January 19, 2018

By Electronic Delivery

U.S Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

Internal Revenue Service
CC:PA:LPD:PR (Notice 2017-67)
Room 5203
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Submitted Electronically at Notice.comments@irscounsel.treas.gov

Re: Notice 2017-67 – Qualified Small Employer Health Reimbursement Arrangements

Dear Sir or Madam:

The Department of the Treasury and the Internal Revenue Service (the "Agencies") released Notice 2017-67 "Qualified Small Employer Health Reimbursement Arrangements" (the "Notice") on October 31, 2017. The Notice provides guidance on Qualified Small Employer Health Reimbursement Arrangements ("QSEHRAs") as added to the Internal Revenue Code (the "Code") by the 21st Century Cures Act, enacted on December 13, 2016. QSEHRAs provide an important means for small employers to continue to reimburse their employees for qualified medical expenses, including premiums for health insurance policies, without violating provisions of the Affordable Care Act ("ACA") as interpreted and implemented by the Agencies. This letter provides WageWorks' comments on the QSEHRA guidance provided in the Notice, as requested by the Agencies.

WageWorks is the leading on-demand provider of consumer-directed spending solutions and services in the United States, serving more than 100,000 employers. WageWorks represents more than 6.5 million participants in consumer-directed accounts, including Flexible Spending Accounts ("FSAs"), Health Savings Accounts ("HSAs") and Health Reimbursement Arrangements ("HRAs") nationwide, and many of our plan-sponsor clients offer insured High Deductible Health Plans ("HDHPs") to their employees, both those qualified to be paired with an HSA and those paired with an HRA. WageWorks has a number of clients that are small employers (as defined for purposes of QSEHRAs) and that have asked us to assist in the administration of these new QSEHRAS or to advise them in the establishment of these arrangements. WageWorks is very appreciative that the Agencies have

issued proposed guidance regarding QSEHRAs and given our place in the market and our customer base, we believe we have unique insight into the issues addressed in the Notice, and, as such, our comments follow

Eligible Employer

Under the statute, in order for an employer to be eligible to establish a QSEHRA it cannot be an applicable large employer, nor can it offer a group health plan to any of its employees.[1] The term "group health plan" is defined by reference to Code §5000A(b)(1). The rules proposed in the Notice regarding when an otherwise eligible employer becomes ineligible to offer a QSEHRA because they have provided some type of health coverage to their employees are unnecessarily broad and will have the unintended consequence of hurting small employers trying to assist their employees with their (ever increasing) healthcare expenses.

Excepted Benefits

The Notice provides that a small employer becomes ineligible to provide a QSEHRA even if it only offers a plan that provides excepted benefits described in Code §9831(c), such as limited scope vision and dental health plans. WageWorks requests that these proposed limitations be changed and that final guidance permit a small employer that offers a plan providing only excepted benefits to be an eligible employer and not be disqualified from offering a QSEHRA. Excepted benefits have generally been carved out of the ACA's requirements, and are not subject to the same rules as traditional group health plans. As such, the term "group health plan" has a different meaning in the context of the excepted benefit provisions, and the Agencies have the authority to interpret Code §9831(d)(3)(b) to provide that an employer that offers a plan providing only excepted benefits would be eligible to offer a QSEHRA. A "group health plan" is defined extremely broadly in Code §5000(b) as a plan of an employer to provide health care (directly or otherwise) to their employees, former employees, or their families. Group health plans must comply with various requirements. This broad definition is modified for certain purposes under the Code such that certain non-major medical ancillary and supplemental benefits (referred to generally as excepted benefits) are not subject to the ACA requirements for a group health plan.[2] Excepted benefits include separate coverage for workers compensation insurance, automobile medical payment insurance, accident or disability insurance, and coverage for on-site medical clinics.[3] It also includes certain health Flexible Spending Account ("FSA").[4] Also included as an excepted benefit, if offered separately, is limited scope dental or vision benefits and long-term care benefits.[5] In addition, coverage for a specified disease or illness or hospital indemnity or other fixed indemnity insurance will be considered excepted benefits if offered as an independent, non-coordinated benefit.[6]

As a practical matter, strict application of the Code §5000(b) definition to QSEHRAs would lead to very few small employers being able to establish a QSEHRA. By way of example, a small employer that offered to its employees an Employer Assistance Plan, limited to a prescribed set of counseling sessions with a mental health professional

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[1] Code § 9831(d)(3)(B).
[2] Code §9832(c).
[3] Code §9832(c)(1).
[4] Treas. Reg, §54.9831-1(c).
[5] Code §9832(c)(2).
[6] Code §9832(c)(3).

and not covering other healthcare needs at all, would be unable to sponsor a QSEHRA. This result would seem to run counter to the very purpose underlying the creation of the QSEHRA statute. It is simply not credible that Congress intended that coverage of excepted benefits would cause an employer to be unable to offer a QSEHRA to its employees. The requirement that no employee has access to employer-provided health coverage was a means of protecting against adverse selection by employers incenting high-risk (and thus high-cost) employees to purchase their coverage on the individual market – thereby driving up costs of coverage on the individual market. Coverage for excepted benefits poses no such risks and employers that offer such coverage should be permitted to offer a QSEHRA. Such a rule would clearly benefit both small employers and their employees.

The QSEHRA provisions are in new section 9831(d) of the Code. Section 9832 does reference a definition of group health plan which applies for purposes of "this chapter," *i.e.*, chapter 100. However, §9833 provides for broad regulatory authority, establishing that the Treasury "may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this chapter." For the reasons discussed above, in the context of QSEHRAs, the term group health plan should not extend to the non-comprehensive coverage offered through excepted benefits. WageWorks believes that allowing a QSEHRA to be established by employers whose only other group health plan offered to employees is an excepted benefit plan is "consistent with the provisions of this chapter [relating to QSEHRAs]."

Carryover Amounts in HRAs and FSAs

Under the Notice,[7] an employer would not be eligible to offer a QSEHRA if it provides current employees with continued access to amounts which accumulated in an HRA in a previous year or carryover amounts in an FSA, although the employer could suspends access to those amounts and thus be eligible to offer a QSEHRA. Such a rule seems counter to the policy behind consumer-directed health accounts such as HRAs and FSAs which is to make individuals better consumers of health care dollars. Such a rule instead incents employees to engage in unnecessary health care spending before the suspension occurs or risk losing access to the funds (similar to how the use-it-or-lose-it rules operated prior to the Agencies updated guidance permitting carryovers). This is the opposite policy result that the Agencies have been seeking in the guidance establishing HRAs and allowing FSA carryovers. A small employer that offered an FSA or HRA before the QSEHRA provision was available should not have employees lose access to health care funds they accumulated due to their being conscientious consumers of health care, and WageWorks asks the Agencies to consider this result when issuing final guidance.

Proof of MEC Requirement

Under Code §9831(d)(2)(B)(ii), a QSEHRA may only make reimbursements to an eligible employee after the employee provides proof that coverage is minimum essential coverage ("MEC"). The Notice[8] provides detailed requirements for how this requirement would be satisfied on a yearly basis, stating that proof would consist of either (i) a document from a third party showing that the employee or individual has MEC coverage and attestation by that individual of such MEC coverage or (ii) attestation by the employee or individual that they have MEC coverage, the date coverage began and the name of the coverage provider. This proof must be

[7] in Q&A 2.
[8] In Q&As 41 and 42

provided at least annually. At each request for reimbursement, the employee must attest that the individual whose expense is being reimbursed continues to have MEC coverage. WageWorks is concerned about the burden such documentation requirements creates, and, given the administrative burdens of collecting the data required, whether such data will be useful in enforcement, especially in light of the penalties for not having MEC going away in 2019. We believe that attestation alone should meet the requirements for reimbursements to be made from the QSEHRA.

WageWorks appreciates the opportunity to provide our comments on the proposed regulations regarding QSEHRAs contained in Notice 2017-67 and thanks the Agencies for all of their work in this area.

Sincerely,

Jody Dietel, ACFCI, CAS
Chief Compliance Officer, WageWorks, Inc.

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