National Business Group on Health®

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

February 18, 2016

Submitted electronically via: Notice.comments@irscounsel.treas.gov

CC:PA:LPD:PR (Notice 2015-87)
Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington DC 20044

Re: Notice 2015-87: Further Guidance on the Application of the Group Health Plan Market Reform Provisions of the Affordable Care Act to Employer-Provided Health Coverage and on Certain Other Affordable Care Act Provisions

Dear Sir or Madam:

The National Business Group on Health is pleased to respond to the Internal Revenue Service's request for comments on guidance provided in Notice 2015-87.

The National Business Group on Health represents 429 primarily large employers, including 70 of the Fortune 100, who voluntarily provide group health plan coverage to over 55 million American employees, retirees, and their families. Our members employ and provide health coverage for employees under a wide variety of work arrangements, including full-time, part-time, seasonal, and temporary. They also often operate multiple lines of business in multiple states and tailor employee work and benefit arrangements to the specific needs of each employee population and line of business.

As our members prepare for implementation of the various Code requirements of the Affordable Care Act (ACA), primary concerns will be (1) minimizing the administrative and cost burdens associated with those requirements and (2) having flexibility to implement and maintain plan designs that lower the overall cost of health coverage.

Being able to adapt their regulatory compliance to current and future work, benefit, and payroll arrangements will reduce compliance burdens and allow plan sponsors to devote more resources to maintaining high-quality, cost-effective health coverage for employees and their dependents. Therefore, we support the Service's proposals to:

- Adjust the reference to 9.5% for purposes of the Code provisions described in Notice 2015-87's Question 12 to reflect the adjustment to the affordability provisions under Code § 36B(c)(2)(C)(iv) and

- Clarify the extent to which the rules under 29 C.F.R. § 2530.200b-2(a) are incorporated into the definition of hour of service under Code § 4980H.

However, our members are concerned with the Service's proposed treatment of opt-out payments for purposes of determining whether an applicable large employer has made an offer of affordable, minimum value coverage under Code §§ 36B, 5000A, and 4980H. Specifically:

- Neither Code § 36B nor Code § 5000A refer to opt-out payments as part of affordability or minimum value determinations for employer-sponsored coverage. To date, our members have relied in good faith on these Code provisions and implementing regulations when determining whether their plans are affordable and provide minimum value.

- Generally, neither our members nor their employees view opt-out payments as part of group health plan costs or the equivalent of salary reductions to pay for health coverage.

- The proposed treatment of opt-out payments would limit plan sponsors' flexibility in tailoring benefits and compensation to the specific needs of their employee populations.

- In some cases, opt-out payments are built into existing collective bargaining agreements, which may not terminate for a number of years. For employers contributing to group health plans under these CBAs, changing the treatment of opt-out payments may change affordability and minimum value determinations when employers have little or no flexibility to modify opt-out payments, premium contributions, or plan designs.

Therefore, we recommend that the Service not treat opt-out payments—unconditional or otherwise—in the same manner as salary reductions for purposes of determining an employee's required contribution under Code §§ 36B, 5000A, and 4980H. In the alternative, we recommend that future guidance exempt (1) payments conditioned on spousal coverage or other factors, (2) payments required under collective bargaining agreements, and (3) insubstantial payments (such as those below $1000) from this treatment.

Finally, we recommend that in setting an effective date for regulations, the Service consider the administrative requirements of large, self-insured group health plans. Most of our members implement plan design changes on a plan year basis, which may or may not coincide with the calendar year. In addition, our members tend to finalize any plan design changes up to a year before their implementation because our members' plans cover large populations, often include different plan options and designs tailored to specific participant populations, and often require coordination with multiple third-party administrators and vendors. Therefore, we recommend that any final rules become effective no earlier than the first day of the first plan year beginning 12 months after the issuance of final regulations.

Thank you for considering our comments and recommendations. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012 if you would like to discuss our comments in more detail.

Sincerely,

Brian Marcotte
President