December 13, 2018

Internal Revenue Service
Room 5205
Ben Franklin Station
Washington, DC 20044

Re: Health Reimbursement Arrangements and Other Account-Based Group Health Plans (REG–136724–17)

To Whom It May Concern:

On behalf of the American Academy of Actuaries[1] Health Practice Employee Benefits Committee and Individual and Small Group Market Committee, we would like to offer comments on the proposed rule regarding Health Reimbursement Arrangements (HRAs), issued jointly on Oct. 29 by the Internal Revenue Service of the Department of the Treasury; Employee Benefits Security Administration of the Department Labor; and Centers for Medicare & Medicaid Services of the Department of Health and Human Services ("the Departments"). The proposed rule would create two new types of HRAs—Integrated HRAs and Excepted Benefit HRAs—which would allow employers to provide HRAs that could be used to pay for individual plan premiums and out-of-pocket health costs.

Integrated HRAs

Potential impact on the individual market. The proposed rule would allow HRAs to be integrated with individual market coverage. An important consideration is how expanding the availability of HRAs would affect the individual market risk pool. There are several ways that integrated HRAs could result in adverse selection in the individual market. However, the proposed rules contain provisions that would limit some sources of adverse selection. This section describes the various avenues for adverse selection, highlights the provisions in the proposed rule that would limit adverse selection, and provides an example illustrating the importance of these provisions.

One way in which integrated HRAs could lead to adverse selection in the individual market is if large employers disproportionately encourage less-healthy workers, directly or indirectly, to use their HRAs for coverage on the individual market. Employers in the large group market as well as self-insured small employers are typically subject to experience rating—that is, premiums reflect the underlying aggregate health status of the employer's workforce. Large employers and

[1] The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

self-insured small employers with a greater share of less-healthy employees could be more likely to offer HRAs integrated with individual market coverage than employers with healthier employees. The resulting adverse selection could worsen the Affordable Care Act (ACA) individual market risk pool and put upward pressure on individual market premiums.

Another adverse selection concern is that less-healthy individuals might prefer to use the HRAs to obtain ACA-compliant individual market coverage, whereas healthy individuals might prefer to use the HRAs to cover out-of-pocket spending or for noncompliant coverage. The proposed rule provides that enrollees may accept the HRA only if individual market coverage is actually purchased, otherwise they must forfeit the funds. This provision should reduce the potential adverse selection in the individual market. The proposed rule explicitly prohibits using the HRA to purchase short-term limited-duration (STLD) coverage in place of individual market coverage. If instead enrollees were given a choice of using HRA funds to purchase either individual market coverage or STLD coverage, healthy employees would be more likely to purchase the less expensive STLD plans, creating adverse selection for the individual market.

Adverse selection in the individual market could also be a problem if experience-rated or self-insured employers are able to target their less-healthy workers or classes of workers for individual market coverage, while offering group coverage to their healthy workers. Due to the much larger size of the employer market compared to the individual market, a small percentage shift of employer market high-cost enrollees to the individual market could have a large negative impact on the individual market risk pool.

The proposed rule contains three important nondiscrimination provisions that, taken together, would reduce the ability of employers to target high-cost workers or groups of workers, thereby limiting adverse selection in the individual market. First, employees could not be offered a choice between traditional group insurance and integrated HRAs. This protection would prevent employers from facilitating employee-level adverse selection. Second, integrated HRAs would have to be offered to an entire class of employees among a set of eight classes enumerated in the rule and any combination of those classes. Because these classes are broader than those that can be used to vary rates for health status under Health Insurance Portability and Accountability Act (HIPAA) nondiscrimination rules, this provision reduces the ability of employers to target high-cost workers by targeting particular worker classes. Allowing employers to define classes more narrowly would increase the opportunity for employers to target high-cost workers, thereby increasing the adverse selection risk in the individual market. Third, integrated HRAs would have to be offered on the same terms to all employees within the class, with exceptions for age and number of dependents. This provision would also limit the ability of an employer to implicitly encourage adoption of integrated HRAs by less-healthy individuals. The exceptions for age and number of dependents are needed because individual market rates vary by age and number of dependents. However, unless the allowable HRA contribution variations by age and number of dependents parallel the individual market plan premium variations by these factors, employers could vary HRA contributions in a way to encourage higher-cost workers to shift to the individual market. The affordability requirements for large employers subject to the employer mandate would also help to ensure that employers do not vary contributions to target high-cost workers.

An additional protection would prevent employers from shifting former employees (currently covered in the employer's group retiree health plan) to the individual market. The proposed rule would require that former employees who are covered in the employer's group retiree health plan be treated as part of the class of active employees that they were in prior to separation. If former employees were to be treated as their own class, there would be a significant concern about adverse selection for the individual market because the former employees are expected to be older and generally less healthy than active employees. We note that this proposed rule would not affect former employees who continue in the employer's group active health plan through a Consolidated Omnibus Budget Reconciliation Act (COBRA) election. Such former employees who continue in the employer's active group health plan through COBRA would be treated as active employees.

Table 1 provides a simplified illustration of the impact on the individual market of shifting a share of the highest spenders in the group market to the individual market and highlights the potentially large increase in average individual market claims. This example underscores the need for nondiscrimination rules to limit the ability of employers to target integrated HRAs solely to particularly high-cost workers.

Table 1. Illustration of the Potential Effect of Shifting Persistent Top Spenders in the Large Group Market to the Individual Market, 2016

Percent of Persistent Top Spenders in Large Group Market Moving to Individual Market Coverage	Average Annual Claims in Individual Market, After Shift of Top Spenders	Increase in Average Individual Market Claims
0%	$4,411	0%
5%	$5,075	15%
10%	$5,726	30%
25%	$7,605	72%
100%	$15,595	254%

American Academy of Actuaries calculations using data from the Kaiser Family Foundation (KFF), the Health Care Cost Institute (HCCI), and the Medical Loss Ratio (MLR) public use file data from the Centers for Medicare and Medicaid Services (CMS). Methodology:

- Number of large group enrollees in 2016 = 143 million = Number of group enrollees (157 million, KFF) – Number of small group enrollees (14 million, CMS data); includes both insured and self-funded employers
- Persistent top spenders represent group insurance enrollees in top 5 percent of total spending in 2015 who were also in the top 5 percent of total spending in 2014. HCCI estimates that 39 percent of the top 5 percent of spenders in 2015 or (1.95 percent of all enrollees) were persistent top spenders.
- Number of persistent top spenders in 2015 = 143 million * 1.95 percent = 2.8 million
- Average claims of persistent top spenders, 2016 = Per capita spending among persistent top spenders in 2015 ($74,045, HCCI) * assumed trend to 2016 (1.05) – cost sharing (assumed maximum out-of-pocket limit of $6,000) = $71,747
- Number of individual market enrollees in 2016 = 14 million (CMS)
- Average individual market claims in 2016 = $4,411 (CMS)
- The average claims in the individual market after the shift of top spenders in the group market is calculated as [$4,411 * 14 million + $71,747 * 2.8 million * percent switching]/(14 million + 2.8 million * percent switching)

Employer offer decisions. Many large employers are interested in transitioning to a defined contribution approach of providing employer-sponsored health benefits. Allowing HRAs to be used to purchase individual market coverage could facilitate such a trend and by increasing enrollment could help stabilize the individual market risk pool as long as a broad cross-section of employers, as opposed to solely those with employees with high health costs, move in this direction. Nevertheless, employers would likely be hesitant to use this approach if they consider the individual market to be unstable or not offering adequate options to their employees. This approach may be feasible to employers only if the premiums in the individual market are not higher than those available in the group market and if cost growth in the individual market is less than or equal to the cost growth in the employer market. Additionally, regulatory actions that put upward pressure on rates in the individual market would reduce the appeal of HRAs to employers.

Although the impact in the short term could be relatively modest, more dramatic effects on the employer and individual markets could arise in the long term if circumstances change—for instance, if the individual market stabilizes and employers prioritize the shift toward defined contribution health benefits.

Affordability guidelines. Under the proposed rule, the affordability guidelines for HRA coverage with respect to the employer mandate would be based on the net employee cost of the lowest-cost silver plan. The lowest-cost silver plan was selected in order to ensure that coverage which is affordable to the employee also provides minimum value (MV), as a bronze plan can have an actuarial value below 60 percent. As opposed to using the lowest-cost silver plan, using the second-lowest-cost silver plan (SLCSP) may be easier for employers administratively—unlike the lowest-cost silver plan, SLCSP premium information is widely available because it is the ACA benchmark plan. In addition, use of the SLCSP would provide consistency with affordability calculations applicable to Qualified Small Employer HRAs.

Special enrollment period. The proposed rule introduces a new special enrollment period (SEP) for newly available integrated HRAs and the Departments have asked whether this SEP should be available annually for non-calendar-year plan years. We note that it would be preferable for employers offering integrated HRAs to use a calendar-year plan year because individual health insurance plans are required to be calendar year. If employees switch individual market plans midyear, they would have less than a calendar year to fulfill deductibles and other accumulators. Even though the plans provide MV on a calendar-year basis, the plans would not be expected to meet MV if enrollees are only in them for a partial calendar year. In addition, it would be difficult for employers to ensure that the HRAs provide affordable coverage when the plan year spans two calendar years and individual market rates for the second year are unknown.

Excepted Benefit HRA

The proposed rule provides a limited excepted benefit HRA that could be offered as an option alongside a traditional group plan. This HRA may provide up to $1,800 per year (indexed to inflation) that could be used to purchase STLD plans or other plans that consist solely of excepted benefits (e.g., vision and dental coverage). Excepted benefit HRAs would not be allowed to be used for non-excepted benefit individual market premiums, other group health premiums, or premiums for Medicare Part B and Part D.

Nevertheless, healthier employees would be able to choose the HRA and STLD plans rather than paying their share of the premium for the employer group plan. Although this option would not be expected to affect the individual market risk pool, it could affect the small group market risk pool. If small employers offering group coverage offer an HRA option and healthier workers disproportionately use it to opt out of the small group plan and purchase an STLD or other excepted plan (or simply use it for out-of-pocket health expenses), the small group risk pool could deteriorate, putting upward pressure on premiums. Given the limited funding available in the HRA and the presence of medical underwriting in the STLD market, healthier workers would be much more likely to select the HRA option compared to less-healthy workers.

Applicability Date

The proposed rule is applicable for plan years beginning Jan. 1, 2020. Individual and small group market initial 2020 rate filings are due beginning in the spring of 2019. Because this rule can be expected to have some impact on these markets, we suggest that rules be finalized prior to rate filing deadlines, or else the effective date be postponed to allow issuers to accommodate the expected impacts of the rule in premium rates.

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We appreciate the opportunity to provide these comments on the proposed rule and would welcome the opportunity to speak with you regarding these comments in more detail and answer any questions you might have. If you have any questions or would like to discuss further, please contact David Linn, the Academy's senior health policy analyst, at 202-223-8196 or linn@actuary.org.

Sincerely,

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