



AMERICAN BENEFITS
COUNCIL

September 6, 2011

Submitted electronically via e-mail to Notice.Comments@irsounsel.treas.gov.

Internal Revenue Service
CC:PA:LPD:PR (Notice 2011-35)
Room 5203
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044
Notice.Comments@irsounsel.treas.gov

**Re: Notice 2011-35 - Request for Comments
Funding of Patient-Centered Outcomes Research Through Fees Payable by
Issuers of Health Insurance Policies and Self-Insured Health Plan Sponsors**

Sir or Madam:

We write to provide comments on behalf of the American Benefits Council (“Council”) in response to Internal Revenue Service (“Service”) Notice 2011-35, Request for Comments on Funding of Patient-Centered Outcomes Research Through Fees Payable by Issuers of Health Insurance Policies and Self-Insured Health Plan Sponsors (“Notice”), issued on June 9, 2011. The Council represents primarily large employers and other organizations that collectively sponsor or administer health and retirement benefits covering over 100 million Americans.

We appreciate the opportunity to provide comments with respect to the implementation of new sections 4375, 4376, and 4377 of the Internal Revenue Code of 1986, as amended (“Code”). These provisions impose a fee on issuers with respect to “specified health insurance policies” and on employers with respect to “applicable self-insured health plans” to partially fund new comparative clinical effectiveness research relating to patient-centered outcomes through the Patient-Centered Outcomes Research Trust Fund. We believe the comments discussed below will assist the Service in

formulating proposed regulations that implement and provide guidance on the requirements applicable to issuers and employers that will be subject to the fee.

CONFIRM THAT CODE SECTION 9832(C) EXCEPTED BENEFITS ARE EXCLUDED REGARDLESS OF INSURED STATUS

Code section 4375 imposes the fee on issuers of fully-insured specified health insurance policies. The term “specified health insurance policy” is defined to exclude any insurance if substantially all of its coverage consists of excepted benefits described in Code section 9832(c), commonly referred to as HIPAA-excepted coverages.

These excepted coverages include certain types of health policies that would otherwise be subject to the fee, such as stand-alone dental and vision coverage, as well as long-term care insurance. Code section 4376 imposes the fee on an “applicable self-insured health plan,” which is a self-insured plan providing accident or health coverage. Code section 4377 defines “accident and health coverage” to mean coverage which, if provided by an insurance policy, would cause the policy to be a specified health insurance policy. Given that Code section 9832(c) excepted benefits are excluded from the definition of a specified health insurance policy, it appears that such benefits would also be excluded from the definition of applicable self-insured health plan. However, confirmatory guidance would be helpful.

Accordingly, the Council urges the Service to provide guidance confirming that coverage, substantially all of which consists of Code section 9832(c) excepted benefits, is excluded from the fee regardless of whether the coverage is self-insured or fully insured, thus creating parity between self-insured and fully insured plans for purposes of the fee.

EXCLUDE EXPATRIATE COVERAGE FROM THE FEE

Code section 4375 defines specified health insurance policy to mean any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals *residing* in the United States. It is unclear whether a policy must be issued with respect to individuals physically residing in the United States or whether it may be issued with respect to individuals who are citizens or residents of the United States but who are living and/or working abroad (so-called expatriate coverage).

The Council urges the Service to clarify that actual physical residence in the United States is required, thus excluding most expatriate coverage from the fee on fully insured specified health insurance policies. In addition, the Council encourages the Service to develop a similar residency requirement for applicable self-insured health plans. To the extent that expatriate coverage includes coverage for an expatriate’s spouse or

dependent who remains domiciled in the United States, the Council requests guidance that, for ease of administration, these individuals may be disregarded when calculating the applicable fee under Code sections 4375 and 4376.

PERMIT DETERMINATION OF COVERED LIVES IN A MANNER THAT DOES NOT RESULT IN DOUBLE-COUNTING

The fee imposed under Code sections 4375 and 4376 is assessed based on the “average number of lives covered under the policy/plan.” In some cases, this may result in double-assessment of the fee with respect to an individual. For example, if all plans of an employer are held within an umbrella plan, each individual may only be counted once despite participating in a number of types of subcoverages offered under the umbrella plan. However, in the absence of an umbrella plan, an individual may end up being counted twice, which could cause the employer to pay multiple fees with respect to a single employee (note: this would also likely be the case with respect to such employee’s spouse or dependent). For example, an individual may be counted once for stand-alone vision (to the extent not excluded as recommended above) and counted again for major medical coverage. Such double-counting could result in an unfairly larger fee to an employer solely as a result of its plan design.

Given the absence of any reasonable basis for this result, the Council urges the Service to permit employers and issuers to only count each individual once as a covered life regardless of the number of plans under which such individual is covered.

DETERMINING “AVERAGE NUMBER OF LIVES COVERED UNDER THE PLAN”

The Notice invites comments on how future guidance could reduce administrative burden by providing for reasonable methods to determine the average number of lives covered under an applicable self-insured plan; on whether guidance should provide a safe harbor that would permit sponsors of applicable self-insured health plans to compute the average number of lives covered using a formula based on the number of participants and one or more additional factors that account for the number of dependents without requiring that actual dependents covered under the plan be counted; and on formulas and factors that could be used to determine the number of dependents for applicable self-insured health plans.

The Council requests that the Service issue guidance permitting use of any of the following “reasonable methods” for reporting covered lives with respect to self-insured plans, so long as a method is used in a consistent manner by the employer:

- (i) Count actual enrolled participants to determine the number of covered lives;

- (ii) Determine the number of covered lives by multiplying the number of enrolled participants by a “dependency” coefficient greater than 1 as already determined for the plan for actuarial or other purposes. The dependency coefficient may vary by categories of primary participant including, but not limited to, active/retiree status and part-time/full-time status; or
- (iii) Any other reasonable method the plan consistently uses to count covered lives for accounting valuation, pricing or other plan design purposes.

We also request guidance permitting employers to use a “snapshot” of participation at one point in time, given that plan enrollment varies over the course of a plan year. Such snapshot would be based on a window chosen by the employer that remains consistent from year to year.

PERMIT FLEXIBILITY AS TO TIMING AND METHOD OF PAYMENT OF THE FEE

The Council requests that the Service issue guidance permitting flexibility as to when an employer must pay the fee by allowing an employer to pay the fee anytime between January 1 of the year following the year for which the fee is assessed and the date upon which the corporate income tax return is due (with extensions) and to choose whether to pay the fee as one annual payment or on a quarterly basis. In addition, the Council urges the Service to provide flexibility as to the party that may pay the fee, *e.g.*, a third-party administrator (“TPA”) as an agent of the employer.

The Council also requests that the Service create a separate form pursuant to which the fee would be transmitted, instead of requiring that the fee be transmitted with the corporate income tax return. This would allow employers more discretion as to when to pay the fee and would permit the employer to delegate payment responsibility to a TPA or other third party as appropriate.

INTERACTION OF RETIREE COVERAGE WITH THE FEE

While retiree coverage may be subject to the fee because it is “established or maintained by an employer for the benefit of its employees or former employees,” we recommend that the Service consider the public policy merits of excluding retiree coverage from the fee. Employers provide a valuable benefit to retirees by, in many cases, voluntarily offering retiree coverage to their employees.

Given the costs associated with providing retiree health coverage and the lack of available coverage alternatives for individuals pre-65, the Council requests guidance confirming that the fee will not be imposed with respect to retiree health coverage. At a minimum, we urge the Service to clarify that the fee will not be imposed for group health plans in which only retirees participate. Such retiree-only plans are already exempt from other provisions of the Patient Protection and Affordable Care Act (“Affordable Care Act”) related to group market reform.¹ We believe this clarification would help ensure that employers remain willing and able to provide this coverage, at least through the start of 2014 when more purchasing options should become available by reason of the state-based exchanges per the Affordable Care Act.

INTERACTION OF COBRA WITH THE FEE

COBRA coverage is arguably not “established or maintained by an employer for the benefit of its employees,” given that it is federally mandated. Since employers are required by federal law to offer COBRA coverage, we believe it would be inappropriate to impose a fee on employers with respect to such coverage. Accordingly, the Council urges the Service to issue guidance expressly excluding COBRA coverage from the fee.

IMPLEMENT TRANSITION RULES

Given the administrative complexity in determining the fee that an employer must pay, the Council urges the Service to provide a transition period allowing good faith compliance for the first two years the fee is in effect. Such good faith compliance may include counting employees (and not spouses and/or covered dependents) as covered lives for such years.

Transition rules could also provide employers with options in determining an administratively practicable way of determining the fee as they develop more complex systems. For example, an employer may be given the option to pay a flat fee based on the number of employees in its controlled group as opposed to the number of covered lives in its plans.

¹ The preamble to the interim final regulations on grandfathered plans noted that statutory provisions in effect exempting group health plans with “less than two participants who are current employees” from HIPAA also exempt such plans from the group market reform requirements of the ACA. See 75 FR 34539-34540, published June 17, 2010.

EXCLUSION OF FSAs, HRAs AND HSAs

In general, most health flexible spending arrangements (“FSAs”) will not be subject to the fee. The Notice requests comments on the type or types of health reimbursement arrangements (“HRAs”) that should be excluded from (or, conversely, included in) the definition of applicable self-insured health plan.

The Council recommends that HRAs also not be treated as applicable self-insured health plans given the significant challenge of counting covered lives for purposes of medical savings accounts (such as FSAs and HRAs), where employers may not know with certainty the number of Code section 152 dependents being reimbursed for medical claims under such accounts.

We also recommend that guidance confirm that Health Savings Accounts (HSAs) established in conjunction with employer-sponsored qualified high-deductible health plans (HDHPs) are not subject to the fee. Employers who sponsor an HDHP typically seek to comply with Department of Labor guidance that sets out conditions whereby the HSA itself is not an employee welfare plan.²

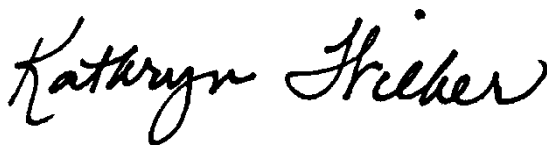
* * *

Thank you for the opportunity to provide comments regarding implementation of new Code sections 4375, 4376, and 4377, which impose a fee on issuers with respect to “specified health insurance policies” and on employers with respect to “applicable self-insured health plans” to partially fund new comparative clinical effectiveness research relating to patient-centered outcomes through the Patient-Centered Outcomes Research Trust Fund. If you have any questions or would like to discuss these comments further, please contact us at (202) 289-6700.

Sincerely,



Paul W. Dennett
Senior Vice President,
Health Care Reform



Kathryn Wilber
Senior Counsel,
Health Policy

² DoL Field Assistance Bulletin 2004-1