April 6, 2012

Submitted electronically via e-ohpsca-er.ebsa@dol.gov

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

RE: Frequently Asked Questions from Employers Regarding Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods

Sir or Madam:

We write to provide comments on behalf of the American Benefits Council ("Council") in response to the above-referenced frequently asked questions ("FAQs") that were published in substantially identical form by the Departments of Labor, Health and Human Services, and the Treasury ("Departments") on February 9, 2012. 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.

The FAQs provide information in response to questions from employers and other stakeholders regarding certain provisions of the Patient Protection and Affordable Care Act ("Affordable Care Act") governing automatic enrollment, employer shared responsibility, and the 90-day limitation on waiting periods. In addition, the FAQs describe approaches that the Departments may propose in future regulations or other guidance.

We commend the Departments for coordinating guidance with respect to the employer shared responsibility requirements, as well as the Affordable Care Act's

provisions regarding automatic enrollment and the permissible 90-day waiting period. We also appreciate the opportunity to provide comments in connection with the FAQs to assist the Departments in developing workable guidance that will allow sufficient time for employers to bring their operations into compliance with the provisions addressed by the FAQs.

NEED FOR FORMAL RULEMAKING

The Council strongly supports the general approach that the Departments have taken in developing guidance with respect to the employer responsibility and related provisions of the Affordable Care Act. More specifically, we appreciate that the Departments have in many circumstances requested public comment outside of the formal regulatory context prior to the issuance of proposed regulations. We believe this approach benefits both the Departments and the public by ensuring that all interested parties have a meaningful opportunity to provide input as guidance is developed.

Notwithstanding, we believe it is important that the Departments begin issuing proposed regulations with respect to the issues addressed in the FAQs in order to permit sufficient time for the issuance of proposed and final rules and for the implementation of such rules by applicability dates.[1] Employers will need sufficient time to adopt or change administrative processes as necessary to bring their operations into compliance with the automatic enrollment, employer shared responsibility, and 90-day waiting period limitation provisions.

REQUEST FOR "COMPLIANCE-FIRST" ENFORCEMENT APPROACH

The Council recommends that the Departments adopt an enforcement approach with respect to the automatic enrollment, employer shared responsibility, and 90-day waiting period limitation provisions that emphasizes compliance assistance, rather than imposition of penalties similar to the approach the Departments are taking with respect to implementation of other provisions of the Affordable Care Act.[2] Specifically, we urge the Departments to expressly affirm a compliance assistance approach in the preambles of proposed regulations and in subsequent final regulations implementing these provisions, rather than imposing penalties on group health plans that are working diligently to come into compliance. We also urge that this compliance enforcement approach be accompanied by an adequate implementation period prior to the applicability date of final regulations or other guidance.

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[1] *See* Council letter dated June 15, 2011, *available at* http://americanbenefitscouncil.org/documents/hcr_shared-irs-comments061511.pdf.

[2] *See* "Questions Regarding Affordable Care Act Implementation" (Sept. 20, 2010), *available at* http://www.dol.gov/ebsa/faqs/faq-aca.html.

AUTOMATIC ENROLLMENT

Section 18A of the Fair Labor Standards Act ("FLSA"), as added by section 1511 of the Affordable Care Act, directs an employer to which the FLSA applies, and that has more than 200 full-time employees, to automatically enroll new full-time employees in one of the employer's health benefits plans (subject to any waiting period authorized by law) and to continue the enrollment of current employees in a health benefits plan offered through the employer.

FAQs issued on December 22, 2010 ("2010 FAQs") stated that it was the view of the Department of Labor that employers are not required to comply with the automatic enrollment requirement until regulations are issued regarding the automatic enrollment requirement. The 2010 FAQs further stated that the Department of Labor intends to complete relevant rulemaking by 2014.

The new FAQs state that the Department of Labor has concluded that its automatic enrollment guidance will not be ready to take effect by 2014, but confirms that, until final regulations under FLSA section 18A are issued and become applicable, employers are not required to comply with the automatic enrollment requirement of FLSA section 18A. The new FAQs make clear that the Department of Labor is sensitive to stakeholder concerns regarding the need for adequate time to comply with any regulations that are ultimately issued.

The Council strongly supports the guidance provided in the new FAQs stating that the Department of Labor has determined that employers will not have to comply with the automatic enrollment requirement until final regulations have been issued and become applicable (even if such date is after 2014). We particularly appreciate the statement that provides that employers will not have to comply with the new rules until final regulations become applicable, and not merely until they have been issued. This is because, following the release of the final regulations relating to the automatic enrollment requirement, most if not all employers will have to develop new administrative procedures to enable them to comply with the new automatic enrollment requirement. Additionally, they will likely need to contract or otherwise collaborate with service providers to implement the new requirements.

EMPLOYER SHARED RESPONSIBILITY - FORM W-2 AFFORDABILITY SAFE HARBOR

The employer shared responsibility provisions, contained in section 4980H of the Internal Revenue Code of 1986, as amended ("Code"), provide that an applicable large employer (for this purpose, an employer with 50 or more full-time equivalent employees) may be subject to an assessable payment if any full-time employee is certified to receive an applicable premium tax credit or cost-sharing reduction payment. Relevant for purposes of this letter, this may occur where an employer offers its full-

time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan that either is unaffordable relative to an employee's household income or does not provide minimum value.

In Notice 2011-73, the Department of the Treasury and the Internal Revenue Service (collectively, the "Service") set forth a safe harbor allowing employers, for purposes of determining whether they owe an assessable payment under Code section 4980H(b)(1), to use an employee's Form W-2 wages (as reported in Box 1) instead of household income in determining whether coverage offered is affordable ("Affordability Safe Harbor").

The Council, in previous comments, expressed support for allowing Form W-2 wages to be used in lieu of household income to determine affordability for purposes of Code section 4980H(b). We similarly support the Departments' intent, as affirmed in the FAQs, to propose regulations or other guidance permitting use of the Affordability Safe Harbor in determining the affordability of employer coverage.[3]

The Affordability Safe Harbor is particularly important given that an employer would otherwise be required to use an employee's household income to determine whether the coverage that it offers is affordable for purposes of the employer shared responsibility requirements. Practically speaking, it would be very difficult, if not impossible, for an employer to know each employee's total household income; employees may not want to disclose such information to their employers. Additionally, requiring the use of household income to determine affordability would raise significant privacy concerns. The proposed Affordability Safe Harbor represents an important step toward ensuring that employers have available to them the information necessary to provide qualifying, affordable minimum essential coverage and, thus, to avoid unwanted penalties under Code section 4980H(b).

Although the Council is supportive of using Form W-2 wages for purposes of determining affordability, we reiterate our previously-expressed concerns that the proposed Affordability Safe Harbor uses Box 1 wages. The use of Box 1 wages for purposes of the proposed Affordability Safe Harbor seems to create a possible disincentive for employers regarding programs and features designed to increase employee participation in qualified retirement plans and/or for the provision of more comprehensive health and welfare plan coverage. This is because an employee's Box 1 wages are reduced to the extent of an employee's elective deferrals into a 401(k) plan or salary deferrals via a Code section 125 cafeteria plan to purchase health and welfare plan coverage. Thus, for example, someone who defers amounts into a 401(k) plan will

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[3] *See* Council letter dated Oct. 31, 2011, *available at* http://americanbenefitscouncil.org/documents/hcr_premium-tax-credit_comments103111.pdf; Council letter dated Dec. 13, 2011, *available at* http://americanbenefitscouncil.org/documents/hcr_4980h_irs-comments121311.pdf.

have lower wages reported in Box 1 of the Form W-2 and, as a result, his or her employer-provided coverage for purposes of Code section 4980H is more likely to be unaffordable when compared to another employee that makes fewer or no elective deferrals. This is also the case for salary deferrals via a Code section 125 cafeteria plan.

Accordingly, we are concerned that the use of Box 1 wages, without appropriate adjustment to reflect an employee's pre-tax salary deferrals into a 401(k) plan or for the purpose of qualifying health and welfare plan coverage, could encourage some employers to pull back on, or otherwise not pursue, increased participation by employees in 401(k) and other qualified retirement plans (for example, through automatic enrollment of employees into 401(k) plans and/or by providing for automatic annual increases in employee elective contribution rates) or health and welfare plans. One way to address this issue would be, for purposes of the Form W-2 Affordability Safe Harbor, to allow employers to increase Box 1 wages by the amount of an employee's pre-tax salary deferrals into qualified retirement plans and cafeteria plans. An alternative way could be by reference to Box 5 wages, with any adjustments as necessary.

The Council strongly urges the Departments to include the Affordability Safe Harbor in any formal rulemaking, with certain modifications to the Form W-2 wages as discussed above.

EMPLOYER SHARED RESPONSIBILITY – LOOK-BACK/STABILITY PERIOD

The FAQs state that Notice 2011-36 described and requested comments on a possible approach that would use a "look-back/stability period safe harbor" method that employers might use in determining whether current employees (i.e., those who are not newly hired or transferred) are full-time employees for purposes of the employer shared responsibility provisions. The FAQs state that the Service intends to issue proposed regulations or other guidance that would allow look-back and stability periods not to exceed 12 months, based on the approach outlined in Notice 2011-36 for purposes of determining whether an employee (other than a newly hired employee) is a full-time employee.

The Council appreciates the confirmation that guidance will be issued allowing use of a look-back/stability period as a safe harbor. As the Council has discussed in prior comments,[4] given high rates of employee attrition and inconsistent hours worked from month to month, a requirement that a determination of full-time status be made with respect to each employee on a month-by-month basis would add significant and unnecessary administrative complexity for many employers and lead to employees'

[4] *See* Council Letter dated June 15, 2011, *available at* http://americanbenefitscouncil.org/documents/hcr_shared-irs-comments061511.pdf.

confusion regarding their health coverage. We strongly support the flexibility that would be allowed by use of the look-back/stability period safe harbor. The look-back/stability period safe harbor would facilitate administration of health coverage and enable employees to understand the parameters of their health coverage on an ongoing basis. We encourage the Departments to permit a look-back (or measurement) period of at least 12 months. This will achieve equitable results, as it will facilitate an employer's determination of full-time employees and also operate to smooth out significant variations in employee hours.

EMPLOYER SHARED RESPONSIBILITY – NEWLY HIRED EMPLOYEES

As discussed above, the Departments have announced that a look-back/stability period safe harbor may be used with respect to employees other than newly hired employees. The FAQs make clear that the Service intends to issue proposed regulations or other guidance that will address how to determine whether a newly hired employee is a full-time employee for purposes of Code section 4980H.

Notably, nothing in the statute requires newly hired employees to be treated any differently from other employees. The FAQs, however, propose a different rule for purposes of determining whether newly hired employees qualify as full-time employees. The FAQs propose that, if, when an employee is hired, based on facts and circumstances, it cannot "reasonably be determined" whether he or she is expected to work full time, and if the employee's hours during the first three months following his or her commencement are "reasonably viewed" as not representative of the average hours the employee is expected to work on an annual basis, then the employer may evaluate the employee's hours over an additional three-month period without being penalized under Code section 4980H.

The Council appreciates that the proposed approach with respect to newly hired employees may be intended to take into consideration the use of seasonal employees or a workforce with high turnover. We believe, however, that the complexity and uncertainty of the proposed approach with respect to determining whether newly hired employees are full-time employees will make it very difficult for employers to implement in a consistent manner. Several elements of the approach are subjective and would necessarily require employers to make judgments on an employee-by-employee basis as to whether the employee is "reasonably viewed" to be full-time going forward. A workable rule requires a simpler, more objective approach that does not require employers to make such predictions. Large employers typically rely on automated systems for making determinations related to employee eligibility and enrollment in health benefits coverage. Subjective rules that require individualized determinations will impede the use of automated systems and undercut the efficiency and accuracy of implementation.

In addition to making compliance more difficult for employers, the proposed approach for newly hired employees also has the potential for creating confusion and uncertainty for employees. Given the Affordable Care Act's individual mandate to maintain health insurance coverage, it is important for an employee to be able to ascertain how he or she will secure and maintain such health insurance coverage.

Accordingly, we strongly urge the Departments to adopt guidance that provides clear, simple methods for determining an employee's status as a full-time employee for purposes of Code section 4980H. We specifically recommend that employers be permitted to use the same look-back period for newly hired employees that it uses for other employees.

90-DAY WAITING PERIOD LIMITATION

Public Health Service Act ("PHSA") section 2708, as added by the Affordable Care Act, provides that, in plan years beginning on or after January 1, 2014, a group health plan or group health insurance issuer shall not apply any waiting period that exceeds 90 days. The term "waiting period" is defined to be the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. Unlike with respect to the employer shared responsibility requirements, the 90-day waiting period provision does not distinguish between full-time and part-time employees. The Council previously submitted comments in response to Notice 2011-36 regarding the 90-day waiting period limitation, including how rules relating to the look-back/stability period safe harbor method for determining the number of full-time employees under Code section 4980H should be coordinated with the 90-day waiting period limitation.[5]

The FAQs state that the Departments intend to retain the definition in existing regulations that the 90-day waiting period begins when an employee is otherwise eligible for coverage under the terms of the group health plan. The FAQs further state that eligibility conditions that are based solely on the lapse of a period of time would be permissible for no more than 90 days; however, other conditions for eligibility, such as full-time status, a bona fide job category, or receipt of a license, would generally be permissible unless the condition is designed to avoid compliance with the 90-day waiting period limitation. The Council supports the Departments' clarification that plans can impose eligibility conditions that are based other than on the passage of time.

However, as the Council has previously commented, we urge the IRS to allow employers some reasonable administrative period following the close of the waiting period to determine eligibility and carry out enrollment procedures. Given the significant administrative tasks attendant to determining eligibility, we urge the

[5] *See* Council Letter dated June 15, 2011, *available at* http://americanbenefitscouncil.org/documents/hcr_shared-irs-comments061511.pdf.

Departments to allow an administrative period of at least 30 days for employers to enroll employees – all employees, not just newly hired employees – following the end of the 90-day waiting period limitation.

To this end, the vast majority of employers carry out enrollment activities as of the first day of a month, rather than in terms of the lapse of a certain number of days. We encourage the Departments to allow an administrative period that is long enough to at least permit enrollment as of the first day of the next month following lapse of the 90-day waiting period limitation, although in no instance should such administrative period be shorter than 30 days. Otherwise, administrative difficulties will ensue if employers are required to enroll employees mid-month.

GUIDANCE ON MINIMUM VALUE REQUIREMENT FOR LARGE AND SELF-FUNDED GROUP HEALTH PLANS

In addition to the need for implementation guidance on the provisions addressed in the FAQs, we are also concerned about the need for timely guidance regarding the "minimum value" requirements related to minimum essential coverage. As discussed below, we believe such guidance should be based on the determination of the value of the benefits covered under "the plan" without regard to the value of benefits provided by external benchmark plans, which large employers are not required to satisfy.

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.

As we have previously commented to the Departments,[6] we read the above language to permit employers broad flexibility in fashioning their plan benefits and

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[6] *See* Council letter dated Oct. 31, 2011, *available at* http://www.americanbenefitscouncil.org/documents/hcr_premium-tax-credit_comments103111.pdf; Council letter dated Jan. 31, 2012, *available at* http://www.americanbenefitscouncil.org/documents2012/hcr_ehb_council-hhs-letter013112.pdf.

those 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%.

We do not believe that Congress intended, or that the text of Code section 36B(c)(2)(C)(ii) permits, the Departments to impose a certain minimum value test on employer-sponsored plans. This includes using the Affordable Care Act's essential health benefits requirement to essentially bootstrap such a result, particularly given that employer-sponsored large group health plans are not required to satisfy the essential benefits requirements. We also urge the Departments to issue guidance that would take into account the full value of annual employer contributions made to health savings accounts ("HSAs") or health reimbursement arrangements ("HRAs") in order to accurately reflect the value of those plans. A bulletin issued by the Department of Health and Human Services on February 24, 2012 regarding actuarial value indicates that the agency intends to propose an approach that allows only "a portion" of the annual employer contribution to an HSA or HRA to be taken into account in valuing a plan. We urge the Departments to instead adopt a rule that would take into account the full value of annual employer contributions made to HSAs or HRAs, since account holders have access to the full amount of such contributions to use for qualified medical expenses.

We are concerned that the approaches under consideration by the Departments 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. For these reasons, we strongly urge the Departments 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.

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We appreciate the opportunity to provide comments regarding the FAQs. 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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