March 11, 2011

Submitted electronically to Notice.Comments@irscounsel.treas.gov.

CC:PA:LPD:RU (Notice 2011-1)
Room 5203
Courier's Desk
Internal Revenue Service,
1111 Constitution Avenue, NW
Washington, DC 20224

Re: Comments Regarding the New Nondiscrimination Rules for Insured Group Health Plans As Set Forth in The Patient Protection and Affordable Care Act

Dear Sir or Madam:

I am writing on behalf of the American Benefits Council ("Council") in response to Notice 2011-1, issued on December 22, 2010 by the Department of Treasury ("Treasury") and the Internal Revenue Service ("IRS") (collectively, the "Department"), which requests written comments regarding the application of the nondiscrimination rules to insured group health plans. This letter follows up on the Council's earlier letter dated November 4, 2010, which was submitted in response to related Notice 2010-63.

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to retirement and health plans that cover more than 100 million Americans.

The Patient Protection and Affordable Care Act (the "PPACA" or "Act"), as amended by the Health Care and Education Reconciliation Act ("HCERA"), in part, adds a new section 2716 to the Public Health Service Act ("PHSA"). New PHSA section 2716 generally provides that insured group health plans must satisfy the requirements of Internal Revenue Code ("Code") section 105(h)(2), and that "rules similar" to section 105, paragraphs (h)(3) (nondiscriminatory eligibility classification), (h)(4) (nondiscriminatory benefits), and (h)(8) (certain controlled groups) shall apply. New PHSA section 2716 is incorporated by reference into Code section 9815(a)(1) to the Internal Revenue Code ("Code") and section 715(a)(1) of the Employee Retirement Income Security Act ("ERISA").[1]

We commend the Department for its continued efforts with respect to the implementation of new PHSA section 2716. The Council appreciates the Department's issuance of Notices 2010-63

[1] For purposes of this memorandum, unless expressly provided otherwise, all references to "PHSA section 2716" should be read to include the parallel provisions in Code section 9815(a)(1) and ERISA section 715(a)(1).

and 2011-1 and the opportunity to provide written comments with respect to new PHSA section 2716.

Our members appreciate the important transition relief that was made part of Notice 2011-1. Given the lack of clarity with respect to the existing nondiscrimination rules for insured arrangements (and self-insured arrangements as well), and the impending start to the 2011 plan year, there was a very real likelihood that at least some employers would have felt compelled by PPACA's insured plan nondiscrimination rules to eliminate group medical coverage for highly and non-highly compensated employees for the 2011 plan year. The transition relief helped avoid loss of coverage for American workers and families by delaying the application of those rules.

As set forth below, it is important that the transition relief provided in Notice 2011-1 be extended at least through plan years beginning in 2013. There remains a significant possibility that imposing new nondiscrimination rules prior to 2014 will compel some employers to eliminate group medical coverage for their highly and non-highly compensated employees. Thus, unless and until meaningful alternatives to employer-sponsored coverage exist – such as beginning in 2014 when individuals can access comprehensive medical coverage through state-based exchanges along with premium and cost-sharing tax credits – the new insured plan nondiscrimination rules should not be imposed because they may deprive a significant number of families of access to important medical coverage.

This letter more fully discusses these issues as well as a range of other concerns regarding new PHSA section 2716. In summary, we recommend the following:

- ***The transition relief provided in Notice 2011-1 for the 2011 plan year should be extended at least through plan years beginning in 2013.*** Such relief will help ensure that no American worker loses coverage by reason of new PHSA section 2716, at least until a time when they may have meaningful alternatives (such as after 2014 when state-based exchanges will be in effect along with premium tax credits).

- ***Any future rulemaking should be issued in proposed form and allow for further written comment; such rulemaking should only become effective after a specified period of time following the issuance of final regulations.*** To ensure that all interested parties have a meaningful opportunity to provide written comments, any future rulemaking should be issued in proposed form only and interested parties have been afforded a meaningful opportunity to provide written comment. Additionally, to ensure that employers have sufficient time to implement any new rules, any final rules should only become effective after a specified period of time following their issuance (*e.g.*, for plan years commencing on or after the anniversary date of final rulemaking).

- ***Clear, Workable Rules Are Also Needed With Respect to Self-Insured Arrangements.*** As discussed in greater detail in our November 4th letter, there is very little interpretive authority regarding Code section 105(h)(2), notwithstanding that Code section 105(h) was added to the Code over 30 years ago. This limited and, we respectfully submit, outdated, inadequate, and unworkable interpretive authority has created great uncertainty over the scope and mechanics of the *self-insured* health plan nondiscrimination rules. Whether as part of this rulemaking process or as part of a

separate initiative, the Council urges the agencies to withdraw the existing regulations that apply with respect to self-insured arrangements ("Existing Regulations") and issue new proposed rules that are clear, workable, and that reflect the benefit plan arrangements offered by employers today.

- ***Any future rulemaking process should acknowledge the Department's authority to issue rules that are materially different from those that currently apply to self-insured arrangements***. It is our understanding the Department is concerned that it may lack sufficient authority to issue rules that diverge from those that apply to self-insured arrangements. Although we fully appreciate the Department's deliberative approach to rulemaking, we believe the express statutory language of new PHSA section 2716(b)(1) provides the Department with the sufficient flexibility to establish rules for insured group plans that differ from those set forth in the Existing Regulations; this includes with respect to any eligibility and benefits test that may apply.

- ***Future rulemaking should take into account the different legal and purchasing environment that will exist post-2013.*** PPACA mandates very significant changes to the health insurance environment in 2014. These include guaranteed issue coverage from state-based exchanges and significant premium and cost-sharing tax credits to ensure that all individuals have the financial means necessary to purchase such coverage. The Council urges the Department to issue rules that not only take into account this changing landscape, but that work in concert with the new reforms. As discussed in greater detail below, to that end, the Council urges the Department to establish a safe harbor rule for purposes of new PHSA section 2716 that takes into account of employer's compliance with certain provisions of the Act's shared responsibility (or "pay or play") requirements.

- ***Additional comments with respect to any future rulemaking***. In addition to the foregoing, we also provide comment regarding the following:

    - To the extent a benefits test is applied, the term "benefits" should be expressly defined as part of any future rulemaking. Such definition should make clear that a "benefit" is limited to only those goods and services that are reimbursable or payable by the plan and thus does not include premium subsidies and waiting periods.
    - Employers should be permitted to treat two plans as a single plan for purposes of any eligibility and benefits test where a third party, licensed actuary certifies that the plans are actuarially equivalent.[2] In determining "actuarial equivalence", state mandated benefits and geographic cost differentials should be disregarded. Additionally, "actuarial equivalence" should be found where (i) a plan is within a specified "corridor", *e.g.*, within X% above or below the actuarial value of the designated plan, or (ii) each of

[2] For purposes of this letter, any references to "actuarially equivalent" are not with respect to PPACA section 1302, where similar terminology is used, but rather are intended solely to encompass the actuarial concept of valuing the economic benefits provided by a plan or arrangement.

the plans to be aggregated provides at least a "bronze" level of coverage, within the meaning of PPACA section 1302.

- An employer should be permitted to use the definition of "highly compensated employee" ("HCE") that applies under Code section 410(b) and corresponding Code section 414(q) for purposes of new PHSA section 2716.

- To ensure that employers have sufficient flexibility to tailor benefit offerings to different workforce populations, employers should be allowed (but not mandated) greater flexibility to differentiate employees, such as by reason of any geographic location or work duties. Additionally, employers should be permitted to provide lower-cost coverage to employees who may not be able to afford the comprehensive coverage being provided to other employee groups. This last proposed rule is necessary to ensure that lower-wage employees continue to have access to important medical coverage, while ensuring that employees within the same controlled group who can afford comprehensive coverage are not denied access to such coverage by operation of the nondiscrimination rules.

- Employers should be permitted to discriminate in favor of non-Highly Compensated Employees.[3] Moreover, plans that cover only non-HCEs should not be subject to nondiscrimination requirements.

- Inpatriate and expatriate plans, given their unique structure and purpose, should be excepted from any nondiscrimination requirements.

- With respect to a multiple employer plan, the nondiscrimination rules should apply at the level of the participating employer and not the plan. Thus, any testing should be the responsibility of each participating employer and any penalties should be determined with respect to each participating employer.

- Where an HCE's coverage is paid for by the HCE on an after-tax basis, the coverage should be ignored for purposes of any nondiscrimination requirements.

- To the extent eventual nondiscrimination rules are based on participation or utilization rates by non-HCEs, any non-HCEs who waive group coverage in favor of other coverage should be deemed participants for purposes of such rules.

- As is the case with respect to tax-qualified retirement and pension plans, employers should be excepted from any nondiscrimination requirements for an up to two-year transition period following any significant business reorganization (such as a merger or acquisition).

[3] The Council recognizes that Code section 105(h)(5) references a "highly compensated individual" ("HCI"). Nonetheless, in light of our requested rule that employers be permitted to use a Code section 414(q) definition of HCE and to avoid any confusion throughout this letter, we shall refer generically to HCEs rather than HCIs.

The Transition Relief Provided In Notice 2011-1 for the 2011 Plan Year Should Be Extended At Least Through Plan Years Beginning In 2013

The Council appreciates the transition relief that was included as part of Notice 2011-1. Absent such transition relief, it is likely that a significant number of employees would have lost access to important employer-sponsored group health coverage by reason of new PHSA section 2716.

The Council urges the Department to extend the transition relief in Notice 2011-1 through at least plan years beginning in 2013. We make this request because of our concern that imposing new nondiscrimination rules at any time prior to 2014 could result in employees (and their families) losing access to affordable, comprehensive medical coverage. This is because, to the extent an employer feels compelled by reason of PHSA section 2716 to cancel group coverage for its employees, affected employees will likely be forced to seek coverage for themselves and their families in the individual insurance market. As the Department is aware, premium rates in the individual market are generally much higher than those that apply to insured group coverage, and in many instances these higher rates may act as a bar to individuals securing coverage. Moreover, the medical underwriting and eligibility rules in the individual insurance market may make individual coverage difficult to obtain or even unavailable.

Beginning in 2014, individuals will be permitted to purchase coverage through their state's health exchange. Additionally, beginning in 2014, lower-income individuals (with household incomes up to 400% of the federal poverty level) will be eligible for significant premium and cost-sharing subsidies to make coverage purchased through an exchange more affordable. These post-2013 developments should help mitigate any adverse consequences that may result by imposing new nondiscrimination rules for insured group plans.

In light of the foregoing, the Council requests that the transition relief provided in Notice 2011-1 be extended at least through plan years beginning in 2013.

Any Future Rulemaking Should Be Issued in Proposed Form And Should Allow For Meaningful Review And Comment. Employers Should be Afforded Sufficient Time to Implement Any Final Rule

The Council urges the Department to issue any future rulemaking in proposed form and provide for proposed effective dates. Doing so will help ensure that all interested parties have a meaningful opportunity to submit comments, which we believe will be helpful to the Department in formulating future guidance.

Additionally, any final rule should be subject to a delayed effective date to ensure that employers have sufficient time to comply with any new rules. Employers will need time to review and understand the final rule, especially with respect to their own group plans. They may also need to modify their existing plan offerings in light of such new rules. This may include formally amending plans; designing and negotiating changes with issuers and service providers; and revising a myriad of plan disclosures and participant notices.. All of this takes time. The Council, therefore, requests that any final rules only be effective for plan years beginning on or after the anniversary date of the issuance of any such final rule, and no sooner than January 1, 2014.

Clear, Workable Rules Are Also Needed With Respect to Self-Insured Arrangements.

As discussed in greater detail in our November 4th letter, there is very little interpretive authority regarding Code section 105(h)(2), notwithstanding that Code section 105(h) was added to the Code over 30 years ago. This appears to be due in large part to the IRS's long-standing "no ruling" position with respect to Code section 105(h) generally. As a result, there exists only Treasury Regulation § 1.105-11, as well as a handful of private letter rulings dating back to the 1980s. This limited and, we respectfully submit, outdated, inadequate, and unworkable interpretive authority has created great uncertainty over the scope and mechanics of the self-insured health plan nondiscrimination rules.

In light of the foregoing, whether as part of this or a separate rulemaking process, the Council urges the agencies to withdraw the Existing Regulations and issue new proposed rules with respect to self-insured plans that are clear, workable, and reflect the benefit plan arrangements offered by employers today.

Any future rulemaking process should acknowledge the Department's authority to issue rules that differ from those that currently apply to self-insured arrangements.

The Department has requested specific comment regarding whether it has sufficient authority to issue rules that diverge from those that currently apply to self-insured arrangements. As noted in our November 4th letter, we believe that the express statutory language of new PHSA section 2716(b)(1) provides the Department with sufficient authority to establish different rules.

When Congress enacted new PHSA section 2716, Congress expressly chose to <u>not</u> incorporate the rules of paragraphs (h)(3) (regarding the nondiscriminatory eligibility test) and (h)(4) (regarding the nondiscriminatory benefits test) in their current form for purposes of new PHSA section 2716. Specifically, new PHSA section 2716(b)(1) states that:

> *Rules similar* to the rules contained in paragraphs (3) [establishing a nondiscriminatory classification eligibility test], (4) [requiring a plan to provide the same benefits to non-HCEs as it provides to HCEs], and (8) [setting forth a controlled group definition of "employer"] of section 105(h) of such Code shall apply. (Emphasis added.)

We read the reference to "rules similar" in PHSA section 2716(b)(1) to clearly provide the Department with sufficient authority to issue substantive rules that diverge from those set forth in the Existing Regulations under Code sections 105(h)(2)-(4), including with respect to the nondiscriminatory eligibility and benefits test.[4] For example, we believe that PPACA gives the Department sufficient authority to promulgate insured plan nondiscrimination rules that allow for increased differentiation among employee groups, such as where based on work duties or

[4] PHSA section 2716 expressly states that insured group health plans must satisfy existing Code section 105(h)(2). Section 105(h)(2) of the Code requires only that the plan "not discriminate in favor of highly compensated individuals as to eligibility to participate, and that "the benefits provided under the plan do not discriminate in favor of participants who are highly compensated individuals." Paragraph (h)(2) does not require the Department to establish an eligibility test that incorporates a utilization component, nor does it prohibit alternative testing approaches to those set forth in existing regulations (such as testing on a geographic basis).

geographic location. We also believe PPACA gives the Department sufficient authority to fashion a set of rules that, similar to the approach that currently applies under the qualified retirement plan rules for cash or deferred arrangements[5], determines a plan's nondiscriminatory eligibility and benefits based on broad access to coverage, *i.e.*, eligibility, versus actual participation.

In addition, the Council does not believe that Code section 105(h) mandates the nondiscrimination rules currently set forth in the Existing Regulations. Thus, as discussed above, we believe the Department has the necessary authority to withdraw the Existing Regulations and propose new, more modern, comprehensive, and workable rules for self-insured plans.

Future Rulemaking Should Take Into Account the Different Legal and Purchasing Environment That Will Exist Post-2013.

Under PPACA, very significant changes to the health insurance landscape will take effect in 2014. These include the establishment of state-based exchanges for the guaranteed-issue sale of qualifying health coverage, and the availability of significant premium tax credits and other subsidies that will make such coverage more affordable.

In light of these important changes, the Council urges the Department to consider issuing rules that not only take into account this changing landscape, but that work in concert. More specifically, the Council urges the Department to establish a set of safe harbor rules for purposes of new PHSA section 2716 that take into account an employer's compliance with all or some of an employer's shared responsibility requirements.

Beginning in 2014, employers with at least fifty full-time employees generally will be required to comply with a host of employer responsibilities, or otherwise be subject to very substantial financial penalties. These rules are more commonly referred to as "pay or play." In order to avoid financial penalty, an employer generally must make available to all full-time employees minimum qualifying coverage ("Qualifying Coverage Rule")[6] and such coverage must be affordable ("Affordable Coverage Rule")[7]. The Affordable Coverage Rule will, in many instances, compel employers to increase their subsidies to such generally non-HCE employees to ensure that their coverage is affordable.

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[5] *See* Treasury Regulation § 1.410(b)-3(a)(2).

[6] *See* new Code section 4980H(a), as added by PPACA section 1513(a). Code section 4980H(a) compels applicable employers to provide "minimum essential coverage" within the meaning of new Code section 5000A(f)(2) generally to all full-time employees, or pay a financial penalty. Individual insurance and small group insurance within the definition of "minimum essential coverage" must provide, at a minimum, the "essential health benefits package" as set forth in PPACA section 1302(a). Accordingly, such insurance shall provide comprehensive medical coverage to all insureds.

[7] *See* new Code section 4980H(c), as added by PPACA section 1513(a). Code section 4980H(c) generally requires employers to provide "minimum essential coverage" that is "affordable" to any full-time employee with household income from 100% to 400% of the federal poverty, or pay a financial penalty.

The Council urges the Department to consider establishing a safe harbor rule that would except an employer from the nondiscrimination rules to the extent the employer complies with the Qualifying Coverage Rule (without regard to the Affordable Coverage Rule). Under such a safe harbor rule, an employer would be deemed compliant for purposes of PHSA section 2716 if it provides at least minimum qualifying comprehensive insured group medical coverage to all full-time employees.[8]

The above proposed rule makes sense for a variety of reasons. First, the Qualifying Coverage Rule effectively operates as a nondiscrimination rule by requiring employers to provide minimum qualifying coverage on a broad basis to all full-time employees. Second, employers, especially smaller employers, need easy-to-follow rules; otherwise compliance rates tend to decline. Given that employers will already need to satisfy the Qualifying Coverage Rule if they seek to avoid significant financial penalty, there is no need to layer on top another set of rules; doing so would likely serve only to confuse many employers and facilitate noncompliance or, alternatively, incent some employers to drop or otherwise forego employer-sponsored coverage altogether. Third, the costs to employers of complying with any nondiscrimination regime should not be ignored. The Qualifying Coverage Rule will impose serious financial costs on most employers. Thus, layering on top another nondiscrimination regime, *i.e.*, PHSA section 2716, would serve only to increase costs for employers, and could encourage some employers to exit the employment-based system altogether.

For these reasons, we urge the Department to establish a safe harbor rule that works in concert with the Act's shared responsibility provisions, as set forth above. We believe doing so will both facilitate increased compliance by employers with the Act's Qualifying Coverage Rule and encourage employers to continue to be a source of valuable health coverage for their employees.

Additional Guidance Is Needed on a Range of Issues.

In addition to the issues discussed above, guidance is needed with respect to a range of substantive issues, on many of which the Department requested written comments. We address these issues below.

- ***"Benefits" should be limited to goods and services that are subject to reimbursement or direct payment by the plan.*** As discussed in our November 4th letter, it is not entirely clear under the Existing Regulations what constitutes a "benefit" that is subject to nondiscrimination requirements. To the extent a benefits test is made part of any future rulemaking with respect to insured group plans, the Council requests that an express definition of "benefit" be included as part of any such rulemaking.

[8] Because post-2013 insured group health plans must provide the "essential health benefits package" within the meaning of PPACA section 1302 (to the extent such coverage is to qualify for purposes of PPACA's individual coverage requirement), whether purchased by an employer through a state-based change or otherwise, the proposed safe harbor rule will ensure that all full-time employees have access to meaningful and comprehensive medical coverage. Additionally, there is no need as part of such safe harbor rule to also mandate compliance by employers with the Affordable Coverage Rule. This is because employers will remain subject to the very significant financial penalties that apply in the event coverage offered to a full-time employee is not affordable. Additionally, to the extent such coverage is unaffordable for a given employee, they will be able to secure coverage through a state-based exchange along with very valuable premium and cost-sharing subsidies.

Additionally, the Council urges the Department to make clear that a "benefit" is limited to only those goods and services that are reimbursable or payable by the plan and does not include premium subsidies and waiting periods.

- ***Actuarial Equivalence should be available to employers for purposes of measuring plan benefits.*** Existing regulations with respect to self-insured arrangements do not appear to allow actuarial equivalent plans to be combined for testing purposes. To the extent plans cannot be tested separately by business unit, job category, geographic location, etc., without regard to other coverage it will likely be very difficult for multi-state employers with insured plans, to prove nondiscrimination unless their plans can be aggregated for testing purposes and treated as single plan. This is because insurance contracts generally may not apply to persons residing outside of the state in which they are underwritten. Accordingly, employers should be permitted to treat two plans as a single plan for purposes of any eligibility and benefits test where a third party, licensed actuary certifies that the plans are actuarially equivalent. "Actuarial equivalence" should be determined without regard to state mandated benefits and geographic cost differentials. Additionally, "actuarial equivalence" should be found where (i) a plan is within a specified "corridor", *e.g.*, within X% above or below the actuarial value of the designated plan, or (ii) (ii) each of the plans to be aggregated provides at least a "bronze" level of coverage, within the meaning of PPACA section 1302.

- ***Employers should be permitted to use a Code section 414(q) definition of "highly compensated employee" ("HCE").*** As the Department is aware, the definition of HCI set forth in Code section 105(h)(5) is substantially broader than the HCE definition that applies to qualified retirement plans under Code section 414(q). This difference is unnecessary and confusing. Thus, the Council requests that the definition of HCI be the Code section 414(q) HCE definition.[9] This definition clearly is more appropriate, as using a single HCE definition will make benefit plans easier to administer, and will avoid an absurd result that could occur under section 105(h)(5) with respect to employers with relatively large low-paid workforces, *e.g.*, turning non-HCIs earning the minimum wage into HCIs simply because of their overtime hours.

- ***Differentiation in benefits by employers should be permitted where based on objective business criteria, including whether such coverage is affordable for employees.*** To ensure that employers have sufficient flexibility to tailor benefit offerings to different workforce populations, the Council urges the Department to issue regulations that permit (but do not mandate) differentiation in benefits by employers across employee groups, such as by geographic location or skill set. Additionally, employers should be permitted to provide lower-cost coverage to employees who make less relative to the employee population to ensure that such individuals have meaningful access to employer-sponsored coverage. Absent such a

[9] Although it may be difficult to interpret Code section 105(h) as permitting use of the HCE definition, the Council believes that the Department may be able to promulgate such an interpretation or at least an enforcement position that has substantially similar effect. At a minimum, the Code section 414(q) HCE definition should apply for the limited purpose of establishing a nondiscriminatory classification per Code section 410(b) and the related regulations.

rule, employers may find themselves unable to provide appropriate medical coverage to different employee groups across a single controlled group. Under such a rule, for example, an employer would be permitted to offer a lower-cost HMO to workers who cannot afford the PPO that is provided to its other employees, or to provide specialized coverage based on unique occupational hazards (such as with respect to electrical line workers or mine workers).

- ***Discrimination in favor of non-HCEs should be permitted and plans covering only non-HCEs should be excepted from any nondiscrimination rules.*** It is not entirely clear under the existing rules that apply to self-insured arrangements whether a plan may discriminate against HCEs in favor of non-HCEs. Notably, tax-qualified retirement plans are generally allowed to discriminate in favor of non-HCEs. Moreover, we can think of no reason why the Department should be concerned by discrimination by employers in favor of non-HCEs. On a related note, plans that apply only to non-HCEs should be excepted from any nondiscrimination rules.

- ***Inpatriate and expatriate plans should be exempt from the nondiscrimination rules.*** Many U.S. employers with operations abroad provide coverage to U.S. residents working abroad. The same is true for foreign corporations that have U.S. operations, where employees may come to the U.S. for a limited period of time. Typically these types of coverage are for a limited duration and are provided to employees only for the duration of their overseas assignment. Given the inherent variability in insurance contracts, and also because of differences in medical systems between countries, the benefits provided as part of such coverage quite often differ from that provided to employees working and residing in the U.S. Any differences in benefits are not based on any discriminatory intent, but rather, are intended to create parity in coverage for recipients of such coverage and to ensure access to comprehensive medical coverage. Given their unique nature and purpose, the Council requests that inpatriate and expatriate plans be excepted from any nondiscrimination requirements.

- ***Nondiscrimination requirements with respect to multiple employer plans should apply with respect to each participating employer and not at the plan level.*** The Council requests that any nondiscrimination requirements apply with respect to each participating employer of a multiple employer plan (as is the case with tax-qualified retirement plans). A contrary rule would effectively prohibit participating employers from providing individualized benefit offerings to their employees; this includes employers in certain high-risk industries that generally seek to provide important, albeit unique or special benefits to their employees (such as miners or electrical line workers). Moreover, if a contrary rule were promulgated, if one participating employer violated the nondiscrimination rules, this could operate to "taint" the whole plan and subject all of its participating employers to substantial monetary penalties and potential ERISA litigation risk.

- ***Discriminatory after-tax coverage should be excepted from nondiscrimination requirements.*** To the extent that discriminatory coverage is paid for by an HCE on an after-tax basis, the coverage should be excepted from PHSA section 2716. This approach generally works with respect to self-insured coverage because it has the

effect of making the arrangement one that is taxed under section 104(a)(3) of the Code, which has no nondiscrimination requirements. For purposes of parity between insured and self-insured arrangements, and because such a rule eliminates any tax benefit to the HCE, the Council requests that the treatment afforded after-tax coverage under Code section 105(h) be applied for purposes of PHSA section 2716.

- ***To the extent that any nondiscrimination rules are based on participation or utilization rates by non-HCEs, non-HCEs who waive group coverage in favor of other coverage should be deemed participating.*** Making coverage available to non-HCEs (provided, of course, that the coverage is at least equivalent to the coverage offered to HCEs) would seem to satisfy the intent of any nondiscrimination regulatory regime, *i.e.*, that non-HCEs have the ability to elect coverage that is the equivalent of that offered to HCEs. A contrary rule would make employers assume the risk of nonparticipation by non-HCEs, even where the coverage is equivalent to, or perhaps even superior to, the coverage offered to HCEs. This could potentially require employers to offer greatly enhanced benefits to only non-HCEs solely to incentivize them to participate. Thus, if the eventual nondiscrimination rules are based on participation or utilization rates by non-HCEs, the Council believes that non-HCEs who waive group coverage in favor of other coverage should be deemed to be participating in the group coverage. For example, if the non-HCE chooses to be covered under a spouse's health plan, a parent's health plan, a plan the non-HCE purchases on the exchange, or another lower or higher cost health plan offered by the employer, he or she should be deemed to be receiving any waived coverage.

- ***Employers should be excepted from the nondiscrimination rules for an up to two-year transition period following a business reorganization (such as a merger or acquisition).*** As permitted with respect to tax-qualified retirement plans, employers should be excepted from any nondiscrimination requirements for an up to two-year transition period following a significant business reorganization, such as a merger or acquisition. Any other rule would place employers in the almost impossible situation of having to comply with nondiscrimination rules before they have sufficient time, resources, or information to do so.

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Thank you for the opportunity to comment and for considering our recommendations. Please contact me at kwilber@abcstaff.org or 202- 289-6700 with any questions or if we can be of further assistance.

Sincerely,

Kathryn Wilber