Employers for Flexibility in Health Care

October 31, 2011

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

Attn: CC:PA:LPD:PR (REG -131491-10)
Room 5203
Internal Revenue Service
P.O. Box 7604
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Washington, DC 20044

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-9974-P
P.O. Box 8010
Baltimore, MD 21244-8010

Request for Comments re:

I) Health Insurance Premium Tax Credit, Internal Revenue Service, Department of the Treasury (REG -131491-10)
II) Eligibility Determinations and Exchange Standards for Employers, Department of Health and Human Services (CMS-9974-P)
III) Request for Comments on Health Coverage Affordability Safe Harbor for Employers, Internal Revenue Service, Department of the Treasury (Notice 2011-73)

We are writing in response to the above proposed rules and requests for comments on behalf of the Employers for Flexibility in Health Care ("EFHC"), a coalition 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.

The Coalition represents employers who create millions of jobs each year, employ a significant workforce in the US, offer flexible working environments for employees, and are a leading contributor to the nation's economic job recovery. Some examples include:

- The retail industry employs one of every five workers today, representing one of the largest industry sectors in the United States and a vital mainstay of our economy;
- The restaurant industry is the second-largest private-sector employer in the nation with about 12.8 million employees;
- Temporary staffing firms provide a wide range of temporary and contract staffing services in virtually every job category and employ approximately 2.6 million temporary and contract workers every day and almost 10 million workers annually;
- There are more than 36,000 supermarkets in the United States employing 3.4 million people;
- There are nearly 825,000 franchised businesses across 300 different business lines creating 18 million jobs;
- The construction industry's employment exceeds 5.5 million jobs;
- The lodging industry accounts for over 1.7 million jobs and represents over 51,000 properties across the United States;
- The convenience and fuel retailing industry employs more than 1.6 million people in more than 146,000 stores nationwide; and
- The floriculture industry (growers, suppliers, retail florists) has nearly 750,000 employees.

The employer requirements under PPACA are of particular importance to us, not only because many in our industries are struggling to remain in business and provide affordable health coverage for our employees, but also because of our industries' unique reliance on large numbers of part-time, temporary, and seasonal workers with fluctuating and unpredictable work hours, as well as unpredictable lengths of service. Maintaining the ability to offer affordable coverage options to our unique workforce under the new requirements of the law is of special concern to us.

The EFHC Coalition welcomes the opportunity to share our comments with the Administration on provisions of PPACA that affect employers, and we appreciate that the Administration has been receptive to the comments from the employer community in developing regulatory guidance. Many in our coalition and the employer community in general remain concerned that the employer requirements under the law are fundamentally unworkable and ultimately will require re-examination through the legislative process, especially the 30 hours per week definition of full-time employee status, the affordability and minimum value standards for employer coverage, the imposition of tax penalties based on a household income test, the complex administrative reporting requirements, and authority given to state insurance Exchanges over employer-sponsored plans.

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 coverage for their employees. It is imperative that the Administration examine these provisions as a whole when developing regulatory guidance because the employer requirements under the law are inextricably linked. In particular, it is necessary to examine together the calculation of full-time employee at 30 hours average per week, the affordability and the minimum value tests, and the additional benefit requirements under the law (e.g., coverage of preventive care at no cost-sharing and the lifting of annual and lifetime coverage limits) in order for us to begin to estimate whether we will be able to maintain affordable coverage options within the confines of the law in 2014.[1]

In addition, providing a clear and administratively workable reporting process to determine individual eligibility for premium tax credits and ultimately to assess employer tax penalties is critical for our members. How the reporting process is structured between employers, state insurance Exchanges, and the federal agencies -- and the timing and frequency of these interactions -- will have a major impact on our administrative processes and costs.

On behalf of the Coalition, we will use this letter to provide a comprehensive set of comments to the Departments of Treasury ("Treasury") and Health and Human Services ("HHS") on the following issues:

I) The affordability safe harbor for employers and minimum value standard;
II) Employer reporting, interaction with Exchanges and federal agencies, and Exchange eligibility determinations and the Internal Revenue Service ("IRS") verification process; and
III) The affordability safe harbor for employers and coordination with the definition of full-time employee under the "look-back" methodology.

[1] It also will be critical to employers' ability to maintain affordable coverage that the nondiscrimination rules issued under §2716 of the Public Health Service Act afford flexibility to design health insurance plans that meet the needs of different segments of their workforces.

I. Affordability Safe Harbor for Employers and Minimum Value Standard

Internal Revenue Code ("IRC") §36B (as created by PPACA §1401) states that in order for an employer-sponsored plan to be considered minimum essential coverage for purposes of an employee's eligibility for a premium assistance tax credit or a cost-sharing subsidy (and therefore potentially an employer's liability for tax penalties), two tests must be met:

1. "Affordability" test: An employee's required contribution with respect to the plan cannot exceed 9.5% of the applicable taxpayer's household income; and
2. "Minimum value" standard: An employer-sponsored plan's share of the total allowed cost of benefits provided under the plan is not less than 60% of such costs.

In the Coalition's June 17 comment letter responding to Treasury Notice 2011-36, we advocated for the consideration of a safe harbor for employers that provides a predictable mechanism to calculate their liability under the law and to determine in advance - before individual tax credits or subsidies are granted and before a tax penalty is imposed on an employer - that their coverage for a full-time employee is affordable and of minimum value. We proposed this safe harbor to be based on the current wages paid by the employer to avoid a myriad of problems in predicting and verifying employee household income. We appreciate Treasury's consideration of our recommendation and believe that the affordability safe harbor for employers outlined in the Treasury notice of proposed rulemaking represents a potential path forward within the constraints of IRC §36B.

Affordability Safe Harbor for Employers

Treasury's August 17 notice of proposed rulemaking (REG -131491-10) anticipates an affordability safe harbor that states *"an employer that meets certain requirements, including offering its full-time employees (and their dependents) the opportunity to enroll in eligible employer-sponsored coverage, will not be subject to an assessable payment under section 4980H(b) with respect to an employee who receives a premium tax credit or cost-sharing reduction for a taxable year if the employee portion of the self-only premium for the employer's lowest-cost plan that provides minimum value does not exceed 9.5 percent of the employee's current W-2 wages from the employer."* The notice states that giving employers the ability to base their affordability calculations on their employees' wages (information employers know) instead of employees' household income (which employers generally do not know and do not want access to) is intended to provide a more workable and predictable method of facilitating affordable employer-sponsored coverage for the benefit of both employers and employees. The Treasury notice clarifies that notwithstanding the affordability safe harbor, employees' eligibility for a premium tax credit would continue to be based on affordability of the employer coverage relative to employees' household income as the general rule under the law.

The Coalition's June 17 letter provided a number of recommendations for an affordability safe harbor, and as such, we strongly endorse the following aspects of Treasury's August 17 notice:

- Clarifying that the statutory language specifies that the affordability of employer coverage is based on the employee premium paid for "self-only" coverage;
- Basing the calculation of the safe harbor on an employee's current wages and thus allowing for the comparison of current premiums to current wages, rather than comparing current premiums to employee household income from prior years;
- Permitting employers to apply the affordability safe harbor prospectively; and
- Retaining the general affordability rule that individual eligibility for premium tax credits and employer liability for penalty assessments will be based on household income, which in most circumstances will likely be a more generous standard, for those employers who cannot meet the affordability safe harbor due to the cost of their plans.

Finally, we recognize that the safe harbor would be based prospectively on estimated or expected employee wages. Consequently, special consideration will be needed for employees with variable pay, such as tipped and commission-based employees.

Estimates for the Affordability Safe Harbor

The members of our Coalition have been undertaking analyses of the practical implications of the affordability safe harbor proposal to estimate whether they can meet the test based on employees' current wages. Employers' ability to meet the affordability test and continue to offer affordable coverage will depend heavily on the standard used to determine minimum value under PPACA, as well as the effect on plan costs of the additional benefit requirements under the law, including the coverage of preventive care at no cost sharing and the lifting of annual and lifetime coverage limits. Employers already are feeling the effects of rising reinsurance costs stemming from the lifting of annual and lifetime limits.

As a starting point, the Coalition estimates that in order to qualify for the proposed affordability test safe harbor based on 9.5% of the current wages of full-time employees, employers would have to offer a plan (of a minimum value) with a monthly employee premium share for self-only coverage of no more than $119 for full-time employees whose incomes are at 138% of the federal poverty level (the effective Medicaid eligibility threshold) and of no more than $345 for full-time employees whose incomes are at 400% of the federal poverty level (the upper-limit for eligibility for premium tax credits). It is important to emphasize that these estimates are based on:

1. The 2011 HHS Federal Poverty Guidelines for one person; and
2. An average 30-hour work week, which is the threshold for classification as a full-time employee under PPACA.

The table below summarizes the Coalition's basic estimates, including the corresponding hourly wages of employees eligible for Medicaid and premium tax credits under PPACA. In addition, the table illustrates that employers could face potential tax penalties for full-time employees who work an average of 30 hours per week with hourly wages between $9.63 and $27.92 and who receive premium tax credits.

Estimates for Individual Eligibility for Medicaid or Tax Credits and Affordability Safe Harbor[1]					
Scenario	Percent of federal poverty level	Annual income	Hourly wage[4]	Affordability test safe harbor (9.5% of current wages)	Estimated employee premium share for self-only coverage for affordability test safe harbor[5]
Minimum wage worker[2] eligible for Medicaid	~104%	$11,310	$7.25	Medicaid eligible	n/a
Statutory upper limit for Medicaid eligibility	133%	$14,484	$9.28	$1,376 per year	$115 per month
Effective upper limit for Medicaid eligibility[3]	138%	$15,028	$9.63	$1,428 per year	$119 per month
Upper limit for eligibility for tax credits	400%	$43,560	$27.92	$4,138 per year	$345 per month

1. Based on 2011 HHS Federal Poverty Guidelines for one person ($10,890).
2. Federal minimum wage ($7.25 per hour)
3. PPACA §2002 (as added by HCERA §1004(e)(2)) requires states to apply an "income disregard" of five percent of the federal poverty level in meeting the income test, resulting in an effective income threshold of 138% of FPL for Medicaid eligibility.
4. Based on the PPACA threshold for classification as a full-time employee (average 30 hours per week) multiplied by 52 weeks.
5. 9.5% of current wages divided by 12 months

It is important to note that employers' estimates are based on 2011 wages currently being paid, current employer contributions, estimates of what will be considered minimum value plans under the law, and the impact of the new benefit mandates under PPACA. It is difficult to create an accurate assessment for 2014 regarding what constitutes an affordable benefit package; this analysis relies on the interplay of many of these factors for which we are awaiting regulatory guidance under the law, as well as analysis of overall health care costs and economic factors affecting wages.

It also remains unclear how Treasury ultimately will treat certain employer-provided benefits, including employee wellness programs and employer contributions to Health Reimbursement Arrangements ("HRAs") or Health Savings Accounts ("HSAs"). Coalition members strongly believe that employers' spending on employee wellness programs and employer contributions to HRAs and HSAs should be counted toward the premium contribution for the affordability test.

Many Coalition members are concerned based on their 2011 estimates that it will be challenging for them to offer coverage with a monthly premium share for employees that fits within the proposed affordability safe harbor based on current wages. In order to offer a plan of minimum value that meets the affordability test, employers' contribution to the plan also must be affordable for the employer. It is critical that the Administration recognize this uncertainty and the need to strike a balance as you issue regulatory guidance around the minimum value standard, which is inextricably linked to the affordability safe harbor.

Not all employers will be able to utilize the affordability safe harbor based on current wages due to the cost of their plans for employers and employees. These employers will fall under the general rule that requires that an employee's premium contribution to the plan cannot exceed 9.5% of the employee's household income. Tax credit eligibility for employees and penalty assessments for employers will also be based on the employee's household income. The Coalition remains concerned about the potential imposition of tax penalties based on a household income test and maintain that it is an unworkable approach for employers who do not have and do not want access to this confidential information. Nonetheless, we recognize that the application of the general rule may be necessary or even preferable for certain employers and we provide some recommendations in section III of our letter regarding the verification of individual eligibility for tax credits based on household income and subsequent imposition of employer penalty assessments.

Minimum Value

Under PPACA, employers are required to provide coverage to their full-time employees that is both "affordable" and meets "minimum value" or face penalties for full-time employees that qualify for tax credits through the Exchange. Code section 36(B)(c)(2)(C)(ii) provides that a plan shall not meet the minimum value if "*the plan's share of the total allowed costs of benefits provided under the plan is less than 60% of such costs*." While neither Treasury nor HHS requested specific comment on the minimum value test, the EFHC is providing initial comment on the definition of "minimum value" in recognition of the tremendous impact that this provision will have on the affordability and administration of employee benefit plans and because this provision is interlocked with the other employer provisions in such a way that any analysis of the affordability provisions is incomplete without an understanding of minimum value.

The minimum value requirement is generally understood to be a 60% actuarial value test. An actuarial value is expressed as a percentage of medical expenses estimated to be paid by a plan for a standard population for a set of allowed charges (typically those services covered by the plan). Consequently, plans with different benefit designs and cost-sharing structures can be actuarially equivalent. *See Setting and Valuing Health Insurance Benefits*, Congressional Research Service (April 6, 2009). Actuarial value is a summary measure of the cost-sharing provisions of a plan for the services it covers, but it does not mean that identical benefits or cost-sharing structures apply

to all plans or all individuals. This distinction is important. Minimum value is a measuring tool; it is not intended to be a plan control.

The minimum value requirement included in PPACA is not a benefit mandate locking employers that provide voluntary coverage into a prescribed package of benefits or rigid cost-sharing structure. Any attempt to create a backdoor mandate through the minimum value standard is a misapplication of the law. In fact, Treasury emphasized in the NPRM that *"the regulations under section 1302(d)(2) are expected … to reflect the fact that employer-sponsored group health plans and health insurance coverage in the large group market <u>are not</u> required to provide each of the essential health benefits or each of the 10 categories of coverage described in section 1302(b)(1) of the Affordable Care Act"* (*emphasis added*).

The majority of employers offer the most comprehensive coverage possible at a price that is affordable for and tailored to their specific workforce. A report from the Department of Labor surveying 3,200 employer plans found a median deductible of $500 and an 80/20 coinsurance paired with a median out-of-pocket maximum of $1,900 in 2009. The report further revealed extensive coverage of hospital, physician, and other medical services. *See Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services* (April, 15, 2011). In addition, several new insurance reforms under PPACA apply to large employers and require coverage of preventive care with no cost-sharing and the lifting of most life-time and annual limits. As a result, many lower value plans will be discontinued in 2014.

Employers in the EFHC Coalition are concerned however that a narrow or inflexible definition of minimum value could hamper their ability to continue to offer affordable benefits to their employees. Employers need a minimum value definition that recognizes the need for flexible benefit design and cost-sharing structures and cannot be based on an overall dollar value of a plan. A workable definition must recognize the great diversity among employer plans. Employer plan costs can vary widely based on the health status of their workforce, size, sector, turn-over rate, local provider networks, and geographic cost factors. A minimum value calculation must allow for standardization that takes into account all of these factors and is administratively simple for all employers.

Regulations should expressly confirm that employer contributions or incentives regardless of how they are paid (including contributions to an HRA or an HSA) should be included in the actuarial value of the corresponding health plan.[2] Regulations should also take into account the value of other employer-provided coverage such as in-house clinics and services and benefits provided by wellness programs. The EFHC Coalition further requests reaffirmation in the minimum value regulations that not all plan options offered by an employer are required to meet the minimum value test. Under PPACA, employers are required to offer at least one plan that meets the affordability and minimum value tests to their full-time employees. 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.

[2] PPACA expressly includes the employer contributions to an HSA, however, many employers also utilize HRAs and wellness programs to supplement employee health plans. *See* PPACA §1302(d)(2)(B) including employer HSA contributions in the actuarial value.

Methodologies for Calculating Minimum Value

The EFHC Coalition strongly urges the Administration to provide a variety of methods that employers may elect for measuring whether the plan's share meets "*60% of the total allowed cost of benefits that are provided by such plan or coverage*." We re-emphasize that minimum value is intended to operate as a general measurement of plan value, not a control on benefit design.

It was not the intent of PPACA to dictate a defined benefit package to large employers that offer coverage. However, we are aware that one methodology under consideration for the minimum value standard would be to place an actuarial valuation on the essential health benefits package as described in PPACA §1302(b)(1) without inclusion of the cost-sharing limitations in PPACA §1302(c). See 1302(d)(2)(A),(C). We want to emphasize that this type of valuation standard raises some significant concerns for employers, and we urge you to contemplate prior to issuing regulatory guidance on the minimum value standard.

Many employers view any attempt to tie voluntary employer benefits to the list of essential health benefits as effectively a mandate to cover the essential health benefits. Tying the minimum value test to the essential health benefits could force employers to change their cost-sharing structures and cover the essential health benefits in order to meet the test. This would cause an undesirable increase in premiums for employers and employees, which runs contrary to other provisions in PPACA, such as the tax on high-cost plans, that encourage employers to control health insurance costs. Furthermore, benefit mandates hit hardest those employers who struggle the most to maintain coverage with continued rising health costs. Some of the employers in our Coalition employ large numbers of low-income workers and will struggle to meet the 9.5% affordability test; subsequently, they will be faced with a difficult calculation of trying to meet both the affordability requirement and the minimum value test. If employers cannot meet both tests, they face tax penalties, and the benefits of offering coverage decrease significantly.

Comparing employer plans to the essential health benefits also raises some practical implications. Actuarial value requires a comparison against a standardized population. It is not clear that the Exchange population will be reflective of the national, large employer population with respect to age, health status or utilization. Further, not all of the benefits included in the essential health benefits are standard in employer plans. For example, it does not make sense to include pediatric dental in the actuarial value of employer coverage given that most employer plans provide dental coverage outside of the health plan. Benefits such as habilitative care and substance use disorder treatment make up a small percentage of the value of a plan, typically less than 5%, but requiring coverage at a 60% cost-sharing level could cause a significant premium increase for some plans.

Consequently, a more reasonable actuarial value calculation would permit plans to exclude benefits that are not currently covered under the plan from the calculation. Including only those benefits covered by the plan would comport with the language of PPACA which refers to minimum value as "*the percentage of the total allowed cost of benefits provided under a group health plan or health insurance coverage <u>that are provided by such plan or coverage</u>*." See PPACA §1302(d)(2)(C), *emphasis added*.

A hallmark of the EFHC Coalition is our consistent plea for flexibility and workable solutions to accommodate the diversity of employers and plans that must comply with these requirements. We appreciate that in its August 17 NPRM under minimum value Treasury notes "*that the regulations will seek to further the objective of preserving the existing system of employer-sponsored coverage, but without permitting the statutory employer responsibility standards to be avoided*."

We strongly recommend that the Administration consider providing multiple methodologies for employers seeking to comply with the minimum value test. Providing multiple methodologies,

especially methodologies that are administratively simple, will be particularly important for small and mid-size employers who will be required to complete the minimum value calculations. Under PPACA, employers with as few as 51 full-time equivalents are required to manage these complex evaluations. See IRC §4980H(c)(2)(A)-(B). Small and mid-size employers frequently do not have the resources within their companies to perform complex actuarial calculations.

PPACA contemplates the use of a variety of actuarial methods and expressly requires "*the Secretary to develop guidelines to provide for a de minimus variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates*." See PPACA §1302(d)(3). The EFHC Coalition encourages the Administration to focus on providing multiple methodologies that employers may elect to utilize to meet the standard such as but not limited to:

- Attestation that the employer plan's predominant cost-sharing arrangement (e.g., co-payments or co-insurance) provides for the plan to pay approximately 60% of the total allowed benefit costs;

- Establishing safe harbor examples to which employers could compare their plans' predominant cost-sharing features, such as deductibles, coinsurance and out-of-pocket maximums, to plan designs expected to satisfy the standard such as a High-Deductible Health Plan as defined by IRC §223 (which has a defined out-of pocket maximum)[3];

- Providing an actuarial valuation from a qualified actuary; and

- Providing other methods that promote ease of administration and are based on a standard population that is reflective of the population covered by employer-sponsored plans in the large group market (i.e., non-elderly, privately insured, employed, etc.).

In addition, the Administration could also utilize its authority to designate specific types of coverage as minimum essential coverage to set certain safe harbor plan designs for employers. See IRC §5000a(f)(1)(E). One such option could be a high-deductible health plan as described in IRC §223.

Transition Relief

The EFHC Coalition also welcomes the recognition in the Treasury notice of proposed rulemaking 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 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.

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

[3] The Congressional Research Service estimated a typical high deductible health plan at actuarial value of 76% excluding the employer's HSA contributions and 93% including an employer HSA contribution of $760. See *Setting and Valuing Health Insurance Benefits*, Congressional Research Service (April 6, 2009).

assistance tax credit or a cost-sharing subsidy (and therefore 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 Treasury NPRM states that the law provides for the affordability test—set at 9.5%—to be adjusted after 2014. PPACA also provides for the Comptroller General, within 5 years of enactment, to conduct a study, including legislative recommendations, on the affordability of coverage, including whether the percentage of household income specified in IRC §36B(c)(2)(C) "*is the appropriate level for determining whether employer-provided coverage is affordable for an employee and whether such level may be lowered without significantly increasing the costs to the Federal Government and reducing employer-provided coverage*." See PPACA §1401(c)(1).

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 standard. 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. We appreciate the Administration's receptivity to our comments. As you contemplate rulemaking on the affordability and minimum value tests, we urge the use of flexible methodologies that recognize diversity in employer-sponsored coverage and create a balanced approach to these provisions that will allow us to maintain the ability to provide affordable, quality coverage to our employees.

II. Employer Reporting, Interaction with Exchanges and Federal Agencies, and Exchange Eligibility Determinations and IRS Verification Process

Employer Reporting Requirements

The EFHC Coalition has been undertaking a comprehensive analysis of the major employer requirements under the law to try to understand the flow and timing of required information and the interaction between employers, insurance Exchanges, and the federal agencies in conjunction with the substantive coverage requirements and imposition of penalties under the law. As you draft upcoming PPACA regulations affecting employers, we urge you to use the regulatory process to create rules that allow for practical and workable administration of employee benefits, predictability of penalties, and uniform and consistent annual reporting requirements. 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.

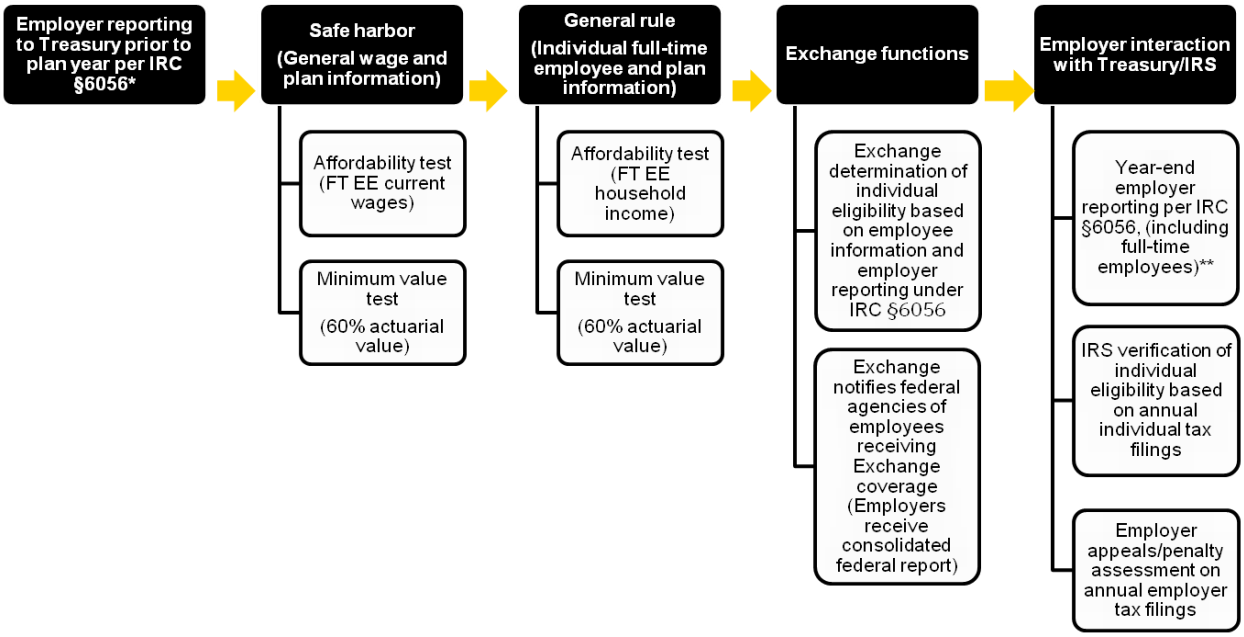
In its August 17 proposed rule (CMS-9974-P), HHS focuses on the information that state insurance Exchanges will need to determine individual eligibility for tax credits, including information about employer-sponsored health plans. As you continue to develop regulations in this area we strongly urge you to consider the following criteria:

- The reporting processes should be simple, minimize redundant reporting, and focus on reducing the administrative burden and associated costs for employers that offer health coverage;
- The reporting process should contemplate the numerous PPACA provisions that require new employer reporting and consolidate reporting obligations to the greatest extent possible on an annual basis, utilizing existing reporting mechanisms where possible;
- The reporting process for employers should be centralized within the Department of Treasury as the Department, along with the IRS, is ultimately responsible for administering the appeals process for employers and the imposition of penalty assessments; and
- The reporting process should recognize that the determination of individual eligibility for premium tax credits by state insurance Exchanges and the assessment of employer tax penalties by the IRS are two distinct and separate processes.

We understand that Treasury and the IRS intend to request comments on the employer information reporting required under IRC §6056. The Coalition urges the Administration to build upon the employer reporting requirements to Treasury under IRC §6056 to create a clear and administratively workable reporting process to verify individual eligibility for premium tax credits and ultimately to assess employer tax penalties. We believe that IRC §6056 could be used to facilitate the use of a single, annual report from employers to Treasury that could include prospective general plan and wage information for the affordability test safe harbor, as well as retrospective individual full-time employee information for the look-back safe harbor.

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

EFHC Proposed Diagram of Employer Requirements



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 by January 31, 2015, could include prospective plan-level information (per statutory list below) to allow employers to utilize the safe harbor. The report also could include employee-specific information regarding the previous calendar year of 2014 (per statutory list below), particularly for employers reporting of their full-time employees to facilitate IRS' verification of individual eligibility for tax credits and assessment of employer tax penalties.

***Employer prospective reporting requirements per IRC §6056 prior to plan year**

- Name, date, and employer identification number of the employer
- Certification as to whether the employer offers full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan. If so, the employer must also report:
  - Length of any wait period
  - Months during the calendar year during which coverage was available
  - Monthly premium for the lowest-cost option in each of the plan's enrollment categories
  - Applicable large employer's share of the total allowed cost of benefits under the plan

****Employer retrospective reporting requirements per IRC §6056 at end of year**

- The number of full-time employees for each month during the calendar year
- The name, address, and TIN of each full-time employee during the calendar year and the months (if any) during which such employee (and dependents) were covered under any such health benefits plans
- Such other information as the Secretary may require

A major challenge to the annual reporting process under IRC §6056 is the statutory deadline of January 31 for those employers who do not utilize a January plan year start date. Employers utilize a variety of enrollment periods and plan year start dates that work best for their workforce. For example, many retailers hold their open enrollment period in February or May with their plan year beginning in April or July in order to have all employees focused on retail sales during their busiest months of September through December. While a January reporting deadline may be workable for end-of-year reporting on full-time employee status and their coverage under the employer plan for the previous year, it poses challenges for prospective reporting on general plan information for the affordability safe harbor. 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.

Exchange Eligibility Determinations

In its August 17 proposed rule, HHS makes clear your view that the law creates "*a central role for the Exchange in the process of determining an individual's eligibility for enrollment in a qualified health plan as well as for insurance affordability programs*" (e.g., Medicaid, CHIP, premium insurance tax credits, etc.). The proposed rule states that Exchanges will interact with employees and their employers in order to determine individual eligibility for premium tax credits or cost-sharing reductions because the employer-sponsored plan does not meet a minimum value standard or is not affordable under IRC §36B. The proposed rule also states that HHS considered whether the Secretary of HHS should determine eligibility for Exchange participation and for insurance affordability programs but chose not to take that approach to keep the eligibility and enrollment functions consolidated at the State level.

While we agree with this state-based approach in principle for providing coverage to the uninsured, we are concerned about the non-traditional roles of the states or HHS making determinations over the affordability and minimum value of employer-sponsored plans. Further, we are concerned that the administrative burden of providing information to 50+ state Exchanges and multiple federal agencies would open the door to inconsistent and duplicative reporting processes and requirements and a significant increase in our regulatory burden and costs, particularly for employers who operate in multiple states.

In the proposed rule, HHS contemplates new reporting requirements (templates or centralized databases) that would require employer reporting directly to HHS and/or the Exchanges. We appreciate the recognition by HHS that the overall goal is to make the process efficient and easy for employees to access and to minimize the burden on employers. However, it is the view of the Coalition that these proposed reporting requirements are unnecessary and would be overly burdensome given the reporting requirements to Treasury under IRC §6056.

As stated above, employers may be able to report the necessary information to Treasury under IRC §6056 on a prospective basis regarding minimum essential coverage under the employer plan that is needed by the Exchanges to assess the coverage being provided by the employer. 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 rely on the information that will be reported to Treasury regarding employer-sponsored coverage. The Exchange will then need to gather employee household income information (which employers do not have) to make their determination about employees' eligibility for tax credits.

We are also examining the reporting requirements under §1512 of PPACA amending the Fair Labor Standards Act that require 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 and a statement that if the employer's plan does not meet minimum value, an employee may be eligible for

a premium tax credit to purchase Exchange coverage. The employer must also notify the employee that, if the employee purchases Exchange coverage, the employee will lose their employer contribution to health benefits and the corresponding tax exclusion for those benefits. This notice may help provide employees with the necessary information needed regarding their employer plan if they choose to seek Exchange coverage. However, we would note that the effective date under the law for employers to provide this notification is March 1, 2013, and we strongly urge the Departments of Labor, HHS, and Treasury to re-examine this requirement date considering that state insurance Exchanges will not be fully operational until 2014.

Exchange Notification to Employer

According to the HHS proposed rule, the Exchange will notify the employer and identify the employee whom the Exchange has determined is eligible for a tax credit or cost-sharing reduction. HHS states that the content of this notice will be determined in future rulemaking. The EFHC Coalition is still discussing whether an approach can be developed that would provide a uniform standard for states to provide this notification to an employer at regular intervals. As one can imagine, a multi-state employer could receive countless notifications from numerous states in a variety of forms for employees seeking Exchange coverage. We encourage the Department to consolidate information from all 50+ state Exchanges using a centralized, federal process that will provide a single report to employers, preferably on a monthly or quarterly basis in order to help employers book their potential financial liability.

The Coalition also concurs with HHS's statement that the Exchange is required to verify information only for those applicants seeking eligibility determinations for insurance affordability programs, which we hope will minimize unnecessary employer interaction with Exchanges.

The EFHC Coalition is also considering other ideas for the interaction between Exchanges and employers upon notification of an employee seeking Exchange coverage, such as the option of allowing an employer to make an election on their form reporting information from IRC §6056 or notify the state that they wish to make a contribution adjustment on behalf of the employee to help them maintain employer coverage. This may be a particularly important option for small to mid-size employers.

IRS Verification, Appeals, Penalty Assessment

We are requesting that the agencies 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.

Furthermore, due to the nature of our workforce, it is also imperative that we are able to utilize the look-back methodology to determine and report full-time employee status for employees receiving premium tax credits. 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.

Thus, we have outlined a potential reporting process under IRC §6056 for Treasury and the IRS that includes the information required to make an accurate assessment of employer penalties for those employees receiving tax credits for Exchange coverage including:

1. Prospective reporting on general plan information regarding minimum essential coverage provided by an employer;
2. Retrospective or end-of-year reporting on specific employee full-time status and coverage; and
3. IRS verification of household income based on individual annual tax filings.

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.

The recommendations we pose are well within the purview of the Administration's regulatory authority and are a reasonable interpretation of PPACA. 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 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*."

III. Affordability Safe Harbor for Employers and Coordination with the Definition of Full-time Employee Under the "Look-back" Methodology

As stated in our June 17 letter responding to Treasury Notice 2011-36, the definition of full-time employee is of paramount concern to the EFHC Coalition because of our industries' unique reliance on large numbers of part-time, temporary, and seasonal workers with fluctuating and unpredictable work hours, as well as unpredictable lengths of service. Treasury Notice 2011-73 requests additional comments on the proposed affordability safe harbor, including its interaction with the proposed "look-back/stability period safe harbor method" used for determining who is a full-time employee.

In general, and as described above, we believe the affordability and look-back safe harbors are compatible and can be coordinated. However, Treasury and the IRS would need to establish reporting structures under IRC §6056 that allow for prospective reporting based on general plan information for the affordability safe harbor and for retrospective reporting that includes employees determined by the employer to be full time based on the look-back safe harbor. The reporting of both prospective and retrospective information could potentially be harmonized by 2015 to be included in a single annual reporting process, thereby avoiding unnecessary administrative complications for employers (with potential modifications for employers with varying plan year start dates) and providing Treasury with necessary information regarding employer-sponsored coverage for their full-time employees. The EFHC believes that both of these safe harbors are critical to the preservation of the current system of employer-provided coverage.

The EFHC Coalition would like to reiterate our support for the proposed "look-back/stability period safe harbor method" for determining which employees would be considered full time for a particular coverage period. In situations where an employee is hired for or promoted to a position that the employer classifies as or reasonably expects to be full-time, the employee will be eligible for the employer's health plan after the applicable wait period. Because the statute does not impose tax penalties on employers who do not offer coverage to part-time employees, it is a reasonable interpretation of the statute to permit employers to select a look-back period to determine if new employees of unknown or part-time status become eligible for the employer's health plan. Employers should have the flexibility to choose the length of the look-back period ranging from 3 to 12 months depending on the nature of their business and their workforce. Employers should also have the flexibility to determine how the look-back period will be measured. For example, employers should have the option of measuring the look-back period from hire date (or start date) to end of look-back period, or hire date to end of plan year. Many employers want the flexibility to enroll newly eligible employees in conjunction with a company's annual open enrollment process.

We believe this methodology not only allows for a longer measuring period, but also for a longer stability period to reduce churn between employer and Exchange coverage, thereby minimizing disruption of employees' coverage, access to providers and annual benefits. Moreover, we strongly concur with the Administration that this approach is more workable than monthly determinations of employees' eligibility for coverage and employers' liability for tax penalties IRC §4980H. The look-back/stability period safe harbor also has the potential to provide the flexibility employers need to preserve flexible work arrangements. Because our coalition members have workforces with high turnover rates and fluctuating work schedules, it is imperative that employees not designated as full time become eligible for coverage only after meeting a plan's eligibility requirements, as established by the employer.

Conclusion

In closing, we would like to thank you again for the opportunity to share our comments with the Administration on provisions of PPACA that affect employers, and we appreciate that the Administration has been receptive to the comments from the employer community in developing regulatory guidance. Because the industries represented in the EFHC Coalition employ large, fluctuating workforces and often sell low-margin consumer goods and services, even small increases in premium costs will place our businesses in the untenable position of being forced to stop offering coverage, forgo hiring of new employees, reduce employee hours to part-time status, raise consumer prices, or some combination of the above. The Coalition is working hard to propose regulatory solutions that make coverage affordable for both employers and employees. We want to be able to offer the most comprehensive coverage possible at a price that is affordable for and tailored to our specific workforces.

As demonstrated in these comments, the interplay of the employer requirements under the law have significant consequences for employers and their ability to maintain flexible work options and affordable health coverage for their employees. Because the employer requirements are inextricably linked, it is imperative that the Administration examine these provisions as a whole when developing regulatory guidance.

We also would like to underscore the following points that we believe are well within your regulatory authority to address:

1. As you contemplate rulemaking on the affordability and minimum value tests, we urge the use of flexible methodologies that recognize diversity in employer-sponsored coverage and create a balanced approach to these provisions that will allow us to maintain the ability to offer affordable coverage options to our employees, including the need for appropriate transition relief and a grace period from penalties in order for us to examine the impact of the law in 2014 and beyond.

2. The employer reporting requirements under the law and the interaction between employers, insurance Exchanges, and the federal agencies in conjunction with the substantive coverage requirements and imposition of penalties under the law are critical administrative and cost components that must be considered. We urge that the reporting processes minimize redundant reporting to multiple states and federal agencies, and that reporting processes be centralized within the Department of Treasury and the Internal Revenue Service, the agencies ultimately responsible for administering the appeals process for employers and imposition of penalty assessments.

3. The affordability safe harbor and the full-time employee look-back safe harbor can be coordinated and are compatible provided a reporting structure is established under IRC §6056 that allows for prospective reporting based on general plan information for the affordability safe harbor and for retrospective reporting that includes employees determined by the employer to be full time based on the look-back safe harbor. The EFHC believes that both of these safe harbors are critical to help us maintain coverage for our employees.

Promulgating regulations that reflect these policy recommendations is critical to coalition members' ability to continue to provide affordable health insurance options and maintain stable coverage to employees.

For questions related to this letter, please contact Anne Phelps, Principal, Washington Council Ernst & Young, Ernst & Young LLP, at 202-467-8416, on behalf of the Employers for Flexibility in Health Care Coalition.

Respectfully submitted,

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Aetna
Allegis Group, Inc.
American Hotel and Lodging Association
American Staffing Association
Associated Builders and Contractors, Inc.
Associated Food and Petroleum Dealers
Brinker International, Inc.
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Jack in the Box, Inc.
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National Association of Convenience Stores
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Robert Half International Inc.
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Alabama Grocers Association
Arkansas Grocers and Retail Merchants Association
California Grocers Association
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Idaho Retailers Association
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Massachusetts Food Association
Minnesota Grocers Association
Missouri Retailers Association
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Nebraska Grocery Industry Association
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