July 2, 2013

Internal Revenue Service  
CC:PA:LPD:PR (REG-125398-12)  
Room 5203, PO Box 7604, Ben Franklin Station  
Washington, D.C. 20044

RE: “Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Tax Credit,” REG-125398-12, RIN 1545-BL43

Dear Sir or Madam:

The Center on Budget and Policy Priorities is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes. We appreciate the opportunity to comment on the proposed regulations on the minimum value of eligible employer-sponsored plans and various elements of the health insurance tax credit.

We agree with many elements of the proposed approach to minimum value (MV), as detailed in our comments below. We agree that minimum value should be calculated in a consistent manner across employer plans, including using the same standard population and basing the calculation on the employer plan’s coverage of essential health benefits (whether or not the employer plan is required to offer such benefits).

We support requiring that employer plans use the MV calculator to determine minimum value if the plans are compatible with the calculator. This will help foster a consistent MV standard across employers. Our comments recommend a number of ways that IRS and Treasury could better ensure that employers use the correct method of determining MV, regardless of whether an actuary is assisting the employer. For example, one recommendation that would greatly improve the accuracy of the MV calculation is to require health insurers and third party administrators to calculate MV for any plans they market or offer to, or operate on behalf of, employers. This would also be a more appropriate approach to ease administrative burden on employers than the safe harbors proposed in the rule. As explained in our comments, we continue to be concerned that the safe harbors will not adequately ensure compliance with the MV requirement.

We urge IRS and Treasury, along with the Departments of Labor and Health and Human Services, to address in the final regulation how compliance with the MV standard will be monitored and enforced. One practical problem is that workers with an offer of employer coverage will initially rely on the information available from their employers about that offer. If the employer’s information is incorrect and the worker actually does not have an offer of coverage that meets minimum value, it is unclear how workers will be informed in a timely manner when this occurs so
that they (and their dependents) may apply for premium credits and obtain coverage through the exchange.

In addition, we strongly urge IRS and Treasury not to adopt the proposed rule on continuation coverage (COBRA). The final rule implementing the premium tax credits contained a special rule that stated COBRA is minimum essential coverage only for the months in which a COBRA-eligible individual is enrolled. The proposed rule drastically limits the application of this special rule to former employees. This ignores the adverse impacts on spouses and children who are COBRA-eligible due to their relationship to an active or former employee. The special rule should be restored and this proposed provision should be dropped.

Sincerely,

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§1.36B-1 Premium Tax Credit Definitions

Rating Area

We support defining rating area in the same way as in section 2701(a)(2) of the Public Health Service Act and 45 CFR 156.255.

§1.36B-2 Eligibility for Premium Tax Credit

Post-employment coverage

In response to numerous comments to the proposed premium credit rule, the final premium credit regulation included a special rule for continuation coverage (COBRA) (§1.36B-2(e)(3)(iv)), which stated that COBRA is minimum essential coverage only for the months in which a COBRA-eligible individual is enrolled. If the individual does not elect to enroll in COBRA, the offer of continuation coverage doesn’t bar the individual from being eligible for premium tax credits.

This proposed rule, however, now drastically (and apparently mistakenly) curtails application of this special COBRA rule just to former employees (including retirees), ignoring the adverse impact on other COBRA-eligible individuals outside of former employees, such as those who are eligible for continuation coverage because of divorce or legal separation, as discussed below. We strongly oppose this proposed change and urge that the final rule adopt the original provision included in the final 36B rule.

First, while the preamble and regulation refer only to active and former employees being eligible for COBRA, other individuals are eligible for continuation coverage based on a spouse or parent’s
eligibility for employer-sponsored coverage as active or former employees. A divorced or legally separated spouse eligible for unsubsidized COBRA coverage, for example, should not be barred from premium credits because her former spouse is still an active employee. (It is also unclear whether the proposed rule would also bar a divorced or legally separated individual from premium credits if their spouse is a former employee, since proposed §1.36B-2(c)(3)(iv) refers only to former employees, not to individuals who are eligible due to a relationship to a former employee.) Likewise, a young adult who is offered COBRA because she ages out of a parent’s employer coverage should not be barred from premium credits (if they are otherwise eligible) because they are eligible for unsubsidized continuation coverage. This is why the final 36B rule included the special rule for COBRA-eligible individuals in the first place.

Second, active employees (and their families) who are eligible for COBRA because of a reduction in hours that makes them no longer eligible for coverage through their employer also should not be barred from premium credits. As noted, COBRA coverage is unsubsidized, with individuals required to pay the entire cost of coverage plus a 2 percent administrative fee. That would likely be unaffordable for many individuals. Problems with affordability are compounded by the assumption that family coverage is affordable if self-only coverage is affordable; family coverage may cost considerably more than 9.5 percent of household income and yet the employee’s spouse and children would be considered to have affordable coverage and be denied eligibility for premium credits in the Marketplace. This is a particularly unacceptable result when the reason the active employee and their family became eligible for unsubsidized COBRA was because the active employee was also experiencing a decrease in work hours that makes them no longer eligible for the health plan offered by their employer.

The special rule adopted in the final 36B regulations is equitable and reflected an understanding of the eligibility rules for COBRA and that such coverage may be unaffordable for all types of COBRA-eligible individuals, not just former employees themselves. The special rule should be restored and this proposed provision should be dropped.

If this proposed provision is adopted despite these serious problems continuation coverage should be subject to the affordability and minimum value requirements that apply to other employer offers of coverage for active employees. If the COBRA coverage fails either test (which is likely in the case of affordability since the COBRA coverage is unsubsidized), the employee and his family would be eligible for premium tax credits and thus an employer could be responsible for the §54.4980H-5 penalty if the worker is still considered full-time.

**Wellness incentives**

We support the proposal to determine the minimum value and affordability of employer-sponsored coverage based on an assumption that cost-sharing and premium rewards available through nondiscriminatory, non-tobacco wellness programs have not been earned. Failure to earn non-tobacco wellness rewards can raise an employee’s premium by as much as 30 percent of the overall cost of coverage, potentially rendering coverage unaffordable. Assuming the rewards as unearned will result in the highest possible premium and/or cost-sharing charges being used to measure affordability and minimum value, thus ensuring that many people who face barriers to participation in non-tobacco wellness programs are treated equitably for purposes of determining whether they are eligible for a premium tax credit through the health insurance marketplace.
However, for purposes of determining affordability and minimum value, the proposed rule would assume tobacco-related rewards of up to 50 percent of the cost of coverage as having been earned. This potentially steep increase in premiums would exacerbate problems of family affordability and could lead individuals and families to not take up the offer of employer-sponsored coverage but leave them barred from the premium tax credits. People who find their employer-sponsored coverage unaffordable due to a tobacco-related wellness surcharge would likely also be faced with a penalty — for themselves and members of their household — for failure to obtain coverage, given the language in the preamble anticipating that tobacco-related wellness penalties would be ignored in the calculation of affordable coverage for purposes of the individual responsibility requirement.

We instead strongly recommend treating tobacco rewards as unearned for the purpose of measuring affordability and minimum value, as the proposed rule would do with other wellness rewards. This would promote a consistent and meaningful measure of the value and cost of employer coverage and simplify the calculation of minimum value and affordability for both employees and employers.

§1.36B-3 Computing the Premium Assistance Credit Amount

*Child born or adopted during a month*

We support the proposal that a child born, adopted or placed with the taxpayer for adoption or foster care is treated as enrolled on the first day of the month rather than delaying eligibility for the premium tax credit or cost-sharing reduction until the following calendar month.

*Adjusted monthly premium*

The proposed rule clarifies that a change to a coverage family, such as the disenrollment of a family member, that occurs during the month does not cause a recalculation of the adjusted monthly premium until the start of the following month; in the month of the change, the adjusted monthly premium is calculated as if all members of the coverage family were enrolled in the QHP for the entire month. We support this provision because it allows time for a family to contact the Marketplace and accurately recalculate the credit and cost-sharing reductions based on its household changes. The provision also simplifies the calculation of the credit during the reconciliation process by avoiding complicated mid-month adjustments. This proposed language provides this stability in the premium assistance calculation while avoiding excess payments for ineligible family members under the amended language in §1.36B-3(d)(2), which prorates the credit in the case of termination of coverage during the month.

*Family members residing at different locations*

The proposed rule clarifies that for family members living in different states, the premium for their benchmark plan is the sum of the premiums of their separate qualified health plans. This approach is similar to the final 36B rule’s approach to determining the benchmark when a silver level plan does not cover all members of a family.
§1.36B-6 Minimum Value

General provisions

We agree that minimum value should be calculated based on a standard population and should be based on coverage of the essential health benefits, even though many plans subject to the minimum value standard will not be required to cover every essential health benefit because they are large-employer, grandfathered, or self-insured plans. We support the lack of a de minimis exception as such an exception would have the effect of lowering the minimum value of a employer-sponsored plan below 60 percent, which would conflict with the ACA.

In general, we recommend that IRS and Treasury revisit the approach to minimum value over time and make any necessary refinements and improvements. The approach may need to be adjusted as more new, relevant data become available, if modifications are made to federal essential health benefits requirements, and as trends in employer plan offerings change over time. In general, the minimum value standard should keep pace with any relevant developments and should ensure that employer offers of coverage either provide a basic level of comprehensiveness or that workers and/or their families are eligible for premium credits through the Marketplace.

Wellness Incentives

Please see our comments above, related to provisions on wellness incentives at §1.36B-2.

Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs)

We agree with the proposals to ensure that only employer contributions to HSAs and HRAs that are newly made available in a given (current) plan year are counted for purposes of MV. We strongly support the position that contributions to a “standalone” HRA not integrated with a health insurance plan would not count toward MV.

We also support the proposal to count employer contributions to an HSA only for purposes of minimum value, not for purposes of determining the affordability of an employer plan, as an employee may not use funds held in HSAs to pay premiums. We support the proposal to permit employer contributions to an HRA to be counted for purposes of affordability, but not for minimum value, when the HRA may be used just for premiums, or for both premiums and cost-sharing charges. We agree that employer contributions to an integrated HRA should count in the minimum value determination, but not the affordability determination, if the HRA may not be used for premiums and can be used only for cost-sharing charges. We agree that this would appropriately limit double counting of employer contributions to HSAs and HRAs in determining affordability and minimum value of employer-sponsored coverage.

As we noted in our comments to the IRS on Notice 2012-31, “Minimum Value of an Employer-Sponsored Health Plan” in June 2012, we remain strongly concerned, however, that an employer plan not required to cover the essential health benefits (such as a self-insured plan or a large employer plan) could cover a very limited set of benefits or provide benefits with significant limitations and still meet the minimum value standard by depositing funds in an HSA or HRA.
workers with significant health needs, and healthy workers who suddenly experience health problems, having some cash in an account would not be sufficient to make up for severe limitations or gaps in the benefits provided under the skimpy employer-sponsored health plan. We urge IRS and Treasury to monitor this issue and to take action if there are signs that HSAs and HRAs, in combination with bare-bones employer offers, are barring workers and their families from premium credits to purchase affordable and comprehensive coverage through the Marketplace.

Methods for Determining Minimum Value

MV calculator

The MV calculator (or the safe harbor, if one applies to a given plan) must be used to calculate MV in cases when features of the plan are compatible with the MV calculator. This prohibits an employer from choosing to go directly to the actuarial certification option for any plan. We support this element of the proposed rule because it promotes greater consistency in the measurement of minimum value across different plans by ensuring that the calculator will be the basis for many, if not most, MV determinations.

However, the final rule should clarify when it is appropriate for an employer plan to use the calculator and when, alternatively, the plan must involve an actuary to make an accurate calculation of MV. Under the proposed regulation, if a plan has features that are not compatible with the MV calculator, then the preamble states that the plan “may” have the result of its MV calculation adjusted by an actuary. The plan does not necessarily have to be reviewed or have its MV result adjusted by an actuary. Only if the plan has features that are not compatible with the MV calculator and these features “may materially affect” the outcome of the MV calculation.

We are concerned about how this will work in practice. We understand that the calculator and safe harbor methods are envisioned as ways that non-actuaries (such as insurance brokers, human resources personnel, or benefit consultants) could determine the minimum value of an employer plan, thus avoiding the need for the employer to pay an actuary. However, it is unclear how someone who is not an actuary would know whether a plan has “nonstandard” features that are not accounted for in the calculator, as well as whether any such features “may materially affect” the outcome of the MV calculation.

One way to simplify the MV determination for employers, while ensuring that the determination is done accurately and consistently, would be to require health insurers that market or offer plans to employers, as well as third-party administrators (TPAs) that contract with employers to administer their health benefits, to calculate the minimum value of the products they offer or administer. Health insurers and TPAs are in the best position to help employers determine whether plans meet the minimum value standard because they employ or contract with actuaries who would be familiar with making those calculations.

Additional steps should be taken to ensure that both actuaries and non-actuaries can adequately determine which method may be used to determine the MV of a given employer plan:
• The final regulation should clarify that an employer plan with a feature that is not accounted for in the MV calculator and that may materially affect the minimum value calculation cannot use either the safe harbor method or the MV calculator without the assistance of an actuary who can make the appropriate adjustments.

• The final regulation should further clarify the standards an employer plan must meet in order to utilize either the MV calculator or a safe harbor when determining minimum value. In particular, greater clarification is needed around what types of plan features the MV calculator does not account for and around what types of features “may materially affect” a plan’s minimum value calculation.

• The final regulation should require employer plans with an MV result of 60 to 65 percent based on the calculator to be reviewed by an actuary if they have not already done so. These plans would be most likely to be materially affected by any feature not accounted for in a calculator or by any mistake that may have occurred in the calculation of MV.

• Clear guidance and instructions are needed for those who may be determining the MV of employer plans. Practice standards being written by the American Academy of Actuaries would not be sufficient to fulfill this purpose because someone who is not an actuary would not be bound to follow them and, indeed, may not even be aware of them. The guidance and instructions we recommend would make clear the eligibility criteria for use of the MV calculator or a safe harbor. For example, our understanding is that the MV calculator assumes a certain scope of benefits and an adequate provider network. The calculator would therefore not accurately determine MV if an employer plan does not cover a category of benefits, leaves out certain items or services included in the various categories, contains significant limitations on benefits (such as visit limits), or offers a drastically narrow provider network that is inconsistent with typical employer coverage. Therefore, among the conditions of using the MV calculator without the involvement of an actuary would be: coverage of all the benefit categories, no excluded items or services that may affect the MV calculation, and a provider network sufficiently similar to what is assumed under the MV calculator.

It would be helpful to create a questionnaire or checklist that would assist people (particularly non-actuaries) in determining whether they may use the MV calculator or a safe harbor, rather than actuarial certification, to calculate the MV of an employer plan. This questionnaire or checklist should be as simple and user-friendly as possible and should help clarify when the involvement of an actuary is needed to adequately determine MV.

Safe Harbors

We continue to oppose the use of the safe harbors as both unnecessary (because employers already have the option of the MV calculator) and difficult to implement effectively (because they fail to address benefit differences and oversimplify plan design). However, if the final regulation maintains safe harbors as an option for employers, then additional safeguards and clarifications are required.
• Employer plans should be eligible to use a safe harbor only if they meet the criteria to use the MV calculator without the need for adjustments by an actuary. This should be clarified in the language of the final rule. It should also be explained in guidance and instructions to personnel involved with determining the MV of an employer plan. Professional guidelines being established by the American Academy of Actuaries would not be sufficient to fulfill this purpose because someone who is not an actuary would not be bound to follow them and may not be aware of them.

• The final rule should clarify that employers do not have to meet exactly the cost-sharing parameters in any safe harbor that is made available. Rather, an employer could meet the specified parameters or provide plan enrollees with more generous cost-sharing protections on one or more of the cost-sharing parameters (such as a lower deductible and higher plan-paid coinsurance) and still be within the safe harbor. To make this clearer, the final rule should define each of the cost-sharing parameters for any available safe harbor in terms of what the enrollee would pay and then require all amounts to meet or be lower than those amounts. For example, the proposed safe harbor with a $3,500 annual medical and drug deductible would be modified to have a $3,500 annual deductible, 20 percent enrollee coinsurance, and a $6,000 out of pocket limit. Any plan that meets those cost-sharing parameters or reduces one or more of them would meet this safe harbor, provided that the other criteria (related to benefits and provider network) have been met.

• Any safe harbors that are finalized are likely to drive employer benefit design, by encouraging more employers to offer plans that align with the safe harbor’s deductibles and cost-sharing charges. In recognition of this, the final rule should include safe harbor options that are more protective of consumers than those that appear in the proposed rule. For example, a safe harbor should be added that includes a low deductible.

**Actuarial Certification**

We agree that an employer plan should seek an actuarial certification of its minimum value when it has nonstandard features that are not compatible with the MV calculator and may materially affect the MV percentage. As noted above, it should be made clearer which plan features are not compatible with the MV calculator and may materially affect the MV percentage, so that it is clear to both actuaries and non-actuaries which method or methods might be appropriate for a particular plan. We agree that an actuarial certification of MV must be performed by a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles, methodologies, and specific standards that may be provided in published guidance. We support the proposal to require the actuary to use the MV calculator and make adjustments to the result based on analysis of any nonstandard features not compatible with the calculator or plan coverage not measured by the MV calculator.

We urge IRS and Treasury, along with other relevant agencies, to review and audit actuarial certifications of MV and supplementary analyses on a regular basis, to determine whether they are being done correctly and in accordance with the required standards. The supplemental analyses
should be made publicly available, and data from them should be used to ensure the calculator and other methods of determining MV can accommodate new trends in employer benefit design.

§ 1.6011-8 Requirement of income tax return for taxpayers who claim the premium tax credit under section 36B

We strongly support amending the current regulation to extend the time available to submit a tax filing when one has claimed advance credit payments. The existing 36B rule requires filing a tax return by April 15, while the proposed rule makes it clear that the filing deadline includes extensions, which give taxpayers an additional six months to make a timely filing. This flexibility provides families with an additional opportunity to comply with the requirement to file in the year in which the tax credits are received. The IRS should further clarify that once filed, a premium tax credit can be amended (and any additional refund claimed) within 3 years of the original filing deadline.