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Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration, Room N-5653
U.S. Department of Labor
200 Constitution Ave, NW
Washington, DC 202103

Attention: RIN 1210-AB43

Ladies and Gentlemen:

Bloom Health is pleased to submit these comments on the interim final regulations implementing the rules for group health plans and health insurance coverage in the group and individual markets under provisions of the Patient Protection and Affordable Care Act (PPACA) regarding preexisting condition exclusions, lifetime and annual dollar limits on benefits, rescissions, and patient protections. The interim final regulations (IFRs) were published by the Departments of Labor, Health and Human Services, and the Treasury (collectively, the Departments) in the Federal Register on June 28, 2010. Our comments will specifically address the Public Health Service (PHS) Act section 2711 regarding lifetime and annual dollar limits on benefits in regards to stand-alone Health Reimbursement Accounts (HRAs) that are not retiree-only plans.

1. Bloom Health's Interest in the Interim Final Regulations

Bloom Health Corporation provides online and phone decision support systems to assist individuals and employers with complex decisions regarding health care coverage options. It also administers or facilitates consumer-driven health care accounts and services, including HRAs, health savings accounts (HSAs), cafeteria plans, and wellness programs. Bloom Health believes that HRAs are an extremely valuable form of employee benefit that will play an important role in the implementation and success of health care reform. While Bloom Health applauds the efforts of the Departments in fulfilling the enormous and complex tasks set before them by Congress in the PPACA, it urges them to avoid interpretations that impose unnecessary limitations on access to health care. HRAs play a vital role in ensuring that millions of American workers can meet out-of-pocket expenses for health care and will continue to seek care when necessary.

2. Health Care Reform and HRAs

Like all forms and methods of health care financing, HRAs were scrutinized in the negotiations and discussions surrounding health care reform. Congress addressed similar forms of employee benefits, imposing new tax penalties on nonqualified distributions from Health Savings Accounts, and limiting the amount that may be set aside to health flexible spending arrangements that are part of cafeteria plans to $2,500.[1] Congress adjusted HRAs slightly by limiting their ability to reimburse non-prescription drugs, but nothing in the PPACA or any portion of the public record suggests that HRAs were to be eliminated or significantly curtailed.[2] By leaving HRAs largely untouched, Bloom Health believes that Congress intended to ensure that HRAs will remain available to help individuals pay for out-of-pocket medical expenses in the post-reform environment.

Notwithstanding the limited treatment of HRAs by Congress in the PPACA, the Departments requested comments in the IFR as to whether the PPACA prohibits freestanding HRAs altogether. The question was raised in connection with Section 2711 of the PHS Act, as added by the PPACA, which generally prohibits group health plans and health insurance issuers offering group or individual health insurance coverage from imposing lifetime or annual limits on the dollar value of health benefits. The Departments note that an HRA would not violate the prohibition on annual or lifetime limits if it was combined with a group health plan without such limits. The Departments further indicated that retiree-only HRAs are generally not subject to the rules in PHS Act section 2711 relating to annual limits.

Implicit in this analysis, however, and in their request for comments, appears to be an assumption by Departments that the account balance of an HRA is the equivalent of an annual or lifetime limitation on a group health plan. It is not.

HRAs are defined contribution health plans. The balance of an individual's account in an HRA is not a lifetime or annual limitation. Each individual account may vary within an HRA to reflect different levels of employer contributions (subject to nondiscrimination rules), utilization (including decisions by individuals preserve their HRA balances for retirement), and investment returns (for funded HRAs).

Annual and lifetime limitations serve a different purpose for a different kind of health plan. They have been used by traditional group health plans (i.e., defined benefit plans), to limit liability for unforeseen high claims. As a result, there have been many circumstances where individuals lost coverage when they needed it. The "Fact Sheet" published with the IFRs on June 22, 2010,

[1] PPACA §§ 9004 and 9005.
[2] PPACA § 9003(c).

provides examples of the problems created by annual and lifetime limitations and the intent of Congress in prohibiting them under the PPACA:

- No Lifetime Limits on Coverage. Millions of Americans who suffer from costly medical conditions are in danger of having their health insurance coverage vanish when the costs of their treatment hit lifetime limits set by their insurers and plans. These limits can cause the loss of coverage at the very moment when patients need it most. Over 100 million Americans have health coverage that imposes such lifetime limits.
    - A teenager was diagnosed with an aggressive form of leukemia requiring chemotherapy and a stay in the intensive care unit. He reached his family's plan's $1 million lifetime limit in less than a year. His parents had to turn to the public for help when the hospital informed them it needed either $600,000 in certified insurance or a $500,000 deposit to perform the bone marrow transplant he needed.

The concern of Congress was that annual and lifetime limits frustrated the purpose of traditional health insurance. The objective of the legislation was to correct this problem. But there is no such confusion or concern about HRAs. Participants fully understand that they are given a certain amount of funds by their employer to use for the reimbursement of health care expenses. When the HRA is depleted, it has fulfilled its purpose, and the understanding of the employer and employee are perfectly in sync.

3. The Importance of Preserving HRAs

In July 2010 the Government Accounting Office (GAO) released an in-depth analysis of HRAs, which includes a literature review of 31 other studies and the experience of two large employers, one public and one private, that adopted HRA programs in 2003.[3] As with the vast majority of similar studies, it concluded as follows:

[3] U.S. General Accounting Office. *Consumer Directed Health Plans: Health Status, Spending, and Utilization of Enrollees in Plans Based on Health Reimbursement* Arrangements, GAO-10-616 (July 2006).

> Spending and utilization for enrollees in HRAs generally increased by a smaller amount or decreased compared with those in traditional plans that GAO reviewed.[4]

It is clear from this and other studies that HRAs combined with high deductible health plans have a significant impact on slowing the cost curve for health care inflation, one of the key goals of health care reform. In the preamble to the IFR, the Departments seem to create some breathing room for HRAs used in this manner, noting that,

> When HRAs are integrated with other coverage as part of a group health plan and the other coverage alone would comply with the requirements of PHS Act section 2711, the fact that benefits under the HRA by itself are limited does not violate PHS Act section 2711 because the combined benefit satisfies the requirements.

But HRAs may also be established and maintained for the benefit of employees who choose to purchase high deductible health plans on the individual market. While this may not be commonplace at the present time, a recent analysis by the Chief Actuary of the Centers for Medicare and Medicaid Services (CMS) indicates that by 2019, 14 million Americans will lose employer-based health insurance coverage due to the relatively high values of subsidies for individuals on the exchange and the relatively low penalties to employers that choose to drop coverage.[5] If these employers provide HRAs for their employees, the same dynamics that generate cost savings through reduced utilization of employer-sponsored group health plans will apply on the exchanges.

Employees with access to HRA accounts who purchase individual policies on the exchanges will be more likely to select lower cost options such as high deductible plans under the "Bronze" coverage category. This will reduce the cost of premium subsidies to the federal government.[6]

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[4] *Id.* The study also notes that individuals who enroll in HRAs tend to be younger and healthier, but that does not explain all of the findings:

> For the public and private employers we reviewed, health care spending and utilization of health care services for the HRA groups generally increased by a smaller amount or decreased compared with the PPO groups, from the period before to the period after switching. Additionally, the majority of the studies we reviewed that examined total or medical spending and controlled for differences in health status or other characteristics of enrollees reported lower spending among enrollees in HRAs and other CDHPs relative to traditional plans.

[5] Richard Foster, Department of Health and Human Services, *Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as amended* (April 22, 2010) (the "Chief Actuary's Study").

[6] If and to the extent that the Departments' proposed interpretation of the application of PHS Act section 2711 to HRAs is influenced by revenue considerations, it should also take into account the Chief Actuary's Study, *supra,* which indicates that most of the loss in employer-provided coverage under the PPACA will occur among small employers with low average salaries. Permitting freestanding HRAs for this population will not result in significant forgone tax revenues, but will generate savings to the government as members use their accounts to assume greater risks, resulting in lower subsidies.

Regardless of where Americans purchase their insurance, the need for resources to "fill in the gaps" has never been more apparent. The following table[7] below outlines average deductible and copayment amounts nationwide:

Average Annual Deductible	
HMO	$699
PPO	$634
POS	$1,061
HDHP	$1,838
Average Copay for In-Network PCP Office Visit	
HMO	$18
PPO	$21
POS	$21
HDHP	$22

The following table[7] displays the high percentages of working Americans who are subject to out of pocket expenses today:

Percentage of Covered Workers Subject to an Annual Deductible	
HMO	16%
PPO	74%
POS	62%
Percentage of Covered Workers Subject to a Copay for a Physician Office Visit	
HMO	94%
PPO	77%
POS	89%

These percentages are unlikely to significantly change as the PPACA continues to be implemented. Whether offered in connection with employer-sponsored coverage or on a stand-alone basis, HRAs for non-retired employees can be an extremely valuable tool for employers to use to help protect their employees, specifically low income employees, from forgoing medical care due to out-of-pocket expenses.[8]

[7] Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009

[8] The Chief Actuary's Study estimates that the out-of-pocket maximum for a family of four in a qualified plan sold on the exchange will be $13,290 in 2014. Cost sharing subsidies are available depending on income, and a family with income between 200 to 300% of the federal poverty level would be eligible for a reduction of 2/3rds of this amount. PPACA §1402(c). But this still leaves potential out-of-pocket costs for that same family in the amount of $4,430. The preservation and promotion of freestanding HRAs among employers that terminate their group health plans will have a significant impact on helping Americans pay these costs and seek medical care when needed.

Although other programs are available to help individuals pay for medical expenses, HRAs provide a unique combination of features that make them especially well-suited for this task. First, HRAs can only be funded with employer dollars, which ensures that the benefit is available (few low income employees will take advantage of salary reduction). Second, HRAs may only reimburse substantiated medical expenses, which ensures that the funds are not used for other purposes. Third, HRAs are subject to nondiscrimination rules that promote uniform contributions among all wage classes of employees.

Whether offered alongside other group health plans, on a freestanding basis, or to retirees, HRAs help employees pay for health care they might otherwise avoid or delay. This in turn helps bend the cost curve by encouraging early treatment of conditions that may otherwise transform into serious illness or chronic diseases. The preservation of HRAs, including freestanding HRAs, will also help reduce the burden on the federal government as small employers terminate their group health plans and employees enroll in the exchanges. By maintaining a simple vehicle for small employers to contribute to the cost of health care, the Departments will promote the goals of health care reform and reduce the cost to the federal government.

4. A Better Interpretation Section 2711 of the PHS Act

Section 2711 of the PHS Act can and should be interpreted to prohibit lifetime or annual limits on HRAs in a practical manner consistent with the definition of an HRA. Consider the following examples:

> Example 1. Employer A offers an HRA to its employees and contributes $500 per year to their accounts, subject to an annual limit on reimbursements of $1,000. After four years without incurring medical expenses, Employee X has accumulated $2,000 in his account. At the end of the fourth year, Employee X is hospitalized and incurs $2,000 in out-of-pocket medical expenses. Although he has accrued $2,000 in his account, the HRA imposes an annual limit on reimbursements of $1,000. The $1,000 limit violates Section 2711 of the PHS Act.
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> Example 2. Employer B offers an HRA to its employees and contributes $500 per year to their accounts, subject to a lifetime limitation on reimbursements of $2,000. Employee Y has routine uninsured medical expenses and spends down the Employer B's HRA contribution each year. At the end of the fourth year, Employer B informs Employee Y that she has met the lifetime limitation under the HRA and is not longer eligible for coverage. The lifetime limit violates Section 2711 of the PHS Act.

Example 3. Employer C offers an HRA to its employees and contributes $500 per year to their accounts. Employer C does not adopt a policy regarding annual or lifetime limitations for its HRA. The mere fact that an employee could spend down his or her account in the HRA to zero in a given year does not mean that the HRA violates the prohibition on annual or lifetime limits under Section 2711 of the PHS Act.

5. Unintended Consequences of Prohibiting Stand-Alone HRAs

Numerous employers throughout the country have chosen to fully vest their employees in their HRA balances. This is especially common among public employers, many of which offer funded HRAs through irrevocable trusts in arrangements that also permit employees to direct the investment of their accounts. While HRAs offered in these programs are typically provided alongside high deductible health plans, dwindling public resources and subsidies available on the exchanges may cause many smaller public employers to terminate their group health plans. This will leave employers and employees "stranded" in funded, fully-vested, stand-alone HRAs.

Even where HRAs are not funded, many employers have made promises to "vest" employees in their unfunded account balances. Other employers may be uncomfortable requiring that employees forfeit unused balances that they have accumulated over time. IRS rules prohibit offering cash or other benefits in lieu of amounts accumulated in an HRA.[9] If the Departments adopt the unusual interpretation they suggest in the IFR, they will need to offer grandfathered protection to current and future HRAs that are established in connection with an employer's group health plan. Ultimately, this exception will swallow the rule.

[9] Notice 2002-45 ("If any person has such a right under an arrangement currently or for any future year, all distributions to all persons made from the arrangement in the current tax year are included in gross income, even amounts paid to reimburse medical care expenses.")

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Conclusion

HRAs are defined contribution health plans. Most major medical plans are defined benefit arrangements. When Congress eliminated annual and lifetime limitations for group health plans, they were clearly addressing the latter form of arrangement. Section 2711 of the PHS Act can be interpreted in manner that is both consistent with the intent of Congress and does not eliminate a common health care benefit that is modest in scope and primarily benefits low wage employees. Bloom Health urges the Departments to consider the needs of ordinary Americans in paying medical care expenses that are not otherwise insured or subsidized, and in preserving all means by which employers may continue in their traditional role of assisting employees with the cost of health care.

Bloom Health Corporation appreciates the opportunity to provide comments on the interim final regulations. If the Departments have any questions, or if we can be of any further assistance, please let us know.

Sincerely,

Abir Sen
CEO, Bloom Health Corporation

10 S 5th St, Suite 645, Minneapolis, MN 55402 p 612-367-8100 f 612-367-8259 www.gobloomhealth.com