AMERICAN LUNG ASSOCIATION.

Harold P. Wimmer
National President and CEO

December 27, 2018

Honorable Alex Azar
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Ms. Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-8010

Ms. Kirsten Wielobob
Deputy Commissioner, Internal Revenue Service
Department of the Treasury
1111 Constitution Avenue, NW
Washington, DC 20220

Mr. Preston Rutledge
Assistant Secretary, Employee Benefits Security Administration
Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Re: Health Reimbursement Arrangements and Other Accounts-Based Group Health Plans (CMS-9918-P)

Dear Secretary Azar, Administrator Verma, Deputy Commissioner Wielobob, and Assistant Secretary Rutledge:

The American Lung Association appreciates the opportunity to submit comments regarding the proposed rule, "Health Reimbursement Arrangements and Other Accounts-Based Group Health Plans (CMS-9918-P)."

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 33 million Americans living with lung diseases including asthma, lung cancer and COPD. As such, the Lung Association is uniquely positioned to comment on the impact this proposed rule will have on lung disease patients.

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In March 2017, the Lung Association committed to a set of healthcare principles (see Appendix A). The principles state that any changes to the healthcare system must achieve healthcare that is affordable, accessible and adequate for patients. Unfortunately, the proposed rule regarding Health Reimbursement Arrangements (HRAs) does not met that standard and we ask the Departments of Health and Human Services (HHS), Department of Treasury (Treasury) and the Department of Labor (DOL) to rescind the proposed rule unless additional protections are put in place to protect patients with pre-existing conditions.

Impact on Lung Disease Patients

The proposed HRA rule provides more flexibility to employers to provide pre-tax accounts to provide health insurance to their employees. The rule would allow employers to use pre-tax funds to subsidize certain classes of employees buying healthcare coverage in the marketplace rather than offering an employer-sponsored health plan, jeopardizing patients' access to quality and affordable healthcare.

Employers with an older or sicker workforce may find this option an appealing and less expensive way to provide some level of healthcare for their employees by providing HRAs for employees to purchase health insurance on the marketplace. An influx of older or sicker individuals onto the marketplace would be problematic for patients, including lung disease patients. Older and sicker individuals would disrupt the risk pool of the marketplaces and increase premiums for marketplace plans. For patients with lung diseases including asthma, COPD and lung cancer, increased premiums could make quality healthcare - healthcare that covers treatments patients need - unaffordable.

Treatment for patients to manage lung disease can be expensive. For example, the annual median cost for a COPD patient is between $1,681 and $10,816 depending on the severity of the disease.[1] These patients' lives depend on healthcare coverage that covers the treatment needed to breathe and is affordable.

Importance of Anti-Discrimination Protections

The American Lung Association was pleased to see HHS, Treasury and DOL recognize the inherent risk of employers discriminating against employees based on their health status, providing sicker employees and employees and their families with pre-existing conditions HRAs to purchase coverage in the marketplace, while offering a traditional employer-sponsored plan to healthier employees and their families. The proposed rule describes several classes of similarly situated employees and would require employers to provide the same health insurance benefit (an HRA or a traditional employer-sponsor health plan) to the entire class of similarly situated employees with the same terms. The Lung Association agrees with HHS, Treasury and DOL that this will help to mitigate some of the potential risk.

The Lung Association believes these protections are vital, both to the stability of the marketplaces and to protect people with pre-existing conditions, including lung disease. Absent these

protections, this rule should not be finalized, as it would have a devastating impact on the health insurance market and harm patients.

The Lung Association also encourages HHS, Treasury and DOL to strengthen these protections. The Administration should not create any new classes, and additional safeguards should be put in place to limit the ability of employers to use the classes to discriminate against individuals with pre-existing conditions and carve out older or sicker employees. The Lung Association encourages the Departments to prohibit small employers from combining classes and to only allow large employers to combine classes if the resulting share of employees meets a specific threshold.

Interaction with 1332 Guidance

The American Lung Association is worried about the potential interactions between the proposed rule and the recent guidance on section 1332 waivers promulgated by HHS and Treasury on October 24, 2018. The proposed rule would likely result in more patients and families purchasing healthcare in state marketplaces. The recent 1332 Waiver Guidance dramatically reinterprets the statutory guardrails of section 1332 of the Affordable Care Act (ACA), inviting states to waive key patient protections of the ACA. The Lung Association with other leading patient advocacy organizations previously submitted detailed comments on the impact the new guidance will have on patients.[2] The new guidance will make it more difficult for patients to access healthcare coverage that is affordable, accessible and comprehensive.

The Lung Association is concerned that employers could push employees into a state marketplace that allows substandard coverage to be sold through a 1332 waiver approved under the guidance. Not only is this confusing for patients, including patients with COPD, asthma and lung cancer, but it jeopardizes patients' access to quality healthcare and ultimately their health. Additionally employers would not be providing their employees with Minimum Essential Coverage (MEC) under this scheme if a state has an 1332 waiver that allows substandard coverage to be sold in the marketplace. The Lung Association encourages HHS, Treasury and DOL to require any plan that is purchased with HRA funds to be MEC.

Special Enrollment Periods

The proposed rule would create a new special enrollment period (SEP) for integrated HRAs. HHS, Treasury and DOL ask if this new SEP should be available on an annual basis for non-calendar year plans. The Lung Association recognizes that this proposal would put extra financial burden on patients. For patients enrolling in plans in the state marketplaces, enrolling during an SEP mid-year would not provide the full 12 months for patients to meet their deductible and maximum out-of-pocket costs (MOOP). This could result in patients having to restart a deductible and MOOP twice every year. For many lung disease patients, this is unaffordable. The Lung Association strongly encourages HHS, Treasury and DOL to not allow an annual SEP for integrated HRAs and rather have employers align their plans with the calendar year.

The proposed rule's affordability test uses the lowest cost silver plan available in the marketplace. The Lung Association encourages HHS, Treasury and DOL to revise this affordability test to the

second lowest cost silver plan. This would both be administratively easier, as the second lowest cost silver plan is a widely known number. It would also align the affordability with Qualified Small Employer HRAs.

HRA Integration with Other Health Plans

The proposed rule inquires about what types of plans should be permissible for HRAs to integrate with. HHS, Treasury and DOL have come to the conclusion that the HRAs should be allowed to integrate with grandfathered plans, arguing that since there are few grandfathered plans left, integrating HRAs with these plans will not impact a large number of people and therefore should be permissible. This stance is flawed.

Grandfathered plans are not required to provide any basic standard of coverage. They are not required to cover preventive services – including tobacco cessation treatment and lung cancer screening. These key treatments and screenings can help save lives and create a more productive workforce. For example, quitting smoking reduces absenteeism at work and people that quit have a higher productivity.[3] It is only logical that employers would want to increase access to treatments to help smokers quit. And as the proposed rule notes, since there are very few grandfathered plans that are still on the market, prohibiting HRA funds to be used to purchase these plans should impact very few individuals.

The proposed rule also inquires whether HRAs should be able to integrate with short-term, limited-duration plans. The American Lung Association strongly opposed the integration of HRAs with short-term, limited-duration plans. These plans provide substandard coverage and jeopardize patients' health. The Lung Association and partners filed detailed comments on the limitations of short-term, limited-duration health plans and the dangers they pose to patients.[4] Additionally, they are not required to provide MEC and could result in legal liability for employers for not providing their employees health insurance.

The American Lung Association strongly opposes integrating HRAs with grandfathered plans or short-term, limited-duration plans. These plans do not provide the necessary patient protections or the screenings and treatments for a healthy workforce.

Excepted Benefit HRAs

The proposed rule does not allow excepted benefit HRAs to be used to pay for insurance premiums. However, the proposed rule would allow expected benefit HRAs to be used to pay for premiums for short-term, limited-duration plans. This policy is misguided. For the reasons stated above and in the previous comments, the Lung Association strongly opposed this move and encourages HHS, Treasury and DOL to change this policy to prohibit excepted benefit HRAs to be used to pay for short-term, limited-duration premiums in the final rule.

Applicability Date

Lastly, the Lung Association encourages HHS, Treasury and DOL to delay the applicability date of this proposed rule for plans beginning on or after January 1, 2021. Issuers must propose their

rates in the spring, potentially before this rule is made final. This uncertainty could push issuers to increase premiums, hurting patients who rely on quality and affordable healthcare through the marketplaces.

The American Lung Association encourages HHS, Treasury and DOL to strengthen protections for patients in the proposed rule expanding HRAs and other account-base group health plans. Absent the changes outlined in these comments, the proposed rule should be rescinded to protect patients' access to quality and affordable healthcare. Thank you for the opportunity to submit comments on this proposed rule.

Sincerely,

Harold P. Wimmer
National President and CEO

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[1] Guarascio, A. J., Ray, S. M., Finch, C. K., & Self, T. H. (2013). The clinical and economic burden of chronic obstructive pulmonary disease in the USA. ClinicoEconomics and outcomes research : CEOR, 5, 235-45. doi:10.2147/CEOR.S34321. Accessed at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3694800/

[2] Partner Comments re: State Relief and Empowerment Waivers (CMS-9963-C). December 18, 2018. Found at: http://www.lung.org/assets/documents/advocacy-archive/health-partner-comments-re-2.pdf

[3] Baker, C. L., Flores, N. M., Zou, K. H., Bruno, M., & Harrison, V. J. (2017). Benefits of quitting smoking on work productivity and activity impairment in the United States, the European Union and China. *International journal of clinical practice*, *71*(1), e12900. Accessed at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5299499/

[4] Partner Comments re: Short-Term, Limited Duration Proposed Rule (CMS-9924-P). April 23, 2018. Found at: http://www.lung.org/assets/documents/advocacy-archive/coalition-comments-to-hhs-re-stld-plan.PDF

Appendix A

Consensus Healthcare Reform Principles

Today, millions of individuals, including many with preexisting health conditions, can obtain affordable health care coverage. Any changes to current law should preserve coverage for these individuals, extend coverage to those who remain uninsured, and lower costs and improve quality for all.

In addition, any reform measure must support a health care system that provides affordable, accessible and adequate health care coverage and preserves the coverage provided to millions through Medicare and Medicaid. The basic elements of meaningful coverage are described below.

Health Insurance Must be Affordable – Affordable plans ensure patients are able to access needed care in a timely manner from an experienced provider without undue financial burden. Affordable coverage includes reasonable premiums and cost sharing (such as deductibles, copays and coinsurance) and limits on out-of-pocket expenses. Adequate financial assistance must be available for low-income Americans and individuals with preexisting conditions should not be subject to increased premium costs based on their disease or health status.

Health Insurance Must be Accessible – All people, regardless of employment status or geographic location, should be able to gain coverage without waiting periods through adequate open and special enrollment periods. Patient protections in current law should be retained, including prohibitions on preexisting condition exclusions, annual and lifetime limits, insurance policy rescissions, gender pricing and excessive premiums for older adults. Children should be allowed to remain on their parents' health plans until age 26 and coverage through Medicare and Medicaid should not be jeopardized through excessive cost-shifting, funding cuts, or per capita caps or block granting.

Health Insurance Must be Adequate and Understandable – All plans should be required to cover a full range of needed health benefits with a comprehensive and stable network of providers and plan features. Guaranteed access to and prioritization of preventive services without cost-sharing should be preserved. Information regarding costs and coverage must be available, transparent, and understandable to the consumer prior to purchasing the plan.