



American Cancer Society
Cancer Action Network
555 11th Street, NW
Suite 300
Washington, DC 20004
202.661.5700
www.fightcancer.org

via electronic submission

December 28, 2018

Steven Mnuchin
Secretary of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

Alexander Acosta
Secretary of Labor
200 Constitution Ave, NW
Washington, D.C. 20210

Alex M. Azar II
Secretary of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Re: REG–136724–17: Health Reimbursement Arrangements and Other Account-Based Group Health Plans
83 Fed. Reg. 54420 (October 29, 2018)

Dear Secretary Mnuchin, Secretary Acosta and Secretary Azar:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the proposed rule to change Health Reimbursement Arrangements (HRAs) and other account-based group health plans. ACS CAN is the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society and supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change as well as legislative and regulatory solutions that will reduce the cancer burden.

ACS CAN understands that the proposed rule would expand the use of HRAs (tax-exempt accounts funded by employers only) in an attempt to help employees pay the premiums and cost-sharing for individual health insurance coverage. This proposed change is in response to the Administration's October 2017 executive order that directed the agencies to expand access to HRAs as well as short-term limited duration (STLD) insurance, and association health plans (AHPs).¹ We previously raised concerns that the order and the subsequent rules on STLD insurance² and AHPs³ would actually weaken

¹ Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States. October 12, 2017. <https://www.whitehouse.gov/presidential-actions/presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/>.

² ACS CAN. CMS-9924-P: Short-Term, Limited Duration Insurance Proposed Rule. April 20, 2018. <https://www.fightcancer.org/sites/default/files/ACS%20CAN%20Comments%20on%20Short-Term%20Rule%20FINAL.pdf>.

³ ACS CAN. Comments on RIN 1210-AB85: Definition of "Employer" Under Section 3(5) of ERISA – Association Health Plans Proposed Rule. March 6, 2018.

protections important to cancer patients and survivors including Essential Health Benefit (EHB) standards, prohibitions on annual and lifetime limits, maximum patient out-of-pocket spending limits and prohibitions on pre-existing condition exclusions. Further, we are concerned that these policy changes could destabilize the insurance market, leaving cancer patients and survivors, along with other individuals with serious or chronic illness, paying higher and higher premiums to maintain meaningful insurance coverage.

The HRA proposal could encourage increased enrollment in expanded STLD plans and AHPs. It also alters EHB standards for most individuals receiving employer-sponsored insurance (ESI) and could result in some individuals losing their ESI or losing their subsidies for a marketplace plan. Following are our specific concerns with this proposal.

New Option for HRAs Integrated with Individual Health Insurance Coverage

Integration Rules

The proposed rule would reverse a previous prohibition and would now allow employers to offer their employees the ability to use employer-provided HRA funds to pay premiums for an individual health insurance plan offered in their area (an “integrated HRA”). This would be an alternative way for employers to provide health insurance to employees (in lieu of offering ESI or group coverage), and to satisfy the mandate for employers to provide health insurance, where applicable. The proposal prohibits an employee who is offered or receives an “affordable” integrated HRA from being eligible for advance premium tax credits (though if HRA funds do not meet the affordability test, the employee can decline the funds and receive tax credits instead).

ACS CAN appreciates the intent of the proposal and shares the administration’s goal of increasing the number of insured. However, we have serious concerns about how this proposal will affect access to health insurance for cancer patients, survivors, and those at risk for cancer.

Some employers who currently offer group health insurance could decide to switch to offering an integrated HRA that is less generous than the previous group coverage. For example, an employee in this type of situation who is a cancer survivor and wants to find coverage on the individual market that is similar to his/her previous group plan may discover that the amount the employer provides through the integrated HRA is not enough to pay for anything other than a high deductible health plan. Having a high deductible may cause him/her to skip follow-up visits or stop taking medication.

This proposed rule could also lead to more individuals becoming uninsured, accidentally or intentionally. Integrated HRAs require the employee to actively seek insurance in the individual market and enroll in a plan. Some employees may not complete the steps to become enrolled or may misunderstand the process. And some employers may become lax in confirming their employees are enrolled and maintaining their status. We are concerned this could cause individuals to have coverage gaps or become uninsured on a longer-term basis. Having adequate and affordable health insurance coverage is a key determinant in surviving cancer. Research from the American Cancer Society shows that uninsured

Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive.⁴

We recognize one of the intents of this proposal is to increase choices for employers and employees, but having many choices is not always a good thing when it comes to the confusing process of enrolling in and using health insurance. The American Cancer Society operates a specialized Health Insurance Assistance Service (HIAS) which provides cancer patients information about health insurance options that may be available to them in their area. HIAS representatives often hear from individuals with cancer about how overwhelming it can be to choose among too many health insurance plans. More choice may also mean more room for error in choosing the right insurance plan – many employees won't know what to make of the multiple choices available on and off the marketplace and are likely to simply choose the plan with the cheapest premium.

Lastly, this proposal could disadvantage lower-income workers who are currently receiving subsidies to be insured in the individual marketplace. If their employer begins offering an HRA that is deemed "affordable," the individual would lose access to their subsidy – even if the amount of the HRA is less than the amount of the federal subsidy. For example, a cancer survivor who previously was able to enroll in a \$0-premium silver-level plan in the marketplace may now only be able to afford a high-deductible bronze plan with his/her HRA funds.

Special Enrollment Period

The proposal authorizes a special enrollment period (SEP) in the individual market for those who gain access to an integrated HRA – without the SEP, these individuals would not be allowed to enroll in a plan until open enrollment season. Unlike some other SEPs, this one will not require proof of prior insurance coverage or have other documentation requirements.

ACS CAN supports the inclusion of this SEP as written, including the advance availability to enroll and the availability of the SEP regardless of prior insurance coverage status or documentation. Some employers will not be on the calendar year cycle for health insurance benefits, and this proposal will allow affected employees the opportunity to enroll immediately and will minimize gaps in coverage.

The Departments asked for comments on whether this SEP should be available to employees in subsequent years after the initial creation of the integrated HRA. ACS CAN supports the continuation of this SEP into future years. If employers make changes to their integrated HRAs – for example, increasing or decreasing the amounts they contribute to employee accounts – such changes are likely to be made at the beginning of their plan year. If an employer's plan year does not align with the official open enrollment period, the employee must be given the opportunity to choose a different plan if their needs have changed based on their employer's action.

We also note that employees who would be using this SEP to enroll outside of open enrollment may have challenges finding enrollment assistance. Resources for outreach and enrollment activities, like the

⁴ E Ward et al, "Association of Insurance with Cancer Care Utilization and Outcomes," *CA: A Cancer Journal for Clinicians* 58:1 (Jan./Feb. 2008), <http://www.cancer.org/cancer/news/report-links-health-insurance-status-with-cancer-care>.

help of enrollment navigators, are extremely limited given the Administration's funding cuts,⁵ and many of the remaining resources are deployed during open enrollment season. We urge the Departments to issue guidance to employers on how to ensure their employees have the help they need to enroll in individual insurance coverage, including in-person and call-center assistance. We also urge the Departments to ensure that navigator programs are adequately funded on a year-round basis in order to ensure that impacted individuals have access to these vital resources.

Preventing Discriminatory Employer Practices

To prevent employers from attempting to send their costliest employees (i.e., those who are high utilizers of health care services) to the individual market and keep their least costly employees (i.e., younger, healthier individuals) on their group health plan, the proposal prohibits employers from offering both an integrated HRA and a traditional group health plan to the same class of employees. Classes of employees are: full-time employees, part-time employees, seasonal employees, employees part of a collective bargaining unit, employees who have not satisfied a waiting period, employees who have not attained age 25, non-resident aliens, and employees whose primary site of employment is in the same rating area. The proposal also requires that if an employer offers an integrated HRA to a class of employees, the HRA must be offered on the same terms for all participants within a class. The amount of money the employer provides in the HRA can vary based on age or number of dependents, but this variation must be applied to all employees in the class.

ACS CAN appreciates the Departments' efforts to prevent employers from engaging in discriminatory practices. Cancer patients and survivors are likely to be higher utilizers of health care services and could be more likely to experience such discrimination. This proposal is also important in maintaining the viability of the risk pool for the individual market – if employers are permitted to send a significant portion of their high-cost employees to the individual market the overall risk pool for the individual market would worsen, resulting in higher premiums.

We recognize the Departments' optimism that an employer may be able to offer this new integrated HRA option to a class of employees who previously were not offered any insurance coverage. But ACS CAN is concerned about the possibility of employers who may decide to switch a class of employees from group coverage to an integrated HRA. Under this proposal, employers would be able to switch part-time employees to an integrated HRA, which potentially provides less generous coverage. Many cancer patients have to reduce their work hours while they are receiving treatment and/or into survivorship,⁶ so it is not unusual for them to go from full- to part-time status. If a cancer patient works for an employer that treats full-time and part-time employees differently in this regard, the change in employment status would have a corresponding change in health insurance coverage. This could be disastrous financially, as deductibles and maximum spending limits could re-set. This could also seriously affect treatment because of changes in provider networks or any number of other disruptions. We ask the Departments to be aware of this type of scenario if finalizing this rule and provide guidance on how to alleviate these effects on employees who are in active treatment for serious health conditions.

⁵ Keith, Katie. "CMS Announces Even Deeper Navigator Cuts." Health Affairs Blog. July 12, 2018.

<https://www.healthaffairs.org/doi/10.1377/hblog20180712.527570/full/>.

⁶ Moran JR, Short PF, Hollenbeak CS. Long-Term Employment Effects of Surviving Cancer. *J Health Econ.* 2011 May; 30(3): 505–514.

Additionally, we recognize that the proposal states that integrated HRAs must be offered on the same terms to all employees in a given class. We agree with the Departments that this provision is important to prevent discrimination of high utilizers of healthcare, like cancer patients and survivors. The Departments also rightfully note that because premium costs in the individual market can vary based on age (individual market plans are allowed to rate premiums based on age up to 3:1) or number of dependents, an employer should be permitted to vary the amount of their integrated HRA to account for these factors – as long as this variation is applied uniformly across the class of employees.

However, the fact that this variation is *permitted*, and not *required* opens the possibility for age-based discrimination. If an employer does not vary the amount it pays towards an integrated HRA based on age, the HRA amount for an older employee will not go as far towards paying premiums in the individual market. An older employee will have to contribute more of their own money to pay premiums, and/or will be forced to enroll in a less generous plan. This situation could disadvantage older employees and could amount to discrimination. While cancer can be diagnosed at any age, the incidence of cancer increases with age. According to the American Cancer Society, 85 percent of all cancers in the United States are diagnosed in people 50 years of age and older.⁷ The potential age discrimination this policy permits therefore could disproportionately affect cancer patients and survivors. We urge the Departments to address this potential discrimination by requiring employer contributions to integrated HRAs to have a direct relationship to premiums charged each employee in the individual market, or by requiring the amounts vary based on age ratings in the individual market.

Options for Integrated Plans

For purposes of this rule, “individual health insurance coverage” refers to coverage offered in the individual market as well as fully insured student health insurance. The Departments state that for a plan to be integrated with an HRA it must be compliant with Public Health Services (PHS) Act provisions that prohibit annual and lifetime benefit limits (PHS Act Section 2711) and require coverage of preventive services at no cost (PHS Act Section 2713). The Departments ask for comments on whether STLD and other non-group coverage should be included in the definition of integration-eligible plans, even though these plans are not required to satisfy PHS Act Sections 2711 and 2713.

ACS CAN urges the Departments to retain the definition of “individual health insurance coverage” as proposed. PHS Sections 2711 and 2713 are some of the foundational patient protections that cancer patients and survivors have come to rely on over the last eight years, as they require plans to offer meaningful coverage and increase access to preventive services and cancer screenings.

Furthermore, ACS CAN opposes any policy that expands or encourages enrollment in STLD plans. More details about this position can be found in the section on Excepted Benefits.

Revisions to Options for Essential Health Benefit Benchmarks

Section 2711 of the Public Health Services Act prohibits plans from having annual dollar limits on Essential Health Benefit (EHB) services. This prohibition applies to group health plans that do not have to comply with other EHB coverage requirements. Under prior regulations and guidance, large group health plans and other applicable payers can choose to define EHB services based on an EHB benchmark

⁷ American Cancer Society. *Cancer Facts & Figures 2018*. Atlanta: American Cancer Society; 2018.

plan from any state or one of the three Federal Employee Health Benefits Program options.⁸ The Departments propose to give employers new flexibility in defining EHB services, as they could choose a benchmark selected by a state based on the new process adopted in the 2019 Notice of Benefit and Payment Parameters. This vastly increases the options for EHB benchmarks, and particularly allows employers to choose an EHB benchmark that potentially includes fewer benefits.

ACS CAN opposed the changes to the EHB benchmark process in the 2019 payment rule because they weaken one of the patient protections most important to cancer patients and survivors.⁹ Under the guise of giving states more “flexibility,” this policy change allows states to choose a less generous benchmark – one that potentially does not represent a real plan sold in that state.

Allowing employers these new options for EHB standards could have serious implications for out-of-pocket spending for employees with serious and chronic illnesses like cancer. It could allow employers to choose weaker EHB standards and classify more services as non-EHB. Once a service is considered non-EHB, a plan could impose an annual limit, and would not have to count patient out-of-pocket spending towards the maximum amount.

This outcome could be particularly harmful to individuals with serious or complex health care needs, such as cancer patients, who benefit the most from the EHB standard and its patient protections. ACS CAN’s Costs of Cancer report showed that under current law, cancer patients already typically pay multiple thousands of dollars in the first 1-3 months after a positive screening or diagnosis. Weakening coverage standards so that plans do not have to cover some elements of cancer care or are allowed to cap their coverage of cancer care, could leave cancer patients vulnerable to higher and unexpected costs even after they have paid their deductible and met their out-of-pocket maximum for the year.

Excepted Benefit HRAs

The Departments propose to allow a “limited excepted” HRA benefit option for employers. This new HRA could be used to provide funds for employees to enroll in STLD plans, supplemental plans (like cancer-only supplemental plans), or COBRA plans. To qualify as an “excepted benefit HRA,” the same class of employee could NOT be offered this type of HRA if they are also offered an integrated HRA. The employer MUST offer a group health plan in order to also offer an excepted HRA, however the employee would not be required to enroll in either program. The amount of an excepted HRA may not exceed \$1,800 annually. The excepted HRA benefit would have to be made available under the same terms to all similarly situated individuals in an employee class regardless of health factors.

ACS CAN opposes this proposal because it could increase the number of individuals enrolled in STLD plans – which fail to provide the coverage a cancer patient needs – or cancer-only supplemental plans without other insurance health coverage (intentionally or unintentionally). We are also concerned that these plans can engage in medical underwriting and thus deny coverage to individuals based on their prior health history.

⁸ Center for Consumer Information & Insurance Oversight. Affordable Care Act Implementation FAQs - Set 18. https://www.cms.gov/ccii/resources/fact-sheets-and-faqs/aca_implementation_faqs18.html.

⁹ ACS CAN. Comments on CMS-9930-P – Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019. November 27, 2017. <https://www.fightcancer.org/sites/default/files/ACS%20CAN%20Comments%202019%20NBPP%20FINAL.pdf>.

An employee enrolled in an employer-subsidized STLD plan who is diagnosed with cancer would likely discover their plan benefits do not cover all the services they need and have very low limits on the services they do cover. Most STLD plans do not cover out-patient prescription drugs or provide very limited coverage.¹⁰ STLD plans are also permitted to medically underwrite and can exclude individuals with a prior cancer history either from enrolling in any coverage or could exclude coverage for all treatment related to the cancer diagnosis. STLD plans also could rescind coverage entirely and leave the employee uninsured at a time when health care services are most urgently needed.

ACS CAN is concerned about the proliferation of non-comprehensive health insurance plans, to the extent that consumers often enroll in them without realizing these products provide limited benefits. The American Cancer Society's HIAS representatives often hear from individuals who are diagnosed with cancer and are shocked to discover that their cancer-only supplemental plan does not cover all of their costs and does not operate like "normal" insurance. Patients who thought they were protecting themselves by enrolling in such plans find out they are actually responsible for thousands of dollars – if not tens or hundreds of thousands – in costs for their cancer care.

While the proposal states that an employee who is offered an excepted benefit HRA must also be offered a group health plan, the employee is not required to accept either or both benefits. This creates the possibility of an employee choosing to enroll in an excepted benefit HRA but declining the group health plan. Many employees may not be aware of the differences in excepted benefit HRAs and group health plans and may simply pick the least costly plan – erroneously assuming that all the options offered are quality, comprehensive insurance. While the proposal does require some notice requirements for excepted benefit HRAs, the notices are not adequate to ensure all employees are fully informed.

Lastly, the nature of STLD and supplemental policies also produce logistical complications when employers offer them as an excepted benefit HRA in tandem with group health insurance. If this section of the rule is finalized despite ACS CAN's opposition, we urge the Departments to answer the following questions:

- If an employee uses an excepted benefit HRA to enroll in a STLD plan, and then the employee's coverage is rescinded because of a cancer or other serious diagnosis, what recourse does the employee have? Is the employer required to give the employee an SEP for their group health plan? Are there implications for the employer's fulfillment of the employer mandate to provide health insurance coverage, where applicable?
- STLD plans last, by definition, less than 365 days. What provisions does an employer have to make for employees whose STLD plan ends before they are able to enroll in another insurance option? Are there implications for the employer's fulfillment of the employer mandate to provide health insurance coverage, where applicable?

We strongly oppose this section of the proposed rule, and urge the Departments to not finalize it, or to not include STLD and cancer-only supplemental policies in the definition of excepted benefit HRAs.

¹⁰ Kaiser Family Foundation. Analysis: Most Short-Term Health Plans Don't Cover Drug Treatment or Prescription Drugs, and None Cover Maternity Care. April 23, 2018. <https://www.kff.org/health-reform/press-release/analysis-most-short-term-health-plans-dont-cover-drug-treatment-or-prescription-drugs-and-none-cover-maternity-care/>

Conclusion

While ACS CAN shares the Administration's goal of increasing the rate of insurance coverage, we do not believe this proposal is the right way to increase coverage. We urge the Departments to withdraw the rule and welcome the opportunity to engage in discussion about how best to ensure that cancer patients, survivors, and those at risk for cancer have access to quality, affordable health insurance coverage.

On behalf of the American Cancer Society Cancer Action Network we thank you for the opportunity to comment on the proposed rule. If you have any questions, please feel free to contact me or have your staff contact Jennifer Singleterry, Senior Policy Analyst at Jennifer.singleterry@cancer.org or 202-585-3233.

Sincerely,

A handwritten signature in blue ink, appearing to read "Kirsten Sloan", is written over a light yellow rectangular background.

Kirsten Sloan
Vice President, Public Policy
American Cancer Society Cancer Action Network