



AMERICAN BENEFITS  

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COUNCIL

May 2, 2013

*Submitted electronically via <http://www.regulations.gov>*

Internal Revenue Service  
CC:PA:LPD:PR (REG-148500-12)  
Room 5203  
PO Box 7604, Ben Franklin Station  
Washington, DC 20044

**Re: Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage**

Sir or Madam:

We write on behalf of the American Benefits Council (“Council”) to provide comment in connection with the notice of proposed rulemaking entitled “Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage” published in the Federal Register by the Department of the Treasury and the Internal Revenue Service (collectively, the “Department”) on February 1, 2013 (“Proposed Rule”). The Proposed Rule provides guidance regarding the requirement to maintain “minimum essential coverage” enacted by the Patient Protection and Affordable Care Act (“ACA”) and the liability for the shared responsibility payment for not maintaining minimum essential coverage. We write to provide our comments with respect to the Proposed Rule.

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.

**CLARIFICATION THAT A SELF-INSURED GROUP HEALTH PLAN MAY CONSTITUTE AN “ELIGIBLE EMPLOYER-SPONSORED PLAN”**

Code Section 5000A(f)(1)(B) provides that “minimum essential coverage” includes coverage under an “eligible employer-sponsored plan.” Code Section 5000A(f)(2), in turn, provides:

The term “eligible employer-sponsored plan” means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is –

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

(B) any other plan or coverage offered in the small or large group market within a State.

Based on the above statutory language, the Council was among several groups that requested clarification, for the avoidance of doubt, that employer-sponsored self-insured group health plans constitute “eligible employer-sponsored plan[s]” within the meaning of Code Section 5000A(f)(2).

The preamble to the Proposed Rule helpfully provides that self-insured group health plans are eligible employer-sponsored plans. Specifically, it provides, “[a]ccordingly, a self-insured group health plan is an eligible-employer sponsored plan.” This clarification in the preamble is very helpful. In addition, we understand that a technical correction to the Proposed Rule itself was issued on March 25, 2013 to, in part, help clarify that that self-insured group health plans are “eligible employer-sponsored plans” for purposes of Code Section 5000A. We appreciate the Department’s clarification in the preamble to the Proposed Rule that self-insured group health plans may constitute “eligible employer-sponsored plans.” We also appreciate the technical correction of March 25, 2013. Nonetheless, we understand that some employer and provider groups continue to be confused by the statutory language as well as the Proposed Rule regarding whether self-insured group health plans may qualify as “eligible employer-sponsored plans.” To eliminate any further doubt, we encourage the Department to consider including a more express statement to this effect in any final rulemaking.

**CLARIFICATION THAT THE MERE AVAILABILITY OF RETIREE COVERAGE DOES NOT CONSTITUTE “MINIMUM ESSENTIAL COVERAGE”**

We note that a proposed regulation issued by the Department on April 30, 2013 with respect to Code Section 36B (“April 30 Proposed Rule”) provides that a retiree is not

deemed eligible for “minimum essential coverage” within the meaning of Code Section 5000A with respect to any employer-sponsored coverage that may be available to him or her, except for the months in which he or she is enrolled in such coverage. Specifically, the April 30 Proposed Rule provides that, “an individual who may enroll in retiree coverage is eligible for minimum essential coverage under the coverage only for the months the individual is *enrolled* in the coverage” (emphasis added). The Council very much appreciates this clarification contained in the April 30 Proposed Rule as it will ensure that retirees are not disqualified from accessing important premium tax credits (“PTCs”) through a state or federally-facilitated health exchange because of their mere eligibility for employer-provided retiree health coverage. We request that this clarification be included as part of any final rulemaking with respect to Code Section 36B and/or Code Section 5000A.

With respect to the above, we note that many employers make available to their retirees a health reimbursement arrangement (“HRA”) for use by such retirees in helping to defray the out-of-pocket medical costs they may incur post-employment. Based on the express statutory language of Code Section 5000A as well as the April 30 Proposed Rule, questions have arisen as to whether a retiree’s ability to reimburse such medical expenses from an HRA could render them ineligible for PTCs under Code Section 36B. The Council intends to submit comments on the April 30 Proposed Rule to address this matter in further detail.

#### **CLARIFICATION THAT SELF-INSURED AND INSURED EXPATRIATE COVERAGE SHOULD BE CONSIDERED “MINIMUM ESSENTIAL COVERAGE”**

On March 8, 2013, the Department, together with the Departments of Labor and Health and Human Services, issued FAQs About Affordable Care Act Implementation (Part XIII). The FAQs provided, among other things, that “coverage provided under an expatriate group health plan is a form of minimum essential coverage under Section 5000A of the Internal Revenue Code.” For this purpose, the FAQs defined “expatriate group health plan” to mean “an insured group health plan with respect to which enrollment is limited to primary insureds who reside outside of their home country for at least six months of the plan year and any covered dependents, and its associated group health insurance coverage.”

We very much appreciate the sub-regulatory guidance providing that an expatriate group health plan constitutes minimum essential coverage for purposes of the individual shared responsibility requirement. Many U.S. citizens and residents spend a significant portion of the year working outside of the United States but do not satisfy the requirements of Code Section 911(d)(1)(A) or (B) (*e.g.*, a citizen that is not a bona fide resident of a foreign country for an uninterrupted period of at least an uninterrupted taxable year, or a citizen or resident who, during any period of 12 consecutive months,


is present in a foreign country or countries during at least 330 full days in such period) and thus are generally subject to the individual shared responsibility requirement. The FAQs provide needed comfort that such individuals (and their covered dependents) will be considered to satisfy the individual shared responsibility requirement for periods during which the individuals work outside of the United States and are covered by an expatriate group health plan. We urge the Department to include the aforementioned guidance regarding expatriate group health plans in final regulations regarding Code Section 5000A.

Additionally, we request that the Department clarify in any final rulemaking that expatriate coverage can qualify as “minimum essential coverage” for purposes of Code Section 5000A regardless of whether such coverage is issued by a domestic or foreign issuer. It is our understanding that many companies provide expatriate group health plan insurance through foreign issuers sited in the country in which employees work. It is not clear based on the text of the FAQs whether foreign issuers are included in considering whether “minimum essential coverage” is offered. We also urge the Department to make clear in final rulemaking that the same result applies with respect to expatriate coverage regardless of whether it is insured or self-funded. Many multinational employers self-insure health coverage that they provide to their employees, including expatriate coverage for employees working abroad. A contrary rule would unnecessarily disadvantage those employers that choose to self-fund their expatriate coverage for their employees.

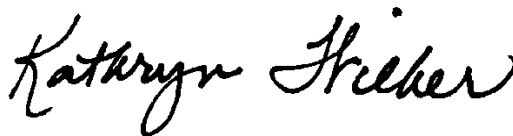
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Thank you for considering these comments submitted with regard to the Proposed Rule. If you have any questions or would like to discuss these comments further, please contact us at (202) 289-6700.

Sincerely,



Paul W. Dennett  
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Health Care Reform



Kathryn Wilber  
Senior Counsel,  
Health Policy