ERIC The ERISA Industry Committee

The Only National Association Advocating Solely for the Employee Benefit and Compensation Interests of America's Largest Employers

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CC:PA:LPD:PR (REG-103058-16)
Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

RE: RIN 1545-BN23 (Information Reporting of Catastrophic Health Coverage and Other Issues Under Section 6055)

To Whom It May Concern:

The ERISA Industry Committee ("ERIC") is pleased to respond to the request of the Internal Revenue Service ("IRS") for comments on the notice of proposed rulemaking under Section 6055 of the Internal Revenue Code ("Code"). The proposed rulemaking was published by the IRS in the *Federal Register* on August 2, 2016. These comments will also review certain aspects of reporting under Section 6056.

ERIC'S INTEREST IN THE PROPOSED RULEMAKING

ERIC is a nonprofit organization representing the nation's largest employers that maintain health care, retirement, and other employee benefit plans covered by the Employee Retirement Income Security Act of 1974. ERIC is the only national association that advocates for large employers on health, retirement and compensation public policies at the federal, state and local levels. ERIC enhances the ability of its member companies to provide high-quality health care benefits to millions of active and retired employees, and their families. These benefits help ERIC members to attract and retain talent and maintain a healthy and productive workforce.

ERIC's members, which sponsor some of the largest private group health plans in the country, are committed to, and known for, providing high-quality, affordable health care. Our members expend considerable resources to maintain plans that cover many disparate populations across a wide range of geographic areas and that operate in all states and territories. These plans provide health care to millions of workers and their families with high standards of quality, cost containment, and effectiveness.

Under Code section 6055 and the current regulations, providers of minimum essential coverage ("Reporting Entities") are generally required to report on Form 1095-B or Form 1095-C the name, address and Taxpayer Identification Number ("TIN") of each responsible individual, the name and TIN of each covered individual (typically, a spouse, domestic partner and/or dependent children), and the months of coverage for all such individuals. If a TIN is not available, the current regulations permit a Reporting Entity to report date of birth. To avoid reporting penalties under the "reasonable cause" rules of Code section 6724, a Reporting Entity must conduct multiple solicitations for missing and/or incorrect TINs.

Among other things, the proposed regulations recommend modifications to the TIN solicitation rules under section 6724. Specifically, the proposed regulations would require Reporting Entities to conduct three

solicitations for missing and/or incorrect TINs.[1] In the case of missing TINs, the proposed regulations indicate that the first solicitation is required when the "account" is "opened"; the second solicitation is required no later than 75 days after the date the "account" was opened (or, if coverage is retroactive, no later than 75 days after the "determination" of coverage was made); and the third solicitation is required no later than December 31st of the year following the year in which the "account" was opened. In the case of incorrect TINs, the proposed regulations do not modify the existing solicitation rules in the Code section 6724 regulations.

While we appreciate the government's attempt to create special TIN solicitation rules for the purposes of Code section 6055 reporting, we do not believe the proposed regulations create a straightforward and workable system under which plan sponsors can collect and report the relevant information to IRS.

First, the proposed regulations take a "band-aid" approach – instead of modifying the Code section 6724 TIN solicitation regulations directly, the proposed regulations take the odd approach of building special Code section 6724 TIN solicitation rules into the existing Code section 6055 regulations.

Second, the proposed regulations continue to require individual-by-individual TIN solicitation – the IRS needs to recognize that group health plan administration occurs at the plan level, and permit periodic TIN solicitation at that level (e.g., quarterly).

Third, the effective date of the proposed regulations (calendar years ending after December 31, 2015) is completely unrealistic – Reporting Entities should be allowed ample time to test and implement any new TIN solicitation processes and should be able to rely on the existing TIN solicitation rules for a reasonable period of time.

Fourth, the proposed regulations don't go nearly far enough to provide TIN solicitation transition relief for existing covered individuals – the selection of the completely arbitrary and retroactive date of July 29, 2016 as the trigger for the second TIN solicitation is simply unworkable.

Finally, the proposed regulations don't clearly define key terms or dates applicable to employer- or union-sponsored group health plans – plan sponsors need to understand precisely when an account is "opened," when a retroactive determination of coverage is "made," how to count "75" days, and how to establish adequate proof of TIN solicitations.

In reviewing the proposed regulations, ERIC members also raised several specific concerns about Code section 6055 and 6056 reporting. Our recommendations and suggestions on both topics are spelled out in greater detail below.

COMMENTS ON PROPOSED REGULATIONS

I. MODIFY THE SECTION 6724 REGULATIONS DIRECTLY

The existing Code section 6055 regulations refer to the Code section 6724 TIN solicitation rules only obliquely – existing Treas. Reg. §1.6055-1(h) includes simple cross-references to the reporting penalties under Code sections 6721 and 6722 and to the reasonable cause rules under Code section 6724. But instead of modifying the

[1] To simplify discussion, this letter will refer to these three solicitations as the "first solicitation," the "second solicitation" and the "third solicitation" rather than use the less-than-clear terminology that appears in Treas. Reg. §301.6724 (where the solicitations are described as the "initial solicitation," the "first annual solicitation" and the "second annual solicitation").

TIN solicitation rules in the Code section 6724 regulations directly, the proposed regulations do so indirectly, by adding a new paragraph (h)(3) to the existing Code section 6055 regulations.

ERIC members believe this approach adds unnecessary complication to the compliance burden. A better, and far more direct approach, would be to modify the existing Code section 6724 regulations to add new paragraphs specifically addressing the application of the TIN solicitation rules in the context of Code section 6055 information reporting. This would promote administrative simplicity both for Reporting Entities and for the IRS – all the applicable TIN solicitation rules would appear in one regulation instead of two regulations.

Another advantage of modifying the Code section 6724 rules directly is that it would permit the IRS to simplify the TIN solicitation terminology for Code section 6055 information reporting. Instead of using the confusing terms "first annual solicitation" and "second annual solicitation" (which are actually the second and third solicitations), the IRS could explain that three solicitations are required for purposes of Code section 6055 reporting and explain when each of those three solicitations are required. The IRS should keep in mind that much of the Code section 6055 and 6056 reporting obligations are being handled by individuals and entities that aren't familiar with the Form W-2 information reporting requirements and the reasonable cause rules; namely, insurance carriers, employer human resource officials, multiemployer plan employees and third party administrators that perform administrative services for group health plans.

II. PERMIT TIN SOLICITATIONS AT THE PLAN LEVEL

The proposed regulations continue the archaic approach of requiring Reporting Entities to make TIN solicitations on an individual-by-individual basis. Each time a health plan enrollment occurs with a missing TIN, a Reporting Entity must follow up with each responsible individual. This individual-by-individual solicitation requirement is further complicated by the proposed 75-day deadline for the second solicitation. In other words, not only would a separate TIN solicitation be required for each separate individual, but many individuals would have different 75-day deadlines for the second solicitation (e.g., separate 75-day deadlines would likely apply to each new hire, each newly-added dependent, each annual enrollee and each special enrollee).

ERIC members urge the IRS to offer alternative TIN solicitation approaches that could be implemented at the plan level. Rather than require Reporting Entities to solicit missing TIN information on an individual-by-individual basis and apply separate 75-day tracking periods to each individual, the IRS could permit group health plans to conduct the second and third solicitations in batch solicitations on a quarterly basis.

For example, assume that the plan administrator of a large group health plan conducts an open enrollment in the Fall of 2016, during which it solicits TIN information (the first solicitation). When coverage becomes effective on January 1, 2017, the plan administrator will be in a position to identify all enrolled individuals (and dependents) who did not submit a TIN, and could easily send the second solicitation to these individuals by March 31, 2017 (by batch mail, telephone calls or email). If some of these individuals do not respond to the second solicitation, the plan administrator could send a third solicitation to the remaining batch at the end of a subsequent calendar quarter (such as July 31, 2017 or September 30, 2017).

Permitting TIN solicitation on a batch basis would better ensure that plan sponsors are able to recover missing TINs, and would also simplify, rather than complicate, group health plan administration for insurance carriers, employer and union plan sponsors, and the third-party administrators that assist in plan administration. It would also make it easier for a Reporting Entity to establish compliance with respect to the TIN solicitation rules, and for the IRS to confirm that a Reporting Entity satisfies the "reasonable cause" rules under Code section 6724.

III. CLARIFY THE EFFECTIVE DATE

The preamble indicates that the proposed regulations are "generally" effective for taxable years ending after December 31, 2015. But the regulations themselves indicate that the applicability date is calendar years ending after December 31, 2014 – the same effective date specified in the existing regulations under Code section 6055.

ERIC members urge the IRS to clarify and delay the "new" TIN solicitation rules. It is simply not possible to implement the new TIN solicitation rules retroactively, and that is particularly true with respect to the 75-day deadline for the second solicitation. Reporting entities will need a reasonable period of time to implement and test the new TIN solicitation rules, and should not be punished for failing to implement rules that are still in proposed form. Penalty relief is particularly appropriate given the confusion that has surrounded, and still surrounds, the minimum standards necessary to demonstrate "good faith" compliance with the Affordable Care Act ("ACA") information reporting requirements.

ERIC members recommend that the IRS take the following actions:

- Clarify that the new TIN solicitation rules for missing TINs will not become effective until the first calendar year (not taxable year) beginning on or after at least six months after the date final regulations are published in the *Federal Register*;

- Clarify that a Reporting Entity may rely on either the existing TIN solicitation rules or the new TIN solicitation rules for all calendar years before the effective date; and

- Extend the "good faith compliance" reporting standard discussed in the preambles of the existing Code section 6055 and 6056 regulations to the 2016 calendar year, in recognition of the ongoing uncertainty and confusion regarding how the Code section 6724 reasonable cause requirements apply to Code section 6055 and section 6056 information reporting.

IV. PROVIDE ADDITIONAL TRANSITION RELIEF

The preamble of the proposed regulations attempts to provide TIN solicitation transition relief for individuals already enrolled in health coverage. Under this transition relief, individuals enrolled in coverage on any day before July 29, 2016 are treated as having opened an "account" on that date. The preamble then elaborates three corollary rules: first, a Reporting Entity is treated as having made the first solicitation on that date (as long as the Reporting Entity actually requested TIN information before that date); second, a Reporting Entity must make the second solicitation at a "reasonable time" after July 29, 2016; and third, a Reporting Entity will be treated as satisfying the "reasonable time" requirement if it makes the second solicitation within 75 days of July 29, 2016.

ERIC members believe these rules are problematic. The proposed transition relief requires a Reporting Entity to identify all individuals who were enrolled in health coverage on an arbitrary date (notably a Friday, not the last or first day of a month), then further determine whether that group includes individuals who have missing TINs, and then further explore whether the subset group with missing TINs were previously asked to provide TIN information. Assuming this can be done, the 75-day clock starts ticking immediately, meaning that transition relief is only assured if the Reporting Entity provides the second solicitation on or before Wednesday, October 12, 2016 (only nine days after comments are due and, this year, the date of Yom Kippur). As one ERIC member put it, this is transition relief "without the relief."

Given the uncertainty and confusion that has surrounded the application of the TIN solicitation rules to the Code

section 6055 information reporting requirements, ERIC members believe the need for broader transition relief is self-evident. Transition relief should not be based on what has or hasn't happened in the past, but on what reasonable steps are taken going forward. The IRS should provide blanket relief for all individuals who were enrolled in health coverage on the first day of the month following the date final regulations are published in the Federal Register as long as a Reporting Entity takes the following actions: (1) the Reporting Entity confirms whether the first solicitation was made in the past, and if that fact can't be confirmed, then the Reporting Entity makes the first solicitation within 90 days of the date final regulations are published; and (2) the Reporting Entity makes the second solicitation within 90 days of the date final regulations are published (or, if the Reporting Entity can't confirm that the first solicitation was made in the past, then 90 days after the first solicitation is actually made). This approach would give all Reporting Entities sufficient time to identify the group of previously covered individuals, and to provide the first solicitation (if necessary) and the second solicitation.

ERIC members also believe that the IRS should expand the transition relief announced in Notice 2015-68 and reiterated in the preamble to the proposed regulations for individuals whose coverage terminated before September 17, 2015. This transition relief again forces Reporting Entities to segment coverage data based on an arbitrary mid-month date, and should be expanded to include all individuals whose coverage terminated before January 1, 2016.

V. CLARIFY TERMINOLOGY

The proposed regulations include several definitions and operating rules that are too vague, particularly for employer- and union-plan sponsors and their administrators who collect TIN information. For example, the proposed regulations indicate that the first solicitation must be made when an account is "opened," defined as the time the Reporting Entity "receives a substantially complete application for coverage (including an application to add an individual to existing coverage)." The proposed regulations also indicate that a Reporting Entity must make the second solicitation no later than 75 days after the date on which the account was "opened," unless coverage is retroactive, in which case the deadline is 75 days after the "determination of retroactive coverage is made."[2] ERIC members have questions and concerns with how these rules are intended to work in actual operation and need the regulations to address these issues before the rules are to apply.

First, let's consider new hires or newly eligible employees. Among ERIC members, group health plan enrollment practices and plan design vary considerably. Some plan sponsors make coverage effective retroactively to an employee's date of hire if the employee submits enrollment materials within 30 days of the date of hire. Other plans make coverage effective prospectively on the first day of the payroll period or the first day of the month following the date a person timely submits enrollment materials. Many health plans impose waiting periods, such that even if a person submits enrollment materials on a timely basis, the person's coverage may not be effective for 30, 60, or even 90 days after the date of hire.

In each of these situations, when does the 75-day clock start and end? Is it the date the employee submits the enrollment materials? Is it the date coverage becomes effective? Assume that a plan sponsor hires 25 eligible individuals on October 3, 2016, gives the new employees 30 days to submit enrollment materials, makes the first

[2] For purposes of this discussion, we note that most group health plan sponsors don't "make a determination" that coverage is retroactive. Whether coverage is retroactive or prospective is typically not determined based on the plan sponsor's discretion but is determined automatically based on plan design (i.e., the plan document says coverage is retroactive to date of hire) or applicable law (i.e., federal law requires group health plans to make coverage for newborn or newly-adopted children retroactive to the date of birth or adoption).

solicitation in all cases, but then ends up with 25 different dates on which the employer "received" applications for coverage. Is it realistic to ask the employer to track 25 different 75-day periods for the second solicitation? What if the coverage is retroactive to date of hire? Does the 75-day clock begin for all 25 employees on October 3, 2016? Or again, are there 25 different 75-day periods measured from each date the plan sponsor received an application for coverage and "determined" that the coverage was effective retroactively? It would greatly clarify matters if the regulations firmly stated that an account opening takes place on the date coverage begins, and that an initial solicitation is deemed to have occurred on the date that enrollment materials are provisioned to an employee.

Similar questions arise for employees who process new enrollments during an annual open enrollment period. Most plan sponsors conduct a multi-week annual enrollment period in the Fall, and subsequently permit employees to verify their coverage selections during a shorter period before the end of the year. Does a plan sponsor "receive a substantially complete application" on the day the enrollment information is submitted, on the last day of the open enrollment period, or on the last day of the verification period? If a plan sponsor conducts an annual open enrollment and ends up with 1,000 missing TINs, is it reasonable to conclude that there are up to 1,000 different account "opening" dates that require the plan sponsor to track up to 1,000 different 75-day enrollment periods?

Last, how does the IRS want Reporting Entities to "count" the requisite 75 days for purposes of the second solicitation? The proposed regulations say only that the "first annual solicitation must be made on or before the seventy-fifth day after the account is opened" without specifying any specific counting methodology. Do the 75 days include business days or calendar days? If the 75th day is a weekend or holiday, does the deadline extend until the next business day?

These are all fundamental questions, the answers to which may determine whether a Reporting Entity satisfies or fails to satisfy the TIN solicitation rules for missing TINs. If three solicitations are required, then the rules should not act as a trap for the unwary, and the lack of specificity regarding the start and end of the 75-day period is just such a trap. As we have suggested previously, ERIC members believe that the IRS needs to consider alternative approaches that would simplify administration and allow Reporting Entities to "batch" the second and third solicitations based on calendar dates (such as the end of specified calendar quarters). The approach advocated in the proposed regulations, requiring individual-by-individual solicitations based on separate 75-day measurement periods, simply isn't practical, particularly for Reporting Entities that that process hundreds, thousands, or more enrollments during the course of a calendar year.

COMMENTS ON FORMS 1095-B/1095-C AND INSTRUCTIONS

In reviewing the proposed regulations under Code section 6055, ERIC members offered several additional thoughts and comments on various issues associated with information reporting on Forms 1095-B and 1095-C. We direct these additional comments to your attention:

Issue #1 – Reporting Offers of COBRA Coverage

The instructions for the 2016 Form 1095-C impose the following regime with respect to individuals who receive an offer of COBRA coverage. For employees who lose health plan coverage based on termination of employment, the instructions indicate that an applicable large employer ("ALE") should use series 1 code 1H (no offer of coverage) on line 14, and series 2 code 2A (employee not employed during the month) on line 16 for any month "for which the offer of COBRA coverage applies" without regard to whether the employee or spouse or dependents enroll in the COBRA coverage. For employees who lose health plan coverage based on a

reduction of hours, an example in the instructions indicates that an ALE should use series 1 code 1B (minimum essential coverage offered to employee only) on line 14, but does not address which series 2 code to use (presumably either code 2B if the employee isn't a full-time employee and doesn't elect COBRA or code 2C if the employee, whether or not a full-time employee, does elect COBRA). The instructions do not provide any guidance related to Part III reporting for individuals who elect COBRA coverage offered by a self-insured group health plan.

We urge the IRS to clarify the instructions in the following ways:

- For employees who remain employed and receive an offer of COBRA coverage, the instructions should permit an ALE to continue to use series code 1E rather than code 1B. If the employee loses coverage based on a reduction of hours, the employee's dependents will also lose coverage. In that scenario, the COBRA coverage offered to the employee must be the same as the coverage offered to other eligible employees, and will generally include an offer of coverage to the employee, spouse and dependents. Permitting the continued the use of series code 1E will help align the Form 1095-C information with the tally of full-time employees noted on the Form 1094-C, Part III, column (a). The IRS should also address directly which series 2 code (or codes) are applicable to such employees.

- The IRS should clarify the meaning of an "offer of COBRA coverage." Under Code section 4980B (and the associated IRS and Department of Labor regulations), offers of COBRA coverage are durationally limited – a plan sponsor may have up to 44 days to provide a COBRA election notice, a COBRA qualified beneficiary then has 60 days to elect COBRA coverage, and the COBRA qualified beneficiary must pay the initial premium within 45 days of making the election. So if an employee has a reduction of hours in January, the "offer of COBRA coverage" may be open for as many as 149 days, but will thereafter close. If the employee does not elect COBRA coverage on a timely basis, or does not pay the first premium on a timely basis, the offer of COBRA coverage ends, and the appropriate series 1 code should be code 1H (no offer of coverage).

- For employees who terminate employment and elect COBRA coverage under a self-insured health plan, the instructions should clarify that an ALE may report the COBRA coverage information either on Form 1095-C, Part III or on Form 1095-B, Part III. As presently drafted, the instructions suggest that ALEs may report coverage information for non-employees on either Form, but in some cases the instructions seem to suggest that a non-employee is a person who was a non-employee for an entire year. In many cases, the coverage information related to COBRA qualified beneficiaries and/or employees who retire during a year is managed by a separate administrator, and can more conveniently be reported on the Form 1095-B. It should make no difference whether a former employee (either a COBRA qualified beneficiary or a retiree) was an active employee during part of the year. IRS should take into account that an employee may fluctuate in and out of an employer plan, or in and out of COBRA coverage, in a given year.

- Finally, the IRS should provide permanent penalty relief for employers with self-insured health plans that submit incorrect information on Form 1095-C (or Form 1095-B) for former employees who elect COBRA coverage. Given the lengthy timeframes described above for electing COBRA coverage, an employer may not know whether a former employee elected COBRA coverage before the applicable filing deadlines. For example, an employee who terminates employment and loses coverage in November 2016 may not actually make a COBRA election (and pay the requisite premium) until several months after the end of 2016. If the employer submits a "corrected" Form 1095-C for such a former employee within 60 days of learning of the COBRA coverage, it should not be subject to reporting penalties.

Issue #2 – Employer Acquisitions

The 2016 instructions do not address issues associated with employer acquisitions. In many industries, it is common for large employers (who are ALEs) to acquire small employers (who are not ALEs). But for the acquisition, the small employer would not have a Form 1094-C/1095-C reporting obligation. Unfortunately, Code section 6056 does not provide any special rules for these acquisitions.

We urge the IRS to clarify when an acquired small employer needs to be reported as a member of an Aggregated ALE Group on Form 1094-C, and when the acquired small employer must take on the responsibility of filing and furnishing Form 1095-C. Every acquisition is different – some acquisitions continue the acquired employer's health plan coverage for a fixed period of time or until the next annual enrollment for the health plan of the acquiring employer. Other acquisitions may terminate the acquired employer's health plan and make the employees of the acquired employer immediately eligible for the health plan of the acquiring employer. From a practical perspective, it takes time and resources to integrate the employees of an acquired employer into the human resource information system of the acquiring employer – typically the best source of data for determining whether particular employees are full-time employees for Code section 6056 reporting purposes.

We suggest that one approach might be to implement Form 1094-C/1095-C reporting rules consistent with the special rules found in Code section 410(b)(6)(C). In other words, if both an acquiring and an acquired employer satisfy the Form 1094-C/1095-C reporting rules prior to the acquisition, then temporary reporting relief would apply for both employers during a specified transition period. The duration of the special transition period should be the subject of IRS reflection and public comment. While the Code section 410(b)(6)(C) transition rule extends to the last day of the first plan year beginning after the change in members of a controlled group, such a rule may be too long for purposes of Form 1094-C/1095-C reporting.

Issue #3 – Agent Reporting

The 2016 instructions (like the 2015 instructions) do not permit agent reporting. Instead, each ALE (or ALE member) with an EIN must separately prepare a Form 1094-C and Forms 1095-C for any employee who was a full-time employee of that entity during the calendar year. In contrast, for Form W-2 and Form W-3 reporting purposes, agent reporting is permitted. For example, one or more members of a controlled group may designate the parent company (or another member of the controlled group) to act as its agent in satisfying the Form W-2 reporting requirements. The designation is accomplished by submitting Form 2678 to the IRS and receiving IRS approval. The agent designation approach is a routine and long-standing process, and allows members of a controlled group to centralize and coordinate their Form W-2 and Form W-3 reporting functions (as well as other employment tax reporting functions).[3]

We urge the IRS to consider expanding the agent reporting process to include Form 1094-C and Form 1095-C reporting. If agent reporting is acceptable for Form W-2/W-3 reporting purposes (and other employment tax purposes), there is no reason that the same process should not be acceptable for Form 1094-C/1095-C reporting purposes. Permitting agent reporting in this context would greatly simplify the reporting obligations of the members of an Aggregated ALE Group and would still provide the IRS with all the information necessary to

[3] For additional information, see the 2016 general instructions for Form W-2 and Form W-3, available here (see page 7) - https://www.irs.gov/pub/irs-pdf/iw2w3.pdf, the instructions for Form 2678 available here - https://www.irs.gov/pub/irs-access/f2678_accessible.pdf, and Rev. Proc. 2013-39, 2013-52 I.R.B. 830 available here - https://www.irs.gov/irb/2013-52_IRB/ar15.html.

enforce the employer shared responsibility provisions of Code section 4980H and the individual shared responsibility provisions of Code section 5000A.

ERIC appreciates the opportunity to provide comments on this IRS notice of proposed rulemaking. If you have questions concerning our comments, or if we can be of further assistance, please contact us at (202) 789-1400.

Sincerely,

James P. Gelfand
Senior Vice President, Health Policy