selecting, and enrolling in individual health insurance coverage. This is especially so given the complex and dynamic individual insurance markets (*e.g.*, in which carriers may enter and/or exit and products may change) and the fact that the vast majority of working Americans may have never before had to navigate the individual health insurance markets to identify and purchase affordable coverage that best meets their needs, having instead relied on the group health plan coverage sponsored by their employers. We anticipate that many employers will want to offer third party resources for use by their employees in assessing, selecting, and purchasing individual health insurance coverage.

Many questions are likely to arise regarding the use of such third party resources including (but not limited to) the following:

- What if the third party is a licensed broker?
- What if the third party is not a licensed broker, but charges a fee to the employer for its services?
- What if the employer merely refers employees to numerous resources and/or brokers, but provides no recommendation or signal of support or preference?
- What if the third party has contractual agreements with carriers or insurers and these arrangements provide a basis for the information that is conveyed to an employer's employees? What if the contractual relationships extend to some, but not all, carriers or products in a given rating area?
- What if the third party has contractual agreements with carriers or insurers, but it utilizes employees and/or contractors that provide assistance without regard to these agreements and/or any related compensation that may be payable to the third party?
- What if the third party has full authority and discretion regarding which insurance to consider with respect to an employer's employees, and the employer has no knowledge of, or role in setting, any compensation payable to the third party (such as in the form of broker/agent compensation)?

As the above list is intended to highlight, while the Council appreciates the Departments' guidance with respect to ERISA as set forth in the Proposed Rule, there are a myriad of important questions with respect to which additional guidance will be needed.

Moreover, because of the potential implications if an individual insurance policy is determined to be part of the employer-sponsored group health plan (such as issues related to state insurance licensing, ACA market reforms (including application of the medical loss ratio rules), and application of ACA risk adjustment provisions), it is imperative that both carriers and employers have as much certainty as possible regarding when an arrangement will or will not trigger ERISA such that the individual insurance policies becomes part of the ERISA group health plan.

In light of the above, whether as part of final rulemaking or otherwise, the Council urges the Departments to issue clear guidance regarding under what specific circumstances the individual insurance policies risk becoming part of the employer's group health plan. To that end, the Council urges the Departments to consider the use of appropriate design-based safe harbors for use by employers and carriers, as applicable.

*Continued ability to use a private exchange model*

Lastly, but related to the above, the Council is concerned that the proposed ERISA guidance, while well-intentioned, could undermine the ability of employers to utilize a private exchange model with ICHRAs.

Employers have used the private exchange model very successfully with regard to retiree HRAs, as well as HRAs integrated with group health coverage. These models have proven very helpful in transitioning individuals to individual health insurance coverage. As noted above, the vast majority of the more than 180 million working Americans covered by employer-sponsored group health plans have likely *never* sought to purchase individual, *i.e.*, non-group, coverage. They have never had to navigate a dynamic individual insurance market; consider network adequacy in the context of adult child dependents living in different locations and who may not be covered by a plan's network; concern themselves with possible clinical disruption associated with product-specific benefit exclusions; and more. Moreover, our employer members want their employees to be enrolled in comprehensive health coverage that best meets their needs. Such coverage helps reduce absenteeism and presenteeism and provides for a healthy, well, and engaged workforce.

Many of these private exchange models may utilize a universe of insurance products or carriers that is less than 100% of those available in the open market. This is driven largely by the fact that the exchange provider may be receiving consideration as the licensed broker/agent of record with respect to the individual health insurance policies offered on the private exchange. Additionally, these models often allow, or otherwise require, an individual to engage with a representative of the private exchange provider who will then work with the individual to identify coverage that it is well-suited for the individual (from many perspectives, including cost, benefits exclusions,

potential for clinical disruptions, and network adequacy). The criteria used by the representatives, as well as the coverage that is made available on the platform, are typically outside of the control or discretion of the employer.

For the reasons noted above, the Council expects that many employers, especially larger employers, may be disinclined to send their employees to the individual insurance markets without appropriate assistance. Additional clarifying guidance is needed, therefore, regarding how various private exchange models may be utilized by employers with respect to ICHRAs.

### **Medicare Related Matters**

As mentioned above, an individual who can receive reimbursements from an ICHRA must be enrolled in individual health insurance coverage. The Council requests clarification regarding: (1) Medicare's anti-duplication requirements, as it relates to eligibility for an ICHRA; and (2) Medicare Secondary Payer rules, specifically clarifying that such rules would not apply to individual health insurance coverage purchased with an ICHRA.

#### *Medicare Anti-duplication*

Medicare prohibits issuers from "knowingly" selling or issuing individual health insurance coverage, including Exchange plans, to an individual with Medicare Part A or Part B (because such coverage would duplicate Medicare benefits). The anti-duplication provision does not apply with respect to the selling of a group policy or plan to one or more employers.

HHS has issued sub-regulatory guidance providing that "[c]onsistent with the longstanding prohibitions on the sale and issuance of duplicate coverage to Medicare beneficiaries (section 1882(d) of the Social Security Act), it is illegal to knowingly sell or issue an Individual Marketplace Qualified Health Plan (or an individual market policy outside the Marketplace) to a Medicare beneficiary. ... [However] [t]he prohibition, set forth in Section 1882(d) of the Social Security Act, applies to selling or issuing coverage to someone who has Medicare Part A or Part B."<sup>3</sup> Thus, per the HHS guidance, the prohibition against the sale or issuance of duplicate coverage to an individual with Medicare applies to selling or issuing coverage to someone *enrolled* in Medicare, but does not apply to selling or issuing coverage to someone *eligible* for Medicare, but not enrolled.

With respect to individuals who were already enrolled in individual health insurance coverage, including coverage sold through an exchange, HHS has also advised that "[w]hile the Medicare anti-duplication provision prohibits the sale or issuance of a policy, it does not provide for discontinuance or non-renewal of a policy

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<sup>3</sup> Frequently Asked Questions Regarding Medicare and the Marketplace August 1, 2014 (updated April 28, 2016), Q.A.1, and Q.A.3. (emphasis added).

already issued, such as when an individual covered by an individual market policy becomes covered by Medicare. ... Medicare eligibility or entitlement is not a basis for non-renewal or termination of individual health insurance coverage.”<sup>4</sup>

In light of the above, it appears that individuals who are enrolled in Medicare would not be eligible for an ICHRA because the anti-duplication provision prohibits the sale of an individual market policy to a Medicare-enrolled individual. However, this prohibition does not apply to individuals who are eligible for, *but not enrolled in*, Medicare, as well as individuals who enrolled in an ICHRA prior to enrolling in Medicare. Persons eligible for Medicare are not eligible for federal tax subsidies, and for individuals who enrolled in an ICHRA prior to enrolling in Medicare, once Medicare Part A coverage begins, any federal tax subsidy the individual receives through the exchange will be discontinued. The Council requests clarification that these same rules will apply for purposes of eligibility for an ICHRA.

The Council also requests clarification as to how an employer will know whether an individual is enrolled in Medicare and, therefore, ineligible for an ICHRA. More specifically, the Council requests the Departments clarify that an employer can require an employee attestation providing that the employee is not enrolled in Medicare to prevent individuals who are enrolled in Medicare from enrolling in an ICHRA.

#### *Medicare Secondary Payer Rules*

The Council also requests that the Departments clarify that individual health insurance coverage purchased with an ICHRA need not comply with Medicare Secondary Payer requirements, specifically the rules regarding the payment of benefits when coverage is primary to Medicare. The Departments should clarify that the same general approach regarding Medicare Secondary Payer under ERISA applies, and that individual health insurance coverage purchased through an ICHRA is not group health coverage subject to the Medicare Secondary Payer rules.

### **ICHRA and Eligibility to Participate in an HSA**

Substantial numbers of employers and employees are utilizing HSA-qualified HDHP coverage. In fact, recent data indicates that as of 2018, close to 30% of employers offering health benefits offer an HDHP/HRA, an HSA-qualified HDHP, or both. *See*, Kaiser Family Foundation, *Employer Health Benefits: 2018 Annual Survey*, 135 (2018).

As noted above, the Proposed Rule is silent regarding how an ICHRA can be used with otherwise-qualified individual HDHP insurance coverage such that the ICHRA enrollee can retain eligibility to contribute to an HSA. Since the ICHRA qualifies as a group health plan for purposes of federal tax rules, including Code section 223, absent clarifying guidance, the Council is concerned that employees who utilize an ICHRA to enroll in individual HDHP insurance policies could be rendered ineligible to contribute to an HSA. Given the growing popularity of HDHPs and HSAs, as well as

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<sup>4</sup> Market Standards for 2015 and Beyond, Final Rule, 79 Fed. Reg. at 30247-48.

the important role of HSAs in helping HDHP enrollees save for and pay out-of-pocket and/or pre-deductible medical costs, the Council is very concerned that uncertainty about HSA eligibility could hinder the adoption of ICHRAs.

To ensure that ICHRAs can effectively be utilized with HDHPs without adversely affecting eligibility for making HSA contributions, the Council urges the Departments to clarify as part of final rulemaking that an ICHRA that is limited to reimbursing premiums for an HSA-qualified HDHP individual policy, post-deductible expenses (as provided in Revenue Ruling 2004-45), and/or excepted benefits, can qualify as disregarded coverage pursuant to Code section 223(c)(1)(B). By providing such clarification, the Departments will avoid the unintended consequence of disincentivizing individuals from participating in HSAs, a consequence that would be contrary to the Departments' stated goal of "expanding access to HSAs...to ensure that newly empowered health care consumers can make well-informed decisions about their care."<sup>5</sup>

### **Permitted Use of ICHRA Funds**

In general, HRA funds may be used to reimburse employees for medical care expenses incurred by employees and their spouses, children, and dependents. The Council understands the Proposed Rule to permit the use of ICHRA funds for all medical care expenses. To the extent that amounts in an ICHRA are not used to pay for individual market major medical insurance that qualifies the individual for the ICHRA, remaining funds may be used for other unreimbursed medical expenses, including out of pocket expenses and premiums for other insurance, such as dental and vision excepted benefits. The Departments should clarify that HRAs, including ICHRAs and excepted benefit HRAs, can be used to purchase any excepted benefit health coverage, including hospital indemnity or other fixed indemnity health coverage and coverage for a specific disease or illness as described in PHS Act § 2791(c)(3), ERISA § 733(c)(3), and Code §2791(c)(3). We note this would not allow HRAs to be used to pay for non-health excepted benefit coverage, such as accident or disability coverage.

We also understand that ICHRA funds need not be used to pay the premiums for qualifying individual market insurance so long as there is substantiation that an individual is enrolled in individual health insurance coverage and seek confirmation of our understanding.

### **Affordability of an ICHRA**

The affordability guidelines in the Proposed Rule generally provide that an ICHRA is considered affordable for an employee for a month if the employee's "required HRA contribution" does not exceed 1/12th of 9.5% (indexed) of the

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<sup>5</sup> See, U.S. Dept. of Health and Human Services, *Reforming America's Healthcare System Through Choice and Competition* (2018), <https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf>.

employee's household income for the year. The formula to calculate the employee's "required HRA contribution" incorporates the monthly premium for the lowest cost self-only silver plan available to the employee through the exchange for the rating area in which the employee resides. The Departments state that choosing the silver plan aligns the Premium Tax Credit ("PTC") eligibility rules with respect to ICHRAs with the PTC eligibility rules for offers of non-HRA employer-sponsored coverage.

The Council appreciates the Departments providing affordability rules in the Proposed Rule and the accompanying Notice. Absent an employer being able to satisfy the ACA's employer shared responsibility provisions with an ICHRA, the option of offering an ICHRA would be illusory for most large employers.

The Council also understands the Departments' interest in tying the affordability calculations to the cost of the lowest cost self-only silver coverage. We request, however, that employers not be required to look to the specific rating area in which the employee resides for purposes of identifying the lowest cost-silver plan to use for the affordability determination. Doing so would require more geographically diverse employers, including multi-state and national employers, to perform a significant volume of individualized calculations, imposing an unnecessary and excessive administrative burden on such employers. Indeed, Treasury and the IRS have already recognized the need for simplicity and certainty in employer calculations of affordability when they provided three affordability safe harbors in their regulations governing the ACA's employer shared responsibility requirements. Accordingly, the Council requests that the Departments provide a safe harbor for purposes of Code section 4980H(b) that would allow an employer to use a single silver plan as a nationwide baseline for its employee population, while still continuing to permit individuals to receive a PTC if the ICHRA was not, in fact, affordable for them.

See below for an additional discussion of affordability issues with respect to the Notice.

### **Excepted Benefits HRAs (EBHRAs)**

The Council supports the Departments' implementation of a new class of excepted benefits, the EBHRA, to provide employers with more flexibility in plan design. While the Council understands the need to limit the amounts available through an EBHRA, we recommend using as the maximum contribution amount the Health FSA limit (\$2,700 for 2019) rather than the \$1,800 provided for under the Proposed Rule. Employees are familiar with the Health FSA limit, and having uniform limits would ease employee education and communication.

We read the Proposed Rule to allow for up to \$1,800 for reimbursement of any medical expenses, except premiums for individual health insurance coverage, premiums for coverage under another group health plan (other than COBRA or other group continuation coverage), or premiums for Medicare Part B or Part D. There appears to be some confusion, however, as some are interpreting the regulation to allow

for reimbursement under the excepted benefit HRA only for premiums for excepted benefits, short-term limited duration policy premiums, and COBRA premiums. We recommend final guidance confirm the first interpretation above to resolve any uncertainty.

Additionally, the Council requests that the EBHRA limit be indexed using unchained CPI-U, or health inflation, rather than to C-CPI-U as the lower indexing amount does not accurately reflect the increases in the cost of medical care over time. Finally, timing of the annual limit announcement for EBHRAs should be coordinated with other account-based plans (for example, FSAs and HSAs) and should take place well before open enrollment. To do otherwise would be to cause unnecessary consumer confusion and complexity as well as avoidable and costly burdens on employers.

### **Notice 2018-88**

The Council appreciates the issuance of Notice 2018-88, which seeks input on important compliance issues related to sections 4980H and 105(h). Clear and workable guidance regarding how employers can offer ICHRAs and at the same time avoid section 4980H penalties is critical to employers adopting a plan design that includes ICHRAs. We have several suggestions, however, for how the guidance in the Notice can be improved in order to make ICHRAs a more workable option for larger employers.

First, the Council asks Treasury and IRS to permit the use of a nationwide or employer-wide standard, such as for example, where an employer is headquartered, for determining “affordability” for purposes of avoiding Code section 4980H penalties. Doing so would avoid the imposition of unnecessary costs and administrative burdens on employers and encourage the use of ICHRAs. This is particularly important given the rise of geographically dispersed employers, the use of telecommuting, and an increasingly mobile workforce.

Second, the Council requests that Treasury and IRS clarify that an employer will be considered to have made an offer of coverage for purposes of Code section 4980H with respect to any employee in a designated class, even if the employee (or dependent child) does not purchase individual health insurance coverage. While the decision to offer an ICHRA is an employer’s choice, whether an individual employee actually enrolls in individual health insurance coverage is outside of the employer’s control and would entail significant administrative burden to determine and monitor enrollment. It is unreasonable and unworkable to tie a potential employer penalty to the individual’s decision whether to purchase coverage where the employer offers an ICHRA.

Third, the Council wholly supports guidance permitting contribution limits to increase based on age, given that an individual’s age is directly related to the price of individual health insurance coverage (per the ACA’s rating rules). Such increases are necessary to ensure that older employees are not relatively disadvantaged compared to younger employees because of the fact that the pricing of individual health insurance coverage is age-rated and, as such, increases with the age of the consumer. While the

Notice clearly permits such increases, additional guidance is required with respect to how an employer may structure them in practice. Specifically, the Notice provides that Code section 105(h) will not be violated if amounts made available to employees in an ICHRA increases based on age so long as the increase is “in accordance with the increases in the price of an individual health insurance coverage policy in the relevant individual insurance market based on the ages of the employees who are members of that class of employees.” It is not clear how such a rule would work in practice, and further examples would be helpful.

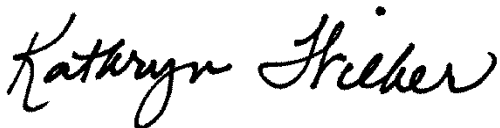
See above for additional comments about affordability in the context of the Proposed Rule.

## CONCLUSION

The Council believes the Proposed Rule will expand the usability of HRAs to provide employees with more choice, provide employers with flexibility to innovate health benefits design and ultimately promote competition in the individual insurance markets.

Thank you for considering these comments. If you have any questions or would like to discuss these comments further, please contact us at (202) 289-6700.

Sincerely,



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American Benefits Council



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