

# Employers for Flexibility in Health Care

June 11, 2012

Submitted electronically via [Notice.comments@irs.counsel.treas.gov](mailto:Notice.comments@irs.counsel.treas.gov) and [EmployerCoverageBulletin@cms.hhs.gov](mailto:EmployerCoverageBulletin@cms.hhs.gov).

Attn: CC:PA:LPD:PR (Notices 2012-31, 2012-32)  
CC:PA:LPD:RU (Notice 2012-33)  
Room 5203  
Internal Revenue Service  
P.O. Box 8010  
Ben Franklin Station  
Washington, DC 20044

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
P.O. Box 7604  
Baltimore, MD 21244-8010

Request for Comments re:

- I) Minimum Value of an Employer-Sponsored Health Plan (IRS Notice 2012-31)
- II) Request for Comments on Reporting of Health Insurance Coverage (IRS Notice 2012-32)
- III) Request for Comments by Applicable Large Employers on Reporting of Health Insurance Coverage Under Employer-Sponsored Plans (IRS Notice 2012-33)
- IV) Verification of Access to Employer-Sponsored Coverage Bulletin (HHS Bulletin)

We are writing in response to the above requests for comments on behalf of the Employers for Flexibility in Health Care ("EFHC") Coalition, a group of leading trade associations and businesses in the retail, restaurant, hospitality, construction, temporary staffing, and other service-related industries, as well as employer-sponsored plans insuring millions of American workers. Members of the EFHC Coalition are strong supporters of employer-sponsored coverage and have been working with the Administration as you implement the Patient Protection and Affordable Care Act ("PPACA") to help ensure that employer-sponsored coverage - the backbone of the US health care system - remains a competitive option for all employees whether full-time, part-time, temporary, or seasonal workers.

For the past year, the EFHC Coalition has participated in numerous meetings with the Administration and has developed substantive policy recommendations in a concerted effort to assist the Administration in developing regulatory guidance on the major provisions of PPACA that affect employers (*see comment letters submitted on April 5 re: Notice 2012-17, October 31 re: Notice 2011-73, et al., and June 17 re: Notice 2011-36 respectively*). Our prior comments, and this letter, stress two overriding themes:

- The employer provisions of PPACA are inextricably linked and should be addressed as a whole, not piecemeal; and
- Transition relief is essential to allow employers sufficient time to implement the myriad and complex new rules, especially relating to plan design and reporting.

We have consistently taken the view that it is imperative the Administration examine the employer provisions as a whole when developing regulatory guidance because the employer requirements under the law are inextricably linked. As we examine the interplay between these new requirements, it is clear they have significant consequences for employers and their ability to maintain flexible work options and affordable health

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coverage for their employees. Thus, we have provided comprehensive comments on the workability of the definition of full-time employee, the 90-day waiting period, the affordability test and minimum value determination, and the reporting requirements under the law. We urge you to issue regulations on the employer requirements in tandem, rather than piecemeal, so that employers can have a comprehensive picture of the employer requirements under the law and take definitive steps toward implementation.

We appreciate the Administration's requests for comments to seek input from the employer community before issuing formal regulatory guidance and the Administration's receptivity to our comments. However, we are increasingly concerned that formal guidance or rules on the employer shared responsibility requirements have not been issued. Our members and companies are growing concerned that if they do not have sufficient regulatory guidance soon, they will not be able to conduct the necessary budget and planning processes to comply with the implementation deadline. To be ready for plan years beginning after December 31, 2013 (and to conduct open enrollment in the fall of 2013), many of our members will need to determine their budgets and plan designs now. The issuance of formal rules is critically important to allow employers sufficient time to determine new benefit designs that meet the law's requirements; to bring their IT systems into compliance for payroll, reporting, and other mechanisms; and to communicate the new rules to their store or company managers and their employees. Based on the Administration's own experience with the length of time needed to budget for, plan for, and develop reporting processes and IT systems, we hope you will recognize that it is unreasonable to expect employers to comply for plan years beginning after December 31, 2013.

The lack of formal guidance and rules underscores the EFHC Coalition's support for the Department of Treasury's ("Treasury") recognition in its August 17, 2011, Notice of Proposed Rulemaking that transition relief may be essential to preserving employer-sponsored coverage as the new requirements under PPACA take effect in 2014. The EFHC Coalition strongly encourages the Administration to delay the implementation of the penalties under Internal Revenue Code ("IRC") §4980H(b) until 2016 to allow the Administration time to evaluate at least one year of data and to provide time for employers to adjust their plan designs as needed. This transition period will help the Administration evaluate the impact of the new requirements and deter employers from reactively dropping coverage if it is determined that revisions to the rules are necessary once all of the provisions are effective. Such transition relief could be provided specifically for employers who offer coverage to employees and are working to meet PPACA's requirements without undermining the intent of the shared responsibility requirements of the law for employers or individuals.

This transition relief may be especially important as the Administration develops guidance with respect to both the minimum value determination and the new reporting requirements under the law. As we will discuss below with respect to the minimum value determination, there is no "standard population" or comprehensive data base with respect to private, employer-sponsored coverage or claims data that currently exists. This data may take time to develop to reflect a variety of employer-sponsored plans post-2014 when all of the new employer provisions are in effect. Depending on how robust the data is and the potential for the imposition of prescriptive benefit limits or cost-sharing structures, we are concerned about being able to offer flexible benefit designs and

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coverage that is desirable and affordable to both employers and employees, particularly in the first year of implementation in 2014.

Similarly, the information needed for verification of individual access to employer-sponsored coverage and the mechanics of the reporting structures between employers, employees, state insurance Exchanges, and federal agencies has not been adequately addressed or made clear in regulations. There is a great deal of risk for costly, time-consuming, and duplicative data collection and reporting requirements. We have discussed at length our concerns about the 50+ state process as issued in the final Exchange regulation (CMS-9989-F) for making individual eligibility determinations about the affordability of employer coverage. This state-by-state approach creates administrative difficulties for multi-state employers and an inconsistent experience for our employees. We have urged consolidation of the employer reporting requirements through the Internal Revenue Service ("IRS") as the central agency responsible for both the verification of individual tax credits and imposition of employer tax penalties. We strongly support the establishment of a separate process in which the IRS verifies employees' eligibility for tax credits before assessing tax penalties on employers. We discuss our recommendations below for potential reporting mechanisms that streamline the data collection process for employers and that provide the necessary information to employees and the agencies for the individual tax credit eligibility and verification processes.

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## I. Minimum value determination for employer-sponsored coverage

Under PPACA, employers are required to provide coverage to their full-time employees that is both “affordable” and of “minimum value” or face penalties for full-time employees that qualify for premium tax credits from the Exchange. IRC §36B(c)(2)(C)(ii) provides that a plan shall not meet the minimum value determination if “the plan’s share of the total allowed costs of benefits provided under that plan is less than 60% of such costs.” How minimum value is determined will have a tremendous impact on the affordability and administration of employee benefit plans and is intricately intertwined with the other employer provisions.

The EFHC Coalition provided initial comments on the minimum value determination in our October 31 comment letter. Among other issues, the October 31 letter urged the Administration to provide a variety of methods that employers may elect to determine minimum value. We encouraged the Administration to provide multiple methodologies that employers may elect to utilize to determine minimum value, including (but not limited to): self-attestation, safe harbor checklists, certification by a qualified actuary, and other methods that are easily administrable and reflective of those covered by employer-sponsored plans in the large and mid-size group markets.

We appreciate that the Administration has outlined its intention to offer employers three approaches to measuring and determining minimum value: a minimum value calculator (“MV calculator”), an array of design-based safe harbors in the form of checklists, and certification by a certified actuary. The availability of multiple methodologies that are administratively simple is particularly important for smaller and mid-size employers who will be required to complete the minimum value calculations. Under PPACA, employers with as few as 50 full-time equivalents are required to manage these complex evaluations. Small and mid-size employers frequently do not have the resources within their companies to perform complex actuarial calculations. Although the number of methodologies available is important, how these methodologies are developed and designed will determine over time whether employers will actually be able to avail themselves of any of the three tools - or be forced to default to the actuarial certification.

In addition, as we noted in our October 31 letter, it was not the intent of PPACA to dictate a defined benefit package to large employers who offer coverage. In particular, the EFHC Coalition is concerned about the determination of minimum value based on the provision of the essential health benefits package in PPACA §1302. We appreciate the Administration’s affirmation that “[e]mployer-sponsored self-insured and insured large group plans are not required to conform their plans to any of the essential health benefit (EHB) benchmarks that the Department of Health and Human Services (“HHS”) intends to propose to apply to” qualified health plans (QHPs) and that “these employer-sponsored plans need not offer all of the EHBs or even cover each of the ten statutory EHB categories.” However, we remain concerned that the determination of whether an employer-sponsored plan provides minimum value will be based on the actuarial value rules to be proposed by HHS with appropriate modifications. How these modifications are developed, measured, and applied in the context of minimum value is critically important to employers who want to maintain the flexibility to design benefit plans that meet the

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needs of a diverse workforce that varies widely based on health status, size, sector, turnover rate, local providers networks, and geographic costs.

Now that the Administration has outlined assumptions to be used in the minimum value determination and options for determining minimum value, we would like to take this opportunity to offer comments and concerns we have with respect to:

- The data set used to create a standard population to determine whether an employer-sponsored plan has met minimum value;
- The treatment of employer contributions to HSAs and HRAs in determining minimum value;
- The particular design aspects and cost-sharing structures of the three options for determining minimum value; and
- The need for a transition period for employers who offer coverage to employees.

The EFHC Coalition further requests reaffirmation in the minimum value regulations that not all plan options offered by an employer are required to meet minimum value. Under PPACA, an eligible full-time employee may access a premium tax credit in an Exchange if an employer does not offer at least one plan that is both affordable and of a minimum value to that employee. However, employees should have the option to enroll in a lower-cost plan offered by the employer as long as that plan meets the other requirements under the law, i.e. preventive care at no cost sharing and the lifting of annual and lifetime limits.

## *1. Assumptions to be Used in Minimum Value Determination*

### *a. Standard Population and Utilization*

In Notice 2012-31, the Administration states its intent to determine minimum value “based on the health expenses expected to be incurred by a standard population, rather than the population that a plan actually covers.” It is our understanding that the Administration will purchase a large claims data set from which it will extract data to determine minimum value. The Administration in Notice 2012-31 also states that “HHS intends to publish continuance tables based on claims and population data for typical self-insured employer-sponsored plans” but not claims or population data for plans that are required under the law to provide EHBs or to meet state benefit mandates.

Given the diversity of the workforce represented by different employers, there is no typical self-insured plan and no typical employer. We are concerned that existing commercially available data sets that are populated with claims data from self-insured large group plans may both require employers to pay a fee to participate in the data set and also allow self-insured employers to opt-out of participation in the larger, de-identified data set. If many self-insured employers choose not to participate, this data set may not be truly reflective of large swaths of the large group market, including small and medium sized employers and low-margin industries. As a consequence, this data set used to determine minimum value may be skewed toward the largest employers who are in a position to provide richer benefit packages. Therefore, the Coalition urges the Administration to ensure that the data set selected is truly representative of a broad range of self-insured plans, including small, mid-size, and large employers; employers

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from a broad range of industries and sectors; and employers with a range of turnover rates.

Employers will be responsible for determining minimum value for plans offered in 2014. Yet, the data set that will drive the determination of minimum value will be based on claims data from self-insured plans from years prior to the full implementation of PPACA. Because of health care cost growth and the costs of compliance with PPACA, we expect employer plans to change in 2014 in ways that are not yet reflected in the data underlying the calculator, making the calculator not truly reflective of the variety of large employer plans.

Furthermore, Notice 2012-31 does not specify how often the claims data for determining minimum value will be rebased or how often the continuance tables, the inputs into the MV calculator, and the checklists will be updated to reflect changes in employer plans over time. Annual rebasing will allow the data to keep up with changes in plan design among large employers and to properly reflect the claims data underlying the most current typical plan designs. This is particularly important with respect to standard and non-standard cost-sharing structures as reflected in the continuance tables, MV calculator, and checklists.

As employers prepare to comply with the affordability and minimum value standards required under PPACA, it will be critically important to make publicly available as soon as is feasible the continuance tables, data elements required by the MV calculator, and the data required by the safe-harbor checklists so that employers can alter their employer plans if necessary prior to 2014. Many employers will need to comply for plan years that conduct open enrollment in the fall of 2013.

### *b. Treatment of employer contributions to HSAs and HRAs in determining minimum value*

In Notice 2012-31, the Administration states its intent to credit only an “appropriate portion” of the amounts contributed by an employer to an HSA or made available to an employee under an HRA in the calculation of minimum value. This “appropriate amount” would be adjusted so that the employer only receives the same credit for HSA or HRA contributions in the numerator of the MV calculation as it would receive for the same amount of first dollar coverage.

We strongly oppose the Administration’s proposal to count only a portion of an employer’s HSA or HRA contribution towards determining minimum value. Regulations should expressly confirm that the employer’s full contribution to an HRA or an HSA be factored into determining whether plans have met minimum value. The entire amount of an employer’s contribution to an HSA or HRA can be used to pay any health care costs not covered by the plan as part of employees’ total health package. While an employee may not choose to use all of an employer’s HSA or HRA contribution in a given year, the contributions can roll over from year to year so that these funds are available to an employee for first dollar coverage at their discretion in subsequent years.

The decision to count only a portion of employer contributions to HSAs or HRAs will likely cause a dampening effect on employer contributions to these plans, making it less

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affordable for an employee to access plan benefits. Further, the employer's contribution to an HSA or HRA is a direct contribution toward employees' out-of-pocket health care costs and offsets the cost of the benefits the employee chooses. These are core elements to achieving both affordability of coverage and flexibility in benefit design.

### *2. Options for Determining Minimum Value*

The Coalition appreciates the Administration's intent to offer employers three options for determining minimum value. We urge the Administration to develop a calculator and checklists that are simple, easily administrable, and viable options for most employers to determine and meet minimum value. We are concerned that both the underlying data set and the design features of these options may be overly limiting, defaulting many employers into the certification option.

In general, it is our understanding that the three options for determining minimum value are intended to be disjunctive but that the options are inextricably linked by the common data set. Further, we understand that the three options will determine minimum value on a pass or fail basis based on whether the plan covers at least 60% of the costs of the coverage of four core benefits in a "typical" self-insured employer plan: 1) physician and mid-level practitioner care; 2) hospital and emergency room services; 3) pharmacy benefits; and 4) laboratory and imaging services.

The Coalition appreciates that the Administration does not explicitly link minimum value to the coverage of the 10 essential health benefits required by QHPs in the individual and small group markets. Furthermore, Notice 2012-31 does not define the scope of the four core benefits. Therefore, we understand these benefits to be broad categories and that meeting minimum value will be driven by the underlying claims captured in the data set. However, employers are very concerned about which cost-sharing features will be applied and how "non-standard" features or quantitative limits will be defined and derived from the data. Furthermore, the Coalition asks that the Administration make clear in the regulations that a de minimis variation of plus or minus two percent is allowed in determining minimum value, just as the Administration has proposed for determining actuarial value of QHPs offered through state-based Exchanges. In addition, the Coalition seeks clarity in the regulation that only in-network plan design applies when determining minimum value.

#### *a. Minimum Value Calculator*

In general, we urge the Administration to develop a minimum value (MV) calculator that is simple, transparent, easy to use, and flexible enough that it will be a legitimate option for determining minimum value by most employers. We are concerned that the standard population reflected in the calculator's data set may actually have benefits valued in excess of the 60% minimum value, creating a de facto minimum value that exceeds the 60% threshold and unnecessarily restricts benefit design.

It is our understanding that employers could use the MV calculator if they do not cover all four core benefits because the employer could provide richer benefits in either the other core benefits or in benefits outside of the four core benefits to meet the 60% threshold. As such, it is critically important that the MV calculator take into account the value of other employer-provided coverage such as in-house clinics (which may require lower cost-

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sharing for on-site prescriptions, diagnostic tests, etc.), wellness programs, or other benefits tailored to a specific employee population. Employers have been employing innovative approaches aimed at improving and maintaining employee health as a means to encouraging preventive health care utilization, improving health outcomes, and lowering health care cost growth. If the value of these benefits is not appropriately captured, many employers may be forced to scale back these important benefits. In addition, it is our understanding that the MV calculator will be able to accommodate and capture the value of a core benefit that is offered as a separate “carve-out plan. This treatment of carve-outs is very important to the Coalition, as many employers provide benefits, such as a prescription drug benefit, separately.

In Notice 2012-31, the Administration does not define the four core benefits but notes that employer plans will not be able to use the MV calculator if they have “nonstandard” features, such as quantitative limits on the four core benefit categories. We urge the Administration to focus the design of the calculator on general cost-sharing inputs, including deductibles, coinsurance, co-payments, and maximum out-of-pocket limits, not a prescriptive list of quantitative limits, which the law did not expressly prohibit or restrict.

It is our understanding that quantitative and cost-sharing limits are generally allowable under the MV calculator except to the extent they are determined to be non-standard according to the continuance tables driven by the underlying self-insured data set. The concept of minimum value is intended to operate as a general measurement of plan value, not a control on benefit design. Without a clearer picture of the underlying data set, it is difficult for employers to know what features may be considered standard or non-standard, and we are concerned that the Administration may be wading deeply into limiting flexibility of benefit design. Because of concerns about the size and type of employer (and, therefore, claims) reflected in the underlying data set, the Coalition is concerned that many employer benefit designs will make them ineligible for the MV calculator – and the safe-harbor checklists – forcing them to use an actuarial certification.

Employers are anxious to know where they fall in comparison to what is currently a blackbox. For example, how far can an employer deviate from the average plan design before it runs afoul of a non-standard limit? What constitutes a material difference from a standard plan? Conversely, can an employer who provides more generous benefits than the standard plan receive “extra credit” in the calculator to reflect that “non-standard” plan generosity? Are all non-standard features relevant to meeting the four core benefits (i.e., non-standard limits on a narrow class of mid-level practitioners)? We understand that it is the Administration’s intent to make publicly available all continuance tables and data elements required in the calculator sometime this summer. We urge the Administration to do so as soon as is feasible and provide employers with an opportunity to test their current plan designs and provide substantive feedback as to benefits that may not be captured by the MV calculator and non-standard features that are sufficiently narrow to be used without adjustment to determine minimum value.

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## *b. Design-based safe harbors*

We appreciate the Administration's intent to issue guidance that would allow employer plans an option to determine whether a plan meets minimum value without using a calculator or acquiring the services of a professional actuary. Notice 2012-31 notes that the Administration will provide several safe harbor options, including coverage equivalent to an IRC §223 high deductible health plan with an employer-funded HSA. We commend the Administration for including a plan design that qualifies under IRC §223 as a safe harbor, as it is a plan design currently defined in statute. We urge the Administration to allow any plan that qualifies under IRC §223 and covers the four core benefits to qualify for the safe harbor.

We would encourage the Administration to also develop checklists that are simple and easy to administer for HMO, PPO and point-of-service plans, such as the checklist developed by Massachusetts' Commonwealth Health Insurance Connector Authority or the simple plan designs contained in Table 1 of the Kaiser Family Foundation's paper entitled "Patient Cost-Sharing Under the Affordable Care Act" (April 2012).

We re-emphasize that minimum value is intended to operate as a general measurement of plan value, not a control on benefit design. Therefore, we would urge the Administration to focus the development of any checklists on general factors that are consistent with measuring plan value, including deductibles, co-insurance, co-pays, and maximum out-of-pocket costs. Prescriptive lists that get into specific quantitative limits of each sub-category of the four core benefits cross the line into controlling benefit design of employer-sponsored plans, which is contrary to the legislative intent of PPACA. Furthermore, we would urge the Administration to develop checklists for each type of general plan design that describe the basic elements necessary to meet minimum value, and not develop checklists that de facto drive up the minimum value of the benefit design above 60% and unnecessarily restrict benefit design.

## *c. Certification by certified actuary*

We appreciate the Administration's intent to allow employers to obtain a certification from a certified actuary to determine minimum value. However, while many employers will elect to use this option as their first choice, we urge the Administration to provide employers the flexibility to choose any of the three options - and not make certification the first and last resort for the majority of employers.

According to Notice 2012-31, the certified actuary would be required to make a determination of minimum value using the plan's benefits and coverage data and the standard population, utilization, and pricing tables (i.e., continuance tables) to be published by HHS. Again, we reiterate our concern that the underlying data set may not be reflective of small and mid-size employers across all types of industries. As a result, those employers who are more likely to have different kinds of quantitative or cost-sharing limits are less likely to be included in and captured by the underlying data set. Furthermore, these employers, many of whom are smaller and have lower margins, will be forced to use the most expensive option for determining minimum value. Given that the certification by an actuary must also be performed against the same limited data set, this option for determining minimum value may be equally unworkable for some employers.

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## 3. *Transition Relief*

The EFHC Coalition welcomed the recognition in the Treasury notice of proposed rulemaking (REG - 131491-10) that transition relief may be essential to preserving the existing system of employer-sponsored coverage as the new requirements under PPACA become effective in 2014. The minimum value standard is a new requirement for employers who may not know prior to 2014 how this provision will affect their plans or how it will work in connection with the other requirements under PPACA. A grace period will be critical as employers seek to understand and comply with PPACA. The EFHC Coalition strongly encourages the Administration to consider delaying the implementation of the penalties under IRC §4980H(b) until 2016 to allow the Administration time to evaluate at least one year of data and to provide time for employers to adjust their plan designs as needed. This dry run will help the Administration evaluate the impact of the standards and prevent employers from reactively dropping coverage if it is determined that revisions to the rules are necessary once all of the provisions are effective.

Further, as discussed above, the data set that will drive the determination of minimum value will be based on claims data from self-insured plans from years prior to the full implementation of PPACA. Because of health care cost growth and the costs of compliance with PPACA, we expect employer plans to change in 2014 in ways that are not reflected in the data underlying the calculator, making the calculator not truly reflective of the variety of employer plans.

Because an employer-sponsored plan must meet the affordability and minimum value tests to be considered minimum essential coverage for purposes of an employee's eligibility for a premium tax credit (and therefore is inextricably linked to an employer's potential liability for tax penalties), we strongly encourage the Administration to consider granting transition relief that includes sufficient time for reexamination of both the minimum value and affordability provisions. PPACA contemplates that these standards may require re-examination. (The Coalition has previously commented on the need to re-examine the affordability test and the minimum value determination.)

We also suggest that smaller or mid-sized employers, or certain low-margin industries such as those represented by the EFHC Coalition, may require a phased-in transition from a lower actuarial value in order to preserve coverage in those markets.

The EFHC Coalition continues to examine the interplay between the affordability test and the minimum value determination. We are working with our benefit managers and actuaries to perform the calculations necessary to estimate how we can provide affordable coverage of the highest value to our employees in 2014.

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## II. Employer reporting requirements

The EFHC Coalition has undertaken a careful analysis of the employer reporting requirements established by PPACA in IRC §§6051(a)(14), 6055 and 6056, as well as PPACA's amendment to the Fair Labor Standards Act that requires employers to inform their employees of their coverage options at the time of hiring through a written notice, including information on the existence of an Exchange. There does not appear to be any significant overlap in the information required to be reported under the new provisions of the Code, although we continue to explore options to consolidate employers' reporting requirements into as streamlined a process as possible.

In order to minimize redundant reporting and frequent and costly interactions between employers and 50+ state Exchanges, we strongly recommend that HHS and the Exchanges build upon the significant information that will be reported to Treasury/IRS regarding employer-sponsored coverage to determine individual eligibility for tax credits to purchase coverage through the Exchanges. This would help maintain the integrity of the process by ensuring that eligibility determinations by Exchanges, eligibility verifications by the IRS, the assessment of any potential tax penalties by the IRS, and the resolution of any appeals processes through the IRS all are based on the same data and centralized in one agency.

In our October 31, 2011, comments to the Administration, the EFHC Coalition outlined a potential reporting process under IRC §6056 for Treasury and the IRS that included the following:

1. Prospective reporting on general plan information regarding minimum essential coverage provided by an employer and general employee wage levels (utilizing the affordability safe harbor);
2. Retrospective or end-of-year reporting on specific employee full-time status and coverage (utilizing the look-back safe harbor to determine the status of employees whose status is unknown at the time of hire); and
3. IRS verification of household income based on individual annual tax filings.

The reporting of both prospective and retrospective information could potentially be harmonized by the January 31, 2015, initial reporting deadline to be included in a single annual reporting process, thereby avoiding unnecessary administrative complications for employers and providing Treasury with necessary information regarding employer-sponsored coverage for their full-time employees. Similarly, we believe it is possible to combine the information that must be reported into a single form for employers who sponsor self-insured plans and must comply with IRC §6055, as well as IRC §6056.

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## ***Prospective reporting***

After further analysis of the employer reporting requirements, the EFHC Coalition maintains that the process we outlined in October provides a potentially workable and administrable approach to the employer reporting requirements under the confines of the law. We strongly urge Treasury and the IRS to establish reporting structures under IRC §6056 that allow employers to prospectively report to the IRS:

- The length of any wait period;
- Monthly employee premium for the lowest-cost plan options and general employee wage levels;
- The employer's share of the total allowed cost of benefits under the plan; and
- The length of look-back period (if applicable).

Allowing employers to report prospectively this information to the IRS would provide the federal agencies and the state-based insurance Exchanges information regarding employer coverage that they could access in real-time via the IRS database to assist in the initial determination of individual eligibility for tax credits.

One of the greatest challenges under the law is ensuring state-based Exchanges have accurate information about the affordability of employer coverage to make the initial determination of individual eligibility for tax credits for Exchange coverage. The law defines affordability as 9.5% of household income, which is information that employers do not know. While the Exchanges will still make eligibility determinations based on an individual's household income, the affordability safe harbor provides a vehicle for employers to prospectively report general employee premium contribution and wage information to demonstrate that the employee premium contribution for self-only coverage does not exceed 9.5% of current wages. This is generally a stricter test than household income, but basing the calculation on current wages provides a more predictable and workable method for employers to ensure that they are offering affordable coverage to employees.

The table below illustrates how general wage bands alongside employee contribution levels could be reported prospectively via IRC §6056 to determine whether the employee premium contribution for self-only coverage exceeds 9.5% of the projected annual wages for a full-time employee. In addition, the table illustrates how prospective reporting can be focused specifically on employees whose current wages indicate that they might be eligible for premium tax credits. While this would not replace the need for Exchanges to make determinations based on household income or for the IRS to verify eligibility for premium tax credits, this information prospectively filed by employers by January 31 would provide a benchmark of basic data about employer plans.

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<b>Potential affordability safe harbor reporting via IRC §6056 by an employer with four contribution levels</b>	
General employee hourly wage levels	Employee monthly premium contribution for self-only coverage <sup>1</sup>
\$9.88 <sup>2</sup> - \$14.99	\$122
\$15.00-\$19.99	\$185
\$20.00-\$24.99	\$247
\$25.00-\$28.64 <sup>3</sup>	\$308
<ol style="list-style-type: none"> <li>1. Employee premium share is 9.5% of the lower wage level (annualized) for each employee contribution level. Based on the PPACA threshold for classification as a full-time employee (average 30 hours per week) multiplied by 52 weeks.</li> <li>2. The 2012 HHS Federal Poverty Guidelines for one person set 100% of the federal poverty level (FPL) at \$11,170. \$9.88 is the hourly wage in 2012 that corresponds with the effective upper limit for Medicaid eligibility (138% of FPL, or \$15,415 in 2012).</li> <li>3. Based on 2012 HHS Federal Poverty Guidelines for one person, \$28.64 is the hourly wage in 2012 that corresponds with the upper limit for eligibility for tax credits (400% of FPL, or \$44,680 in 2012).</li> </ol>	

### ***Retrospective reporting***

IRC §6056 requires that employers report by January 31 to the IRS: 1) the number of full-time employees for each month during the calendar year; and 2) the name, address and tax identification number of each full-time employee during the calendar year and the months (if any) during which the employee (and dependents) were covered under a health plan offered by the employer. The tally of full-time employees in this report would include employees determined by the employer to be full time based on the proposed look-back/stability period safe harbor method. Due to the nature of our workforce, it is imperative that we are able to utilize the look-back methodology to determine and report full-time employee status. End-of-year reporting by employers on their full-time employees combined with IRS verification of household income based on individual tax filings will allow for more accurate assessment of employer penalties. The EFHC Coalition believes that the employer affordability safe harbor and the look-back/stability period safe harbor are critical to the preservation of the current system of employer-provided coverage.

We urge the Administration to consider waiving the retrospective reporting requirements for employers who voluntarily prospectively report affordability and minimum value information to the IRS and simply require employers to provide additional information for individuals who the IRS determined to be eligible for tax credits. This approach could be tested in 2014 and 2015 to help avoid the IRS being overwhelmed by an influx of unnecessary data on millions of employees (and their dependents) covered by employer-sponsored plans. Alternatively, we urge the Administration to consider delaying the retrospective reporting requirements to allow employers sufficient time to develop new reporting systems or make changes to existing systems.

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In addition, we continue to explore alternative reporting processes that might be less onerous. Per conversations with the IRS, we are considering options such as an exception-based reporting process that would substantially ease reporting requirements for employers who can demonstrate over time that only a minimal percentage of their employees go to Exchanges and are determined eligible for tax credits.

The EFHC Coalition also asks the Administration to consider potential modifications of the January 31 deadline for employers with varying plan year start dates to avoid a situation in which employers and other health insurance issuers would have to include data from two different plan years in their reports to IRS and statements to individuals. Reporting processes may need to be set up that allow for rolling reporting deadlines for employer plan level information to utilize the affordability safe harbor, rather than one calendar year report in January for these employers.

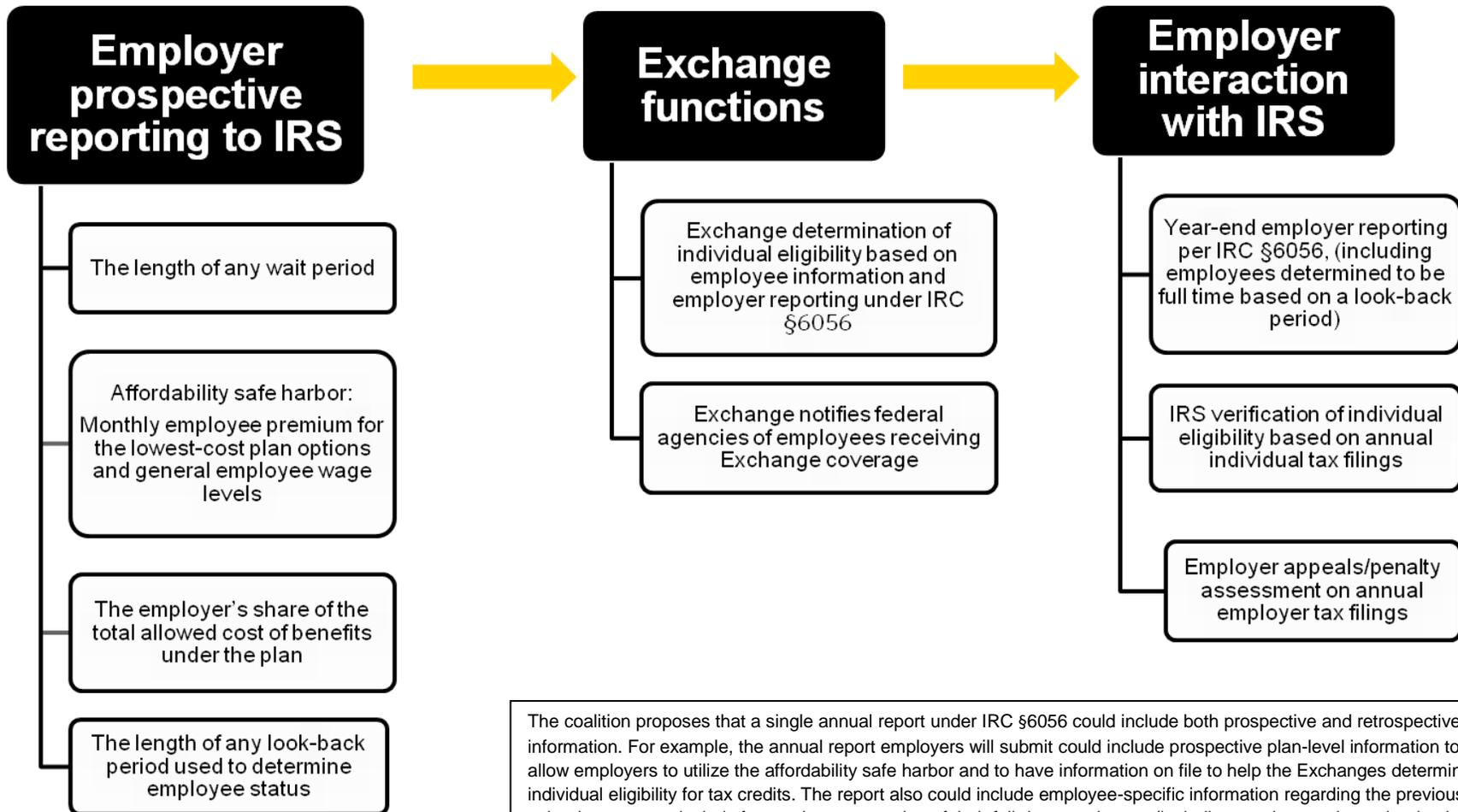
The Coalition also urges the Administration to recognize that IRC §6056's requirement that employers report to the IRS "the monthly premium for the lowest-cost option under the employer's plan" could be problematic for employers who offer more than one plan at the same cost to employees. It is unclear whether employers would be required to report on each plan at that cost level. In such an instance, the employer should be deemed to have met its reporting requirements if it provides information for any plan at that cost level.

Employers are exploring how best to develop communication materials about their plans by building upon IRC §6056's requirement to provide statements to individuals including information about the monthly premium for the lowest-cost option under the employer's plan and the employer's share of the total allowed cost of benefits under the plan. This statement will provide an important opportunity for employers to communicate with employees about the health coverage employers offer, whether that coverage is affordable to employees, and whether the coverage meets the law's minimum value determination.

The diagram below represents a basic schema of the major employer requirements and depicts the EFHC Coalition's recommendations for a prospective flow of information and timing of the process under PPACA's employer requirements.

# Employers for Flexibility in Health Care

## EFHC Proposal for Employer Reporting



The coalition proposes that a single annual report under IRC §6056 could include both prospective and retrospective information. For example, the annual report employers will submit could include prospective plan-level information to allow employers to utilize the affordability safe harbor and to have information on file to help the Exchanges determine individual eligibility for tax credits. The report also could include employee-specific information regarding the previous calendar year, particularly for employers reporting of their full-time employees (including employees determined to be full time based on a look-back period) to facilitate IRS' verification of individual eligibility for tax credits and assessment of employer tax penalties.

# Employers for Flexibility in Health Care

## ***IRS Verification, Appeals, Penalty Assessment***

We ask the agencies to consolidate the information reporting, the appeals processes, and the assessment of employer tax penalties within a single federal entity, preferably the Department of Treasury and the IRS. We urge the Department of Treasury to utilize their regulatory authority under IRC §4980H and the Internal Revenue Code generally to interpret the statute in ways that allow for practical and workable administration of employer benefits and provide predictability of potential penalties for employers, including how and when an employer will be notified of its total liability for federal tax penalties for a given year.

We feel strongly that the determination of individual eligibility for premium insurance tax credits or cost-sharing subsidies by state insurance Exchanges should be a separate and distinct process from the subsequent verification of individual household income data and determination of employer penalty assessments by Treasury and the IRS. This is necessary because the Exchanges will make eligibility determinations in real-time based in part on employee self-reporting of their household income and employment status. Reporting of household income may often be incomplete. Even if an attempt is made to verify household income with the IRS during the coverage year, it likely will be based on prior year tax returns and might not accurately capture current household income. Treasury and IRS will not be able to verify accurately employees' household income until their annual individual taxes are filed, which may occur after the coverage year.

We believe it is critical that the IRS verify individual eligibility for a premium tax credit based on household income once the individual's tax return has been filed for the previous year. Verification by the IRS is necessary because this is the standard by which employers will be held liable for penalties under the law and is information that cannot be known to an employer and often may not be truly verifiable in real time by Exchanges.

Finally, given the need to have complete and accurate information to appropriately assess any employer penalty, we suggest that penalties be assessed once a year after all employer and employee verifications are complete. Additionally, we encourage Treasury to coordinate any penalty assessment that captures total liability for an employer on a given year with an employer's annual corporate tax filing and ask that it be made clear that IRS traditional appeals processes are available to employers to engage with the IRS to ensure the accuracy and appropriateness of any assessments.

Failure to develop a workable reporting and verification system will increase the administrative burden and costs for employer-sponsored plans without creating any benefit for employees or the quality of their health care.

To the extent the Administration reaches a different conclusion, we encourage the Departments to include our recommendations in the report due to Congress no later than

# Employers for Flexibility in Health Care

January 1, 2013, (as required by PPACA §1411) recommending legislative changes related to “the rights of employers to adequate due process and access to information necessary to accurately determine any payment assessed on employers.”

## **Conclusion**

We thank you for the opportunity to provide comments and look forward to continuing to work with the Administration on the development of workable regulations that maintain employer-sponsored coverage as a competitive option for all employees whether full-time, part-time, temporary, or seasonal workers.

For questions related to this letter, please contact Christine Pollack, Vice President, Government Affairs, Retail Industry Leaders Association, at 703-600-2021 or Anne Phelps, Principal, Washington Council Ernst & Young, Ernst & Young LLP, at 202-467-8416.

Respectfully submitted by the Employers for Flexibility in Health Care Coalition and the following signatories,

7-Eleven	National Club Association
Adecco Group North America	National Council of Chain Restaurants
Aetna	National Federation of Independent Business
Allegis Group, Inc.	National Grocers Association
American Hotel & Lodging Association	National Public Employer Labor Relations Association
American Staffing Association	National Retail Federation
Associated Builders and Contractors, Inc.	National Restaurant Association
Associated General Contractors of America	OSi Restaurant Partners, LLC
Auntie Anne’s, Inc.	Pep Boys
Benjamin’s Ltd. of Galena	Petco Animal Supplies, Inc.
Best Buy Co., Inc.	Randstad US
College and University Professional Association for Human Resources	Regis Corporation
DSW, Inc.	Retail Industry Leaders Association
Food Marketing Institute	Ruby Tuesday, Inc.
International Association of Amusement Parks & Attractions	Society of American Florists
International Franchise Association	Texas Roadhouse, Inc.
Jo-Ann Fabric & Craft Stores	TrueBlue
Kelly Services, Inc.	Yum! Brands, Inc.
LaRosa’s, Inc.	Alabama Grocers Association
ManpowerGroup	Alabama Restaurant Association
National Association of Convenience Stores	Arkansas Grocers and Retail Merchants Association
National Association of Health Underwriters	Colorado Restaurant Association
National Association of Wholesaler-Distributors	Connecticut Food Association
	Florida Restaurant & Lodging Association
	Georgia Restaurant Association
	Illinois Retail Merchants Association

## Employers for Flexibility in Health Care

Indiana Restaurant Association  
Kentucky Association of Convenience  
Stores, Inc.  
Kentucky Grocers Association, Inc.  
Louisiana Restaurant Association  
Louisiana Retailers Association  
Maine Grocers Association  
Maryland Retailers Association  
Restaurant Association of Maryland  
Massachusetts Food Association  
Retailers Association of Massachusetts  
Minnesota Grocers Association  
Minnesota Restaurant Association  
Mississippi Hospitality and Restaurant  
Association  
The Retail Association of Mississippi  
Missouri Grocers Association  
Missouri Restaurant Association  
Montana Food Distributors Association  
Nebraska Grocery Industry Association  
Nebraska Retail Federation  
Nevada Restaurant Association  
Retail Association of Nevada  
New Hampshire Grocers Association  
Food Industry Alliance of New York State  
New York State Restaurant Association

North Carolina Retail Merchants  
Association  
Northwest Grocery Association  
Ohio Council of Retail Merchants  
Ohio Restaurant Association  
Oklahoma Grocers Association  
Oklahoma Restaurant Association  
Pennsylvania Food Merchants  
Association  
Pennsylvania Restaurant Association  
South Carolina Retail Association  
Tennessee Hospitality Association  
Texas Restaurant Association  
Texas Retailers Association  
Utah Restaurant Association  
Utah Retail Merchants Association  
Utah Food Industry Association  
Vermont Grocers' Association  
Virginia Retail Federation  
Washington Food Industry Association  
Washington Retail Association  
West Virginia Retailers Association  
Wisconsin Restaurant Association  
Wyoming Lodging and Restaurant  
Association  
Wyoming Retail Association

### **Attachment:**

Employers for Flexibility in Health Care Coalition October 31, 2011 Comment Letter