June 11, 2012

Submitted Electronically: Notice.Comments@irscounsel.treas.gov

CC:PA:LPD:RU (Notice 2012-31)
Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

RE: Notice 2012-31 Minimum Value of an Employer-Sponsored Plan

To Whom It May Concern:

The U.S. Chamber of Commerce (the "Chamber") submits these comments in response to Notice 2012-31 which requests comments regarding the Minimum Value of an Employer-Sponsored Health Plan ("Notice"), which was published in the Internal Revenue Bulletin on May 14, 2012. This Notice seeks comments on several possible approaches to determining whether health coverage under an eligible employer-sponsored plan provides minimum value within the meaning of §36B(c)(2)(C)(ii) as added to the Internal Revenue Code by §1401 of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as "PPACA").[1] This Notice was published by the Internal Revenue Service ("IRS") and the Department of the Treasury ("Treasury").

The Chamber is the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector and region, with substantial membership in all 50 states. More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. Therefore, we are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large. Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business – manufacturing, retailing, services, construction, wholesaling, and finance – is represented. These comments have been developed with the input of member companies with an interest in improving the health care system.

[1] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (2010). [hereinafter referred to as "PPACA"].

Overview: Provide Flexibility and Reduce Burdens

We appreciate the pragmatic efforts of the IRS in promulgating regulations to advance the PPACA's statutory requirements in ways that will be both minimally burdensome and appropriate given the statutory language. We appreciate the reiteration that the determination of minimum value for plans in the large group market and self-insured plans will differ from the determination of qualified Health Plans (QHPs).[2] Specifically, the Notice correctly reiterates:

> Employer-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 HHS intends to propose to apply to QHPs.[3]

We urge you to craft regulations that provide as much flexibility as possible.

Broaden the Safe-Harbor Checklist: Presume Minimum Value

We strongly recommend that the safe harbor concept be broadened, particularly given the report issued by the Department of Health and Human Services[4] last fall: "Approximately 98 percent of individuals currently covered by employer-sponsored plans are enrolled in plans that have an actuarial value of at least 60 percent." This report was conducted when employers were still permitted to provide coverage for employees through so-called mini-med plans, which have low annual limits. Given that only two percent of individuals were then covered by plans which failed to meet the 60 percent actuarial value threshold, it will be an even smaller percentage once these plans are outlawed.

As the Notice itself states, there are significant differences between the large group market versus the small group and individual markets. Therefore, we recommend that the safe harbor be extended generally to allow all self-insured plans as well as all plans offered through the large group market to be deemed as satisfying the minimum value requirement and meeting the 60 percent actuarial value threshold. The IRS should simply *presume* that these plans meet the 60 percent actuarial value requirement if the employer in good faith believes that the plan meets this threshold. Given that nearly all individuals covered by employer-sponsored plans have this level of coverage, it is unreasonable to burden employers with proving in the affirmative what the report shows the overwhelming majority of employers already offer. Instead, the burden should be on employees to disprove what is nearly uniformly the case. The IRS should instead require employees to assert that their employer-sponsored coverage deviates from the norm and ask employees to contact their issuer or third party administrator if the employee believes that the employer-sponsored coverage they have does not satisfy this minimum value requirement.

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[2] Notice 2012-31, page 3
[3] Ibid.
[4] Actuarial Value and Employer-Sponsored Insurance, APSE Research Brief, U.S. Department of Health and Human Services, November 2011 (available at: http://aspe.hhs.gov/health/reports/2011/AV-ESI/rb.shtml)

Fair Treatment of All Available Account Dollars: Fully Count Employer Contributions

Consumer-focused health care products like health savings accounts (HSAs), flexible spending accounts (FSAs), and health reimbursement accounts (HRAs), in conjunction with high-deductible health plans, provide businesses and employees with health insurance coverage options that provide high value at lower cost. These products are widely used and are increasing in popularity. Just last month, a report was issued indicating that 13.5 million individuals are enrolled in HSAs with High Deductible Health Plans (HDHPs)[5] and almost a quarter (23%) of employers offering health coverage provide their employees with either an HSA or HRA option.[6] These less expensive options are being picked by a broad array of consumers with varied demographic and health risk factors and are an important coverage option for many Americans.

Treatment of HSAs and HRAs in Calculating Minimum Value

We dispute the position taken in this Notice (and in the Actuarial Value and Cost-Sharing Reduction Bulletin by the Department of Health and Human Services) that, when calculating the minimum value of the contribution made by the employer to an HSA or HRA, only a portion or "appropriate amount" of these employer contributions would be credited to the actuarial value calculation. Instead, the entire amount of the employer contributions should be included. While employees *may* only use a portion of HSA and HRA funds to pay for health care services in a given year, employees are entitled to, and have the ability to, use the full amount. Similarly, that entire contribution is paid by the employer to cover the costs of the employee's health benefits. Failure to include the entire employer contribution to an employee's HSA/HRA when determining minimum value will under-estimate the total number of dollars that employers pay for an employee's health benefits.

While it is true that the consumer is not required to use the entire HSA contribution in a given year, it is also true that the amount an employer contributes to an HSA does not change based on how much of the prior year's contribution has been used. Adjusting the employer's HSA contributions in this manner not only undervalues the money that the employer is paying toward an employee's health benefits, but it also undercuts the viability of these products. Funds not spent can also roll over from year to year so that they are available to an employee to use for health care costs at their discretion in the following year.

Employer contributions to HSAs and HRAs are made to assist employees with certain first-dollar health care costs. Employers do not monitor to see whether the full amount of the contribution is spent – it is offered to employees as a part of their health care benefit and should be treated in this way. Adjusting the employer's contributions to not reflect the actual amount paid by the employer could inadvertently undercut the viability of these products by causing a chilling effect on employer contributions to these plans, ultimately resulting in fewer affordable insurance options for Americans and less flexibility in benefit design for employers.

[5] AHIP Center for Policy and Research, "2012 HSA Market Census," (May 2012).
[6] Kaiser Family Foundation/Health Research & Education Trust, "Employer Health Benefits – 2011 Survey," (September 2011).

We strongly encourage the IRS and the Department of Health and Human Services to reconsider this treatment to ensure that this valued and popular products and accounts continue to be viable choices for employers and their employees.

Conclusion

We urge the IRS to continue to work carefully, pragmatically and cooperatively with the numerous stakeholders and we look forward to continuing to work together in the future.

Sincerely,

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