ERIC

The ERISA Industry Committee

September 6, 2011

Submitted to Notice.Comments@irscounsel.treas.gov

CC:PA:LPD:PR (Notice 2011-35)
Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Attention: Notice 2011-35

Ladies and Gentlemen:

The Patient Protection and Affordable Care Act ("ACA") imposes fees on issuers of health insurance policies and sponsors of self-insured group health plans to fund comparative clinical effectiveness research relating to patient-centered outcomes. The ERISA Industry Committee ("ERIC") is pleased to respond to the request of the Department of Treasury and the Internal Revenue Service (collectively, the "Agencies") in Notice 2011-35 for comments regarding the implementation of the comparative effectiveness research fee.

ERIC's Interest in the Comparative Effectiveness Research Fee

ERIC is a nonprofit association committed to the advancement of the employee retirement, health, incentive, and welfare benefit plans of America's largest employers. ERIC's members sponsor some of the largest private group health plans in the country. These plans provide high-quality, affordable health care to tens of millions of workers and their families.

ERIC's members are committed to, and known for, providing high quality, affordable health care. Employers do not have unlimited resources to spend on health care, however. ACA has imposed a number of expensive new mandates on employer health plans that were already struggling to cope with ever-increasing medical costs. Many of ERIC's members are approaching, and many have already reached, the tipping point: they cannot spend more money on health care, so that every additional dollar needed to satisfy a new administrative requirement or pay a new fee or excise tax is a dollar that must be recovered by reducing employees' health benefits.

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The comparative effectiveness research fee is assessed for seven years based on the average number of lives covered under a group health plan. In addition to paying the fee, ERIC's members will have to develop administrative systems that will enable them to determine the average number of covered lives for a variety of group health plans covering a large and dynamic work force. The fee and the associated administrative costs apply at a time when ERIC's members are struggling to cope with a mounting roster of expensive health mandates. ERIC's members have a vital interest in ensuring that the method for computing the fee does not impose unnecessary administrative burdens or costs on employers.

Comments Regarding Comparative Effectiveness Research Fee

The comparative effectiveness research fee applies to each plan year ending after September 30, 2012, and ending before September 30, 2019.[1] The amount of the fee is $2 ($1 for plan years ending before October 1, 2013) times the average number of lives covered under "a specified health insurance policy" or an "applicable self-insured health plan" during the policy or plan year.[2] For plan years ending during fiscal years 2015 through 2019, the fee is adjusted for increases in national health expenditures.[3]

1. The requirements for calculating the fee should be easy and inexpensive to administer.

The Agencies should not require employers to establish costly tracking systems to determine the actual average number of lives covered under an applicable self-insured health plan. Instead, the Agencies should allow employers to use simplifying techniques to estimate the average number of covered lives. ERIC recommends that the Agencies (1) allow employers to use any reasonable method to determine the average number of lives covered under a plan, and (2) provide employers with safe harbor methods for determining the average number of covered lives.

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[1] Code § 4376(a) and (e).

[2] Code §§ 4375(a) and 4376(a). "Specified health insurance policy" means any accident or health insurance policy, except for those described in section 9832(c) of the Code (*e.g.,* limited scope dental or vision benefits, long-term care benefits, and certain health flexible spending arrangements). Code § 4375(c) Applicable self-insured plan means any plan providing accident or health coverage (except those items described in 9832(c)) if any portion of the coverage is provided other than through an insurance policy. Code § 4376(c).

[3] Code §§ 4375(d) and 4376(d).

a. Employers should be permitted to use any reasonable method to determine the average number of covered lives.

Employers currently track enrollment in their plans at times and in a manner designed to meet their business needs. Although some employers may track enrollment on an ongoing basis, most employers determine the number of participants enrolled in a self-insured plan only at the beginning and end of the plan year for purposes of including the number of participants in the plan's annual report on Form 5500.

Employers are not currently required to track the number of dependents covered under a group health plan for any purpose. This information is not reported on Form 5500 or needed to satisfy any other legal obligation. As a result, some employers do not collect information regarding the number of dependents who participate in their plans. Other employers might maintain records regarding dependents covered under a health plan for business purposes, but the records will not necessarily permit the employer to determine the aggregate number of dependents covered under the plan on a specific date or in a specific year.

The Agencies should allow employers to use any reasonable method to determine the average number of lives covered under their plans. A flexible rule will permit employers to rely on the systems or resources that they currently use to determine enrollment in their health plans.

b. The Agencies should provide employers with safe harbor methods for determining the average number of lives.

In addition to giving employers the flexibility to use any reasonable method to determine the average number of covered lives, the Agencies should provide safe harbor methods that include simplifying assumptions for determining the number of participants and dependents enrolled in self-insured plans. ERIC recommends that the Agencies include at least two safe harbor methods: one method based on the number of participants shown on the Form 5500 annual report filed for a plan, and another method that would require employers to count the number of employees or retirees enrolled in the plan on one day each month. We describe these safe harbor methods in more detail below.

Each method of determining the average number of lives has advantages and disadvantages from an employer's perspective. Depending on the employer's circumstances, a method that works well in one year might not be appropriate in a different year. The Agencies should make clear that an employer has the flexibility to change the method it uses from year to year.

1. Allow employers to determine the average number of lives using information reported on Form(s) 5500.

Under the Form 5500 safe harbor, an employer would determine the average number of participants by adding the number of participants reported on the Form 5500 for the beginning of the plan year and the number of participants reported for the end of the plan year and dividing by two.

Because dependents are not reported on the Form 5500, the safe harbor should permit employers to use the following assumptions to determine the number of dependents covered under the plan:

- For participants enrolled in single plus one coverage, employers may assume 1 dependent;
- For active employees enrolled in family coverage, employers may assume 2 dependents;[4] and
- For retirees enrolled in family coverage, employers may assume 0.65 dependents.[5]

2. Allow employers to determine the average number of lives by counting the number of employees or retirees covered.

In addition to the Form 5500 safe harbor, ERIC recommends that the Agencies allow employers to determine the average number of lives by counting the number of employees or retirees enrolled in a plan for a selected day during each month in the plan year, adding the monthly counts, and dividing by 12. Employers should be permitted to determine the number of dependents either by using the same method (*i.e.* by counting the number of dependents for a selected day during each month, adding the monthly counts, and dividing by 12) or by using the method described above under the Form 5500 safe harbor for estimating the number of dependents.

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[4] According to the U. S. Census Bureau's 2005-2009 American Community Survey, the average household size is estimated to be 2.60, and the average family size is estimated to be 3.19. *See* http://factfinder.census.gov/servlet/ACSSAFFFacts. If one assumed that all members of an employee's household or family were eligible to be covered as dependents under an employer's group health plan, the employee would count as one family member, and the average number of dependents would be between 1.60 and 2.19.

[5] Based on surveys conducted by the Kaiser Family Foundation and Hewitt, the typical ratio of family members to retirees is commonly understood to be 0.65. *See Retiree Health Benefits Examined*, *Findings from the Kaiser/Hewitt 2006 Survey on Retiree Health Benefits* (December 2006) *available at* http://www.kff.org/medicare/upload/7587.pdf (showing that the ratio of covered retirees to covered retirees and dependents is 1.65).

2. The fee should not apply to Health Reimbursement Arrangements or Employee Assistance Plans

The comparative effectiveness research fee does not apply to self-insured health plans under which substantially all of the benefits are excepted benefits described in section 9832(c) of the Code.[6] The statute lists certain benefits, such as limited scope dental and vision benefits, that are treated as excepted benefits; but the statute also gives the Agencies authority to issue regulations treating similar limited benefits as excepted benefits.[7] Excepted benefits are exempt from many group health plan mandates enacted in ACA and earlier statutes.

Health reimbursement arrangements ("HRAs") and employee assistance plans ("EAPs") should be classified as excepted benefits that are exempt from the comparative effectiveness research fee and other group health plan mandates. Health reimbursement arrangements provide reimbursement for medical expenses up to a low annual dollar limit, typically a few thousand dollars. Employee assistance programs are treated as group health plans (if at all) only because they offer counseling benefits or other very limited types of health benefits. The design and purpose of these programs are incompatible with most of the group health plan mandates.

If HRAs and EAPs are subject to the group health plan mandates, employers will not be able to continue to offer these programs. For example, as the Department of Health and Human Services recently recognized, applying the restrictions on annual limits to stand-alone HRAs "would result in a significant decrease in access to HRA benefits."[8] Accordingly, ERIC urges the Agencies to work with the Department of Labor and the Department of Health and Human Services to issue regulations confirming that EAPs and stand-alone HRAs are excepted benefits under section 9832(c).

Regardless of how the Agencies define "excepted benefits," however, the Agencies should make clear that both EAPs and HRAs are exempt from the comparative effectiveness research fee. Although these arrangements are considered group health plans for some purposes, they provide very limited health

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[6] Code §§ 4375(c) and 4376(c).

[7] Code § 9832(c)(2)(C). The Agencies have previously exercised this authority in order to treat most health flexible spending accounts as "excepted benefits." 26 C.F.R. § 54.9831(c)(3); *see also* 29 C.F.R. § 2590.732(c)(3) *and* 45 C.F.R. § 146.145(c)(3) (creating parallel rules under ERISA and the Public Health Service Act).

[8] CCIIO Supplemental Guidance (CCIIO 2011–1E): Exemption for Health Reimbursement Arrangements that are Subject to PHS Act Section 2711 (Aug. 19, 2011). HHS issued a blanket waiver exempting stand-alone HRAs from the restriction on annual limits through 2013.

benefits. The comparative effectiveness research fee should not apply to limited arrangements such as these.

3. The fee should be administered in a way that avoids duplication.

The comparative effectiveness research fee will fund the efforts of the Patient-Centered Outcomes Research Institute to identify more effective means to manage diseases and other health conditions. We assume that Congress imposed this fee on employers and insurers because it believed that these entities might realize benefits from the research in the form of lower health care expenditures. It is clear, however, that employers will not realize multiple savings with respect to a single covered individual. Accordingly, the Agencies should not require an employer to pay the fee more than once with respect to the same covered individual. ERIC believes that this approach is consistent with the intent of the provision imposing the fee.[9]

ERIC recommends that the Agencies adopt the following rules to avoid duplicating fees. An employer should be permitted to apply these non-duplication rules regardless of whether the employer uses a safe harbor method or an actual headcount to determine the number of covered lives.

a. Employers should be permitted to treat all of their accident and health benefits as one applicable self-insured plan for purposes of the fee.

The fee is based on the number of lives covered under an "applicable self-insured health plan." For purposes of determining the fee, all self-insured accident and health benefits offered by an employer should be considered one applicable self-insured health plan, so that an employer will count each individual to whom it provides self-insured accident or health benefits only once for purposes of determining the fee. If employers are not permitted to aggregate plans, an employer might be required to pay a higher fee merely because it has structured its accident and health coverage as separate plans for unrelated business reasons.

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[9] The Congressional Budget Office ("CBO") and Joint Committee on Taxation estimated that the fee would generate revenue of $0.1 billion starting in 2012 and increase to $0.5 billion in 2013. Although these reports do not explain the number of lives covered for purposes of reaching this estimate, a report issued by the CBO in 2008 estimated that in 2009, 160 million people would have health insurance provided through an employer or other job-related arrangement. If 160 million people are covered by insurance, including self-insured health plans, charging one dollar for each person would result in $0.16 billion in revenue. If individuals who were covered by more than one plan were counted more than once, this number would substantially increase, and would be well over CBO's projected $0.1 billion in revenue.

In the preceding comment, ERIC recommended that the Agencies exempt EAPs and stand-alone HRAs from the comparative effectiveness research fee. If the Agencies do not adopt this recommendation, the Agencies should at least allow an employer to aggregate these programs with the employer's accident and health plans to avoid paying duplicate fees for individuals who are covered under both arrangements. The following examples illustrate the need for this rule:

- An employer maintains a major medical plan and an EAP that provides counseling benefits. All employees participate in the EAP, and some employees participate in the major medical plan. For purposes of calculating the fee, the Agencies should allow the employer to treat the major medical plan and the EAP as a single plan so that the employer pays only one fee for each participant who is covered under both the EAP and the major medical plan.

- An employer maintains a major medical plan and an HRA. If the Agencies determine that the fee applies to HRAs, the Agencies should allow the employer to treat the major medical plan and the HRA as a single plan so that the employer pays only one fee for each participant who is covered under both the HRA and the major medical plan.

Although the plan aggregation rule should apply to EAPs and HRAs, the rule should not be limited to these programs. Employers offer a variety of group health plans to employees and their dependents, and there are many circumstances in which the same individual might be covered by more than one of the employer's group health plans during a plan year. In all of these circumstances, an employer should be permitted to aggregate its group health plans in order to avoid paying duplicate fees for the same individual. In addition, because data concerning specific covered individuals is often divided among different service providers in a way that makes it impossible to identify each individual with dual coverage, the Agencies should permit an employer to use sampling techniques or other reasonable methods to estimate the number of individuals who are covered by more than one plan.

A plan aggregation rule also will prevent an employer from paying duplicate fees merely because an individual makes a mid-year change in plan enrollment. For example, suppose an employee who retires during the year is enrolled in an employer's health plan for active employees before he retires and is enrolled in the employer's separate health plan for retirees for the remainder of the year. The individual should be counted only once for purposes of the fee. Similarly, suppose an individual marries during the plan year and is permitted to change from the employer's high-deductible health plan to the employer's low-deductible health plan as a result of the change in marital status. The individual should be counted only once.

The Agencies should make clear that this "one plan" rule does not prevent an employer from maintaining one or more of its accident or health benefit programs as separate plans for other purposes, such as for purposes of COBRA, HIPAA, or the ACA mandates. For example, a retiree-only plan that is maintained as a separate plan for purposes of the retiree-only exemption from certain HIPAA requirements and the ACA mandates under section 9831(a)(2) of the Code will not lose its retiree-only status merely because it is treated as part of a single plan covering both active and retired employees for purposes of calculating the comparative effectiveness research fee.

b. Employers should be permitted to exclude from their calculation of covered lives employees who are enrolled in insured accident or health coverage.

If an employer maintains insured health coverage for its employees, the Agencies should permit the employer to exclude individuals who are enrolled in the insured plan from the employer's calculation of the average number of covered lives. The employer should be permitted to assume that the insurer will pay the fee with respect to participants covered by a group health policy or HMO. The employer and insurer may agree between themselves to what extent the fee will be passed through to the employer as a premium increase or other charge.

c. Employers should be permitted to pro-rate the fee to account for participants who are not enrolled in a plan for an entire year.

Employers should be permitted to pro-rate the fee to take into account changes in enrollment during the year. For example, suppose an employer sells part of its business during 2012. The employer's average number of covered lives for each of the first eight months of the plan year is 10,000; but after the sale, the average number of lives covered for the remaining four months is 6,000. In this example, the employer's fee should equal $8,666.67 (($1 x 10,000) x 2/3) plus (($1 x 6,000) x 1/3). Similarly, if some or all of an employer's plan becomes (or ceases to be) insured during the year, or if the employer acquires a business during the year, the employer should be permitted to pro-rate the fee to reflect these changes.

d. An employer, for purposes of the fee, should be permitted to include all members of the employer's controlled group.

A controlled group of employers, within the meaning of sections 414(b), 414(c), 414(m), and 414(o) of the Code, should not be required to pay duplicate fees with respect to employees who are members of the same controlled group. In some cases, an employee who works for more than one business within the controlled group will be covered by more than one group health plan: for example, the employee might be covered both by the parent's group health plan and by a group health plan maintained by a subsidiary. In other cases, an employee might transfer during the year from one business to another, so that the employee will be covered

by one controlled group member's group health plan for the first part of the year and by another controlled group member's group health plan for the last part of the year. The members of the controlled group should not be required to pay duplicate fees for the same covered individual in these circumstances.

A rule treating members of the same controlled group as a single employer will also reduce the administrative burden associated with computing the fee. Some employers assign responsibility for collecting and maintaining enrollment data for all plans maintained within the controlled group to one member of the group. The Agencies should not require employers to incur additional expense in order to determine this enrollment information separately for each member of the controlled group merely for purposes of determining the fee.

Although members of a controlled group generally will wish to be treated as a single employer for purposes of the fee, the Agencies should not prohibit a member of a controlled group from choosing to be treated as a separate employer. Accordingly, the Agencies should permit, but not require, all members of an employer's controlled group to be treated as a single employer for purposes of the fee.

4. The deadline for filing the fee should be no earlier than the deadline for filing the Form 5500 for the applicable plan year.

a. The fee should not be due before the deadline for filing the Form 5500 for the plan year.

Employers are required to pay a fee for each plan year ending in each fee cycle. Each fee cycle runs from October 1st through September 30th, and the first cycle begins on October 1, 2012. The Agencies should provide that the fee will be due no earlier than the deadline (including extensions) for filing the Form 5500 for the plan year. If the plan is exempt from the Form 5500 filing requirement, the fee should be due no earlier than the date on which the Form 5500 would have been filed if the plan had been subject to the filing requirement, assuming that the employer had requested the automatic 2½-month extension of the filing deadline.

b. If an employer has treated plans with different plan years as one plan for purposes of the fee, the fee should not be due before the deadline for filing the Form 5500 for the plan year designated by the employer.

If the employer has treated plans with different plan years as a single plan for purposes of calculating the fee, the employer should be permitted to designate the latest plan year as the relevant plan year for paying the fee. The fee will be due no earlier than the deadline (including extensions) for filing the Form 5500 for the designated plan year. For example, for the first fee cycle ending September 30, 2013, if an employer maintains a calendar year plan with its plan year ending on

December 31, 2012, and a fiscal year plan with its plan year ending on August 31, 2013, the employer may designate the plan year for its aggregate plan as the fiscal year ending on August 31, 2013, and the deadline for filing the fee would be keyed to the plan year ending August 31, 2013. Thus, the deadline for filing the fee would be no earlier than March 31, 2014 (or June 15, 2014, with extensions).

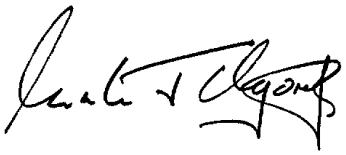
This rule will allow an employer to aggregate plans with different plan years and to use the Form 5500 safe harbor to determine the average number of covered lives, taking into account the information reported on each of the Forms 5500 filed for plan years ending within the fee cycle. If the employer uses a different method to determine the average number of covered lives, this rule will provide a single deadline for calculating and paying the fee for multiple plans that are treated as a single plan. The single deadline will ensure that the employer pays only one fee with respect to each covered life for each fee cycle.

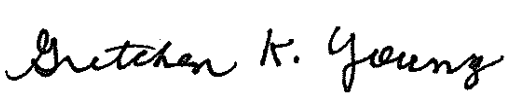
5. Transition rules might be necessary based on the Agencies' guidance implementing the comparative effectiveness research fee.

If the Agencies adopt ERIC's recommendations, including the safe harbor methods for determining the average number of covered lives, employers should have the data necessary to pay the fee by the deadline for the first fee cycle (as proposed in our comments), and should not need a transition period. In contrast, if the Agencies do not adopt ERIC's recommendations, it is likely that employers will need a transition period to develop the systems and procedures necessary to determine the average number of covered lives in their group health plans. In this case, however, ERIC will not be able to determine what transition rules will be necessary until the Agencies issue guidance explaining how the new payment structure will operate and what new data will be required.

ERIC appreciates the opportunity to provide comments on the comparative effectiveness research fee in response to Notice 2011-35. If the Agencies have any questions concerning our comments, or if we can be of further assistance, please let us know.

Sincerely,





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