October 31, 2011

Submitted electronically via http://www.regulations.gov

Internal Revenue Service
CC:PA:LPD:PR (REG–131491–10)
Room 5203
PO Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Notice of Proposed Rulemaking - Health Insurance Premium Tax Credit

Sir or Madam:

We write to provide comments on behalf of the American Benefits Council ("Council") in response to the Notice of Proposed Rulemaking ("NPRM") issued by the Department of the Treasury ("Department") regarding the Health Insurance Premium Tax Credit, 76 Fed. Reg. 50,931 (Aug. 17, 2011). The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to health and retirement plans that cover more than 100 million Americans.

Section 1401 of the Patient Protection and Affordable Care Act ("Affordable Care Act") amended the Internal Revenue Code ("Code") to add section 36B, allowing a refundable premium tax credit to help individuals and families afford health insurance coverage by reducing a taxpayer's out-of-pocket premium cost. The NPRM implements Code section 36B. We appreciate that the NPRM has been issued in proposed form, which provides interested parties the opportunity to provide comment prior to any implementation.

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Below are our comments and recommendations with respect to final regulations or other guidance implementing the Affordable Care Act's premium tax credit provisions, as contained in Code section 36B. Also included below are certain comments regarding the related Code section 4980H, which sets forth the rules with respect to employer shared responsibility.[1] We begin with our comments regarding Code section 36B.

LARGE AND SELF-FUNDED GROUP HEALTH PLANS AS MINIMUM ESSENTIAL COVERAGE

In determining an individual's eligibility for a premium tax credit under Code section 36B, the statute as well as the NPRM make clear that the individual must not be eligible for affordable "minimum essential coverage," as defined in Code section 5000A(f).

The preamble to the NPRM states that the Department will issue future guidance providing that "minimum essential coverage" for purposes of the Affordable Care Act includes self-funded employer-sponsored group health plans. Specifically, it states that "an employer-sponsored plan will not fail to be minimum essential coverage solely because it is a plan to reimburse employees for medical care for which reimbursement is not provided under a policy of accident and health insurance (a self-insured plan)."

The Council supports the interpretation reflected in the preamble and recommends that future rulemaking implementing Code section 4980H affirm that self-funded plans may qualify as minimum essential coverage.

APPLICATION OF ESSENTIAL BENEFITS REQUIREMENTS TO LARGE AND SELF-FUNDED GROUP HEALTH PLANS

Under the Affordable Care Act, to qualify as "minimum essential coverage" for purposes of the individual and employer mandates, small group insurance policies generally must provide coverage for certain "essential benefits," as set forth in section 2707 of the Public Health Service Act, as added by the Affordable Care Act ("Essential Benefits Requirements"), which will be set forth in a to-be-enumerated list of federally mandated benefits. Recently, the Institute of Medicine ("IOM") issued a report, at the request of the Department of Health and Human Services, regarding criteria and methods that could be used to develop the list of essential benefits. Among other things, the report stated that the essential benefits package should be based on what small businesses typically offer.

The NPRM affirms that the Essential Benefits Requirements do not apply to large group health plans. The Council appreciates and supports this affirmation. The NPRM

[1] Notice 2011-73 requests comments regarding the affordability safe harbor for employers. The Council intends to submit a separate comment letter in response to Notice 2011-73.

does not expressly reference self-funded plans as also being excepted from the Essential Benefits Requirements. We read the statute to except both large group and self-funded plans from the Requirements and believe this is good policy in light of employer considerations. As noted in past comments by the Council, employers are uniquely positioned to design plans in ways that best meet the needs of the employer's workforce. Additionally, they have significant interest in providing comprehensive health care to their employees to make sure they remain healthy and at work.

Accordingly, the Council requests that the affirmation contained in the NPRM be reiterated in formal rulemaking and expressly except self-funded plans from the Essential Benefits Requirements.

APPLICATION OF MINIMUM VALUE REQUIREMENT TO LARGE AND SELF-FUNDED GROUP HEALTH PLANS

As noted above, in determining whether an individual is eligible for a premium tax credit under Code section 36B, one must determine whether such individual has access to minimum essential coverage that meets affordability and "minimum value" requirements. As to whether a plan provides minimum value, Code section 36B(c)(2)(C)(ii) states that an eligible employer-sponsored plan generally provides minimum value if the plan's share of the total allowed costs of benefits provided under the plan is at least 60% of those costs. Specifically, the statute provides:

> Except as provided in clause (iii) [relating to actual coverage under an eligible employer-sponsored plan], an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

We read the above language to permit employers broad flexibility in fashioning their plan benefits and that employers are not to be subject to specific benefit mandates so long as the plan's share of total allowed costs are at least 60%.

Notwithstanding the clear language of the statute, the preamble to the NPRM states:

> We are also contemplating whether to provide appropriate transition relief with respect to the minimum value requirement for employers currently offering health care coverage.

Although unclear, the above language appears to signal an intention by the Department to issue future rules that would articulate and impose a certain benefit value test on employer-sponsored plans, subject to a transition period.

We do not believe that the statutory language permits such a result and using the Essential Benefits Requirements to essentially "bootstrap" a regulatory minimum value test would be inappropriate and inconsistent with Congressional intent. We are concerned that such an approach would not only increase the cost and complexity for employers of providing coverage to employees, but also lead to some employers exiting the system altogether. Moreover, large employers have a significant interest in providing comprehensive benefits that will best keep their workforce healthy and allow them to attract and retain that workforce. For these reasons we strongly urge the Department to give further consideration to the issuance of any rules that would operate to mandate a specific minimum value test for benefits and increase costs for employers and employees alike.

CODE SECTION 4980H

In addition to providing proposed guidance with respect to Code section 36B, the NPRM also provides important and helpful insight into how the Department is considering implementing rules with respect to Code section 4980H. The following are comments with respect to certain statements contained in the NPRM regarding Code section 4980H and related issues.

1. Affordability Safe Harbor for Employers

The preamble of the NPRM states that future proposed regulations under Code section 4980H are expected to provide an affordability safe harbor for employers, pursuant to which the determination of whether an employer-sponsored plan imposes a premium that is affordable or unaffordable will be based on an employee's Form W-2 rather than an employee's total household income. Notice 2011-73 requests comments on such safe harbor.

The Council commends the Department for providing the safe harbor in the NPRM that Form W-2 wages will be used instead of total household income. This safe harbor is needed because it is very difficult, if not impossible, for employers to know each employee's total household income. This is because employers typically do not have access to the types of information necessary to determine an employee's household income and because employees typically (and for obvious reasons) may not want to disclose that information to their employers. The clarification, therefore, will ensure that employers have available to them the information necessary to provide qualifying, affordable minimum essential coverage and avoiding penalties under Code section 4980H to the extent that is their intention. We note that a contrary rule would have raised significant privacy concerns.

The Council strongly recommends that the safe harbor be included in any final rulemaking.

2. "Offer" Requirement Extending to Dependent Coverage

Code Section 4980H(b) – Affordable Coverage. The Council fully supports the clarification provided in the NPRM that the Code section 4980H(b) "affordability test" will be based on the employee's premium cost for self-only or individual coverage under the employer-sponsored plan (rather than the premium cost for dual or family coverage, as applicable).

The Council believes this clarification will ensure that employers who seek to provide important health coverage to their employees and avoid the penalties under Code section 4980H are able to do so. This is because basing the test on the premium cost of family coverage would significantly raise the cost to employers of providing health coverage to their employees and would have resulted in more employees losing access to employer-sponsored coverage – coverage that is often designed to provide the most comprehensive and efficient coverage for the employee.[2]

Code Section 4980H(a) – Minimum Essential Coverage. The preamble to the NPRM states that future guidance will provide a safe harbor for employers whereby they are not subject to penalty under Code sections 4980H(a) or (b) to the extent (i) they make minimum qualifying coverage available to a full-time employee *and his or her spouse and dependents*, and (ii) the self-only coverage made available to the employee is affordable based on the employee's Form W-2 wages.

As noted above, the Council fully supports a rule that permits employers to determine whether coverage is affordable to an employee based on his or her Form W-2 wages. Moreover, the Council fully supports a rule that bases affordability of coverage for purposes of the Code section 4980H(b) penalty on self-only coverage. What remains unclear, however, is whether for purposes of the penalty provision of Code section 4980H(a), an employer must offer qualifying, minimum coverage to not only a full-time employee but also to the employee's spouse and dependents. It is clear from the preamble that this would be the case for purposes of the above-referenced affordability

[2] Per the preamble to the NPRM, the Council understands that whether an employee's spouse or dependent is eligible for a premium tax credit would also be based on whether the self-only coverage provided by an employer to the employee is affordable within the meaning of Code section 36B(c)(2)(C)(i). Therefore, to the extent that the self-only coverage available to an employee is affordable, his or her spouse and dependents would not be eligible for the premium tax credit for qualified health plan coverage purchased through a state exchange. While the Council fully supports basing the penalty under Code section 4980H(b) on the cost of self-only coverage – and believes that is indeed the correct result – the Council believes all individuals should have access to meaningful and affordable coverage. Thus, the Council is supportive of a rule that makes the premium tax credit available to an employee's spouse or dependents where dual or family coverage, as applicable, is otherwise unaffordable for the employee's spouse or dependent (measured by the family's household income as defined in Code section 36B(d)(2)).

safe harbor. What is not clear, however, is the specific rule that would apply for purposes of Code section 4980H(a).

In this regard, the Council remains concerned about a rule that would require for purposes of Code section 4980H(a) that an employer be required to offer qualifying coverage not only to its full-time employees but also to the spouses and dependents of such full-time employees. As we mentioned in our comments relating to the definition of full-time employee, the Council believes the statute is unclear but that the best reading of the language is that an employer may, but would not be required to, offer coverage to spouses and dependents in order to not be assessed the penalty under Code section 4980H(a).

We believe this interpretation with respect to Code section 4980H(a) is supported by both employer practice as well as common sense. The interpretation is consistent with current employer practices where employers who offer health coverage do so primarily on behalf of their employees (especially full-time employees). Although many employers do provide family coverage to full-time employees, many do not. Decisions by employers to provide dependent coverage are based not only on cost issues for the employer, but also on other very important and practical considerations, *e.g.,* dependent coverage is less prevalent in high turnover and/or lower wage industries.

An alternative interpretation, which would require all "applicable large employers" to offer dependent coverage to full-time employees, could lead employers (especially in industries in which many employers do not currently provide dependent coverage) to offer dependent coverage that is likely unaffordable to the full-time employee. This is not because the employer wants to make such coverage unaffordable; quite to the contrary. Rather, this is because the increased premium subsidies that the employer would be required to pay in order to make the dependent coverage affordable are likely to be, in a great many instances, just too significant for the employer to shoulder. Such a result is neither good policy, nor is it good for employee morale and relations. Moreover, the statutory language with respect to the "affordability" penalty under Code section 4980H(b) appears to quite clearly apply only with respect to self-only coverage offered to a full-time employee. Accordingly, it seems unlikely to us that Congress intended for employers to have to pay a penalty for purposes of Code section 4980H(a) unless they offer unaffordable coverage to their full-time employees.

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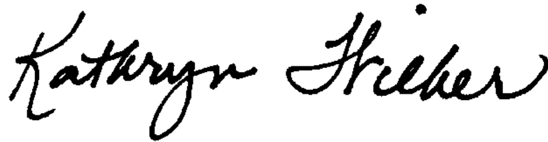
We appreciate the opportunity to provide comments regarding the NPRM issued in connection with the premium tax credit described in Code section 36B. If you have any questions or would like to discuss these comments further, please contact us at (202) 289-6700.

Sincerely,



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