July 11, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9928-NC
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted Electronically to: http://www.regulations.gov

Re: Submission of Comments

Dear Sir or Madam:

The Employers Council on Flexible Compensation (ECFC) appreciates the opportunity to submit comments to the Department of Health and Human Services in furtherance of the Department's aim to reduce regulatory burdens and improve health insurance options under Title I of the Patient Protection and Affordable Care Act (the ACA).

ECFC is a membership association dedicated to preserving and expanding employer-provided tax-advantaged benefit choices for working Americans, including account-based benefit plans which provide benefits in areas such as health care, child care, and commuting. These benefits provide families with the support they need to meet their everyday living expenses and remain productive members of the workforce. ECFC's members include employers who sponsor employee benefit plans, including Health Reimbursement Arrangements (HRAs), Flexible Spending Arrangements (FSAs) (including dependent care assistance FSAs), and health savings accounts (HSAs), commuter and parking benefits as well as insurance, accounting, consulting, and actuarial companies that design or administer employee benefit plans. ECFC member companies assist in the administration of cafeteria plan and health benefits for over 33 million employees.

Importance of Consumer-Directed Health Arrangements

Many employers are moving toward higher deductible health plans or plans that increase the cost sharing amounts borne by employees. In addition, employers are acting to reduce the costs of their health coverage options, yet continue to protect employees from higher out of pocket costs by moving to account-based, consumer-directed arrangements. Consequently, consumer-directed benefit arrangements, such as FSAs, HRAs and HSAs, are of increasing importance to American workers and their families, covering an estimated 100 million Americans. Any regulatory changes that the Department could make that supports these consumer-directed health arrangements would empower patients and promote consumer choice in the financing health care and health insurance needs.

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Stand-Alone Health FSAs

Issue: Under the current HIPAA rules, benefits provided under a health FSA are only excepted for a class of participants if other group health coverage (not limited to excepted benefits) is made available for the year to that class of participants. 26 C.F.R. § 54.9831-1(c)(3)(v)(A), 29 C.F.R. § 2590.732(c)(3)(v)(A), and 45 C.F.R. § 146.145(c)(3)(v)(A). Under guidance issued by the Department, the Department of Labor and the Internal Revenue Service, coverage that was considered an "excepted benefit" under the HIPAA rules still would be considered an "excepted benefit," and the new insurance market reform rules under the ACA would not apply to these plans. However, if not considered an excepted benefit because other group health plan coverage is not offered to those participants (i.e. a stand-alone health FSA), the FSA would be subject to the ACA insurance market reforms which include a prohibition on annual and lifetime limits on benefits. If an employer offers a stand-alone health FSA plan which is not considered an excepted benefit the employer will be subject to an excise tax. Consequently, employers that do not offer group health plan coverage will not give employees the ability to finance their health care expenses on a pre-tax basis though a stand-alone health FSA. This deprives employees of an important tax advantaged means of paying for health expenses.

Comment/Recommendation: We urge the Department to take this opportunity to review the excepted benefits regulations and eliminate the so-called group health plan "footprint" requirement so that health FSAs are allowable for employees even if there is no group health plan coverage offered to them through an employer (either because the employer does not offer group health coverage, or does not offer group health coverage to that particular class of employees).

First, employers who do not offer group health plan coverage (or do not offer it to a particular class of employees) may wish to enable their employees to receive the benefits of a health FSA. The ability to pay for some healthcare expenses on a tax-advantaged basis may be particularly important for employees who do not have access to the tax benefits of an employer-sponsored major medical plan (e.g., because their employer may not offer such coverage or because the employee may be subject to a waiting period or is otherwise not yet eligible for coverage).

In addition, the landscape has changed substantially since the pre-ACA period when the FSA exception was first adopted. Unlike when the FSA regulatory exception was first added, there is no longer a concern that employers would try to mask substantive group health coverage as an FSA excepted benefit. There is no longer a concern that FSA coverage would be offered by employers as a substitute for group health coverage. Under the ACA, as codified in 26 U.S.C. § 125(i), salary reductions for health FSAs are capped at $2500, so FSAs cannot provide substantial benefits to substitute for group health coverage. Moreover, under the FSA exception "maximum benefit" requirement (26 C.F.R. § 54.9831-1(c)(3)(v)(B), 29 C.F.R. § 2590.732(c)(3)(v)(B), and 45 C.F.R. § 146.145(c)(3)(v)(B)), employer contributions cannot exceed $500 or, if greater, two times the employee salary reduction contribution. Since passage of the ACA, it has become abundantly clear that Health FSAs cannot serve as a replacement for (or be confused with) group health coverage.

The rule that prevents all health flexible spending arrangements from being considered excepted benefits is a rule created through the regulatory process – not the legislative process – and that rule may be changed through a similar regulatory process. The regulation that does not allow stand-alone health FSAs from being considered an excepted benefit eliminates a means for employees to finance their health care needs. Consequently, the Department should re-examine and change this rule so that there are additional opportunities for employees to finance their health care needs through a stand-alone health FSA.

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We hope that the Department will work to reduce the regulatory burden associated with consumer-directed health plans imposed by the ACA. If you have any questions regarding our recommendation or would like further information regarding consumer-directed health plans, please contact ECFC's Legislative and Technical Director, Bill Sweetnam, at 202.465.6397 or at wsweetnam@ecfc.org.

Sincerely,

William F. Sweetnam, Jr.

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Legislative and Technical Director

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