June 6, 2022

The Honorable Charles Rettig
Commissioner, Internal Revenue Service
U.S. Department of Treasury
1111 Constitution Avenue NW
Washington, DC 20224

RE: REG-114339-21

Dear Commissioner Rettig:

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefits specialists. The members of NAHU work daily to help millions of individuals and employers of all sizes purchase, administer, and utilize health insurance coverage, including helping them comply with all applicable laws, such as the Affordable Care Act (ACA). Since 2014, our members have been helping clients on the individual level regarding eligibility for premium tax credits and on the employer-level concerning compliance with the affordability and minimum-value requirements in the ACA's employer-shared responsibility provisions. As such, NAHU members have a wide volume of direct experience with the so-called "family glitch" on the individual health insurance consumer and employer group health plan sponsor levels. We are grateful to have the opportunity to comment on the proposed rule titled "Affordability of Employer Coverage for Family Members of the Employees," published in the *Federal Register* on April 7, 2022.

The proposed rule would change the employer coverage "affordability" rules for people who have access to group health coverage through their familial relationship to an eligible employee. This regulatory change would establish that a spouse or other qualified dependent of an employed individual may be offered access to employer-sponsored health coverage through their relative's group health plan that is "unaffordable" for them for ACA premium-tax credit eligibility purposes. Such coverage offers may be deemed "unaffordable" to them even though their employee relative has an affordable offer of self-only coverage from the same employer group health plan sponsor. Finding a solution to the family glitch has long been a policy priority of NAHU so our organization supports the intent of this proposed measure. However, we have many significant concerns about the proposed timeline and believe much more regulatory and sub-regulatory guidance, as well as data, is needed to effectively implement this measure.

Proposed Implementation Timeline

The timeline outlined in the proposed rule would make this change effective for taxable years beginning after the finalization of the rule. The preamble of the proposed regulation notes that the IRS intends to

finalize this matter no later than the end of 2022, meaning that it will affect the 2023 health coverage year and the rapidly forthcoming 2023 individual market open enrollment season, which is slated to begin for the federal health insurance marketplace and most state-based health insurance exchanges on November 1, 2022. While NAHU members appreciate the impact the proposed rule could have on many Americans by increasing their access to subsidized individual market coverage, as well as the Biden administration's desire to expand that access to lower-cost health insurance as soon as possible, our members believe that rushed implementation will cause a wide range of inadvertent negative effects on individual subsidy-eligible consumers and the overall health insurance market. As such, we recommend a delay in regulatory action until at least 2023 (meaning an effective date of January 1, 2024, or later) so that consumers, employers and federal and state officials will have adequate time to prepare and mitigate the impact of unintentional consequences outlined in detail below.

Overall Market Uncertainty Due to Potential Upcoming Changes to Current Sources of Subsidized Health Insurance Coverage

Right now, due to policy changes related to the COVID-19 pandemic and related economic upheaval, millions of Americans have greater access to Medicaid coverage. Millions of other Americans have access to some level of expanded premium tax credit subsidies due to the American Rescue Plan Act. However, the length of time of the expanded Medicaid access is tied to the end of the pandemic national health emergency, which is currently predicted to end this coming October. Expanded subsidy access is also slated to conclude at the end of 2022, and the legislative status of a proposed extension of the increase in subsidies is uncertain. So, as it stands, the overall state of currently subsidized health insurance could be in upheaval during the upcoming 2023 individual market open enrollment period (OEP), which for most Americans will be from November 1, 2022, to January 15, 2023. Subsidy-level and Medicaid eligibility status uncertainty for many Americans this fall will not allow for accurate premium determinations heading into the OEP.

Many individuals already struggle to understand how existing premium tax credits work, what factors impact their eligibility, and how changes to their income and employer coverage status may impact their costs and ultimate federal income tax liability. NAHU members routinely encounter individuals who have made income-related mistakes concerning their premium tax credits and exchange-based coverage. The result for many is having to pay back their premium tax credit, sometimes for great sums of money. These unfortunate occurrences have happened during normal enrollment years. If this regulation is finalized and implemented for 2023, consumers will have to juggle adjustments to Medicaid and overall income levels related to looming subsidy changes, but then factor in the new subsidy-eligibility criteria this rule could create. Doing all of this at the same time is likely to result in even more errors. A year extension in the implementation timeframe will allow for some of these uncertainties to be resolved, allowing for a smoother transition to enrolling this population.

Impact on Individual Health Insurance Marketplace Consumers

It is also important to acknowledge the impact this change will have on the spouses and other dependents who may be become eligible for subsidized exchange-based coverage and the individual market. A shift to the individual market and subsidized coverage may not be in the best overall financial or medical interest of spouses and dependents, despite the initial allure of potential subsidy eligibility. Families will need to consider overall household income, which will impact exchange-based eligibility, as well as factors like separate (and thereby higher) maximum out-of-pocket limits and deductibles when considering a potential shift away from employer-based coverage for all or part of their family. Scope of medical coverage, provider and facility access, and customer service, support and health plan design features all have an intrinsic value, as well. There are other benefits of being part of an employer-sponsored group plan. Individual coverage is not always as robust or innovative as what is offered through many employer-sponsored plans, particularly when employer coverage access comes through a self-funded group plan. Another consideration is enrollment and year-round coverage support. Despite best efforts, there are likely to be many Americans who will switch to exchange-based subsidized individual coverage, then will not have access to the kind of enrollment and year-round claims and coverage assistance they had previously in the employer-based system.

This rule assumes a degree of education about the cost and design of employer plan coverage that both employers and employees are not prepared for right now. Employees and their families will need to have and simultaneously synthesize an extraordinary amount of financial and health coverage information available to them from both their employer plan and the exchange-based options. The exchange notices required as part of the ACA could be a source of this information, but that requirement only applies to employers that are subject to the Fair Labor Standards Act, which is most, but certainly not all, entities that offer group coverage. Currently, applicable employers are only required to distribute the exchange notice to employees when they hire them, so there is no available mechanism to ensure all potentially affected employees and relatives have the financial and coverage information they will need to make informed choices. The Department of Labor's template exchange notice for group plan sponsors would also need to be updated to accurately reflect the new coverage realities of this rule. Bottom line: Both employers and employees will need substantial time to adjust to the proposed regulatory changes, and there are no guarantees that employer group health plan sponsors will educate (or are even capable of educating) their employees about cost options in a way needed to make this successful.

Individual Health Insurance Market Impact

Changes to the makeup of the individual health insurance market nationally also will shift costs and risks. Health insurance issuers are working on their final individual market plan designs and proposed rates for the 2023 plan year right now, when there is tremendous uncertainty about the number of Americans who will be eligible for subsidized individual coverage in 2023. As we know from recent history, when the status of cost-sharing reduction payments was unclear to issuers at the time they were developing future-year premium rates, issuers will need to be extraordinarily conservative in their upcoming rate

estimations to protect their risk pools and financial solvency for the year ahead. A delay in implementation by a year or more will allow issuers to set premium rates for the first time based on better data and clarity about what the market they will be insuring will be like.

Impact on the Employer-Based Health Insurance Market

While we recognize the intent of the proposed rule is to expand access to coverage, it is important to note the impact this proposed change could have on the volume of individuals covered through their employers. The preamble to the proposed rule indicates that 5.1 million Americans are impacted by the family glitch, but the Administration only anticipates 200,000 people will gain coverage in the marketplace under the new rule. NAHU members believe that this estimate is very low and likely based on a lack of accurate employer plan data. Any sizable shift in the size of the employer group market will have an overall impact on market stability and costs that could reverberate nationwide.

On an individual employer level, any decline in the overall coverage population will have an impact on premiums. In most cases, it will take at least one renewal cycle to affect costs.But, make no mistake, in any group plan where a sizable number of dependents and spouses leave for the exchange, the price impact for the employer and remaining employees will be significant.

Individual group health plan sponsors also need to be mindful of participation requirements. If enough spouses and dependents leave an employer plan due to the policy changes outlined in the proposed rule, then there is the potential for some employer groups to fail to meet participation requirements, lose their access to purchase coverage and be forced to pay a costly penalty. There is also equity of benefits to employees to consider. If an employer shifts and provides more coverage for spouses and dependents to keep them on the employer plan, will that cause an imbalance of benefits and pay as compared to employees who are receiving self-only coverage?

Impact on Non-Calendar-Year Plans and Plan Participants

This proposed rule would take effect for the 2023 tax year, and individuals who could be newly eligible for premium tax credits due to its changes would need to enroll in exchange-based coverage during the 2023 open-enrollment window, which generally will be between November 1, 2022, and January 15, 2023. This timeline works for individuals whose employer-plan open-enrollment window for the 2023 plan year lines up with the exchange open-enrollment window. Even in calendar -year employer plans, that might not be the case. What this proposal fails to take into consideration is the impact on spouses and other dependents who are eligible for coverage through non-calendar-year plans. In the employer market, calendar-year plans are common, but they are less than half of all group plans. Put another way, somewhere in the neighborhood of 80 million to100 million Americans with group coverage will have their group plan renew at a different time than the exchange open-enrollment window, and it is unclear how those individuals will be able to effectively compare cost and plan options

For non-calendar-year plan participants, not only do we need to consider the different times of the enrollment windows, but also the IRS's existing rules for IRC Section 125 "cafeteria plans." If a person enrolled in employer coverage a different time of year and their employer-based premium contributions to said plan are deducted from their compensation on a pre-tax basis using a Section 125 plan (which is the case for virtually all employer-based health insurance coverage), then the employer group plan sponsor and the affected employee and relatives are bound by IRC Section 125's requirements. This means that even if a spouse or dependent can drop their employer-based coverage and opt for exchange-based individual coverage based on this regulatory change, they would technically not be eligible to leave their cafeteria plan mid-year without a qualifying event, so the cost of the spouse and/or dependent's premiums would still need to be deducted from the employee's paycheck for the duration of the cafeteria plan year. The only way to rectify this would be: 1) the IRS adopting a change to existing Section 125 plan rules to allow for a special qualifying event for employees to make mid-year election modifications for spouses and/or qualified dependents who no longer have an offer of "affordable coverage" due to this rule; and (2) for the employer-sponsored plan to adopt a cafeteria plan amendment regarding this potential change to mid-year election policy. Otherwise, both employer plan sponsor and the affected employees will face tax consequences and health plan administrative consequences should they allow for or make inappropriate mid-year Section 125 plan modifications.

Verification of Employer-Sponsored Coverage

Based on the final 2023 Notice of Benefit and Payment Parameters, the federal exchange will move to a customer attestation that they do not have an offer of affordable and minimum value group coverage in 2023. This policy change does not seem to anticipate this proposed rule, which, if finalized, will likely bring many people from the group market to the exchanges. To protect the stability of the employer-based coverage system and ensure that people are not obtaining premium tax credits inappropriately (thereby exposing themselves to significant tax and coverage consequences), the implementation of this rule will necessitate a means of verifying employer-based coverage offers for individual and family coverage with far greater specificity than a simple individual-level attestation.

The proposed rule specifies that when a family with access to group-sponsored health insurance applies for potentially subsidized individual-market coverage through the federal marketplace or a state-based exchange, the exchange will perform the following affordability determinations: (1) a determination for the employee based on the cost of self-only coverage; (2) separate determinations for any related individuals based on the cost of family coverage; and (3) additional determinations for any related individuals who have an offer of coverage from another employer. The most logical way for the federal and state-based exchanges to complete these determinations and to verify employer-based coverage offers would be through a modification of the existing ACA employer coverage reporting system.

Legislation is pending that would simplify the employer reporting process and potentially significantly ease the coverage-determination and verification processes for health insurance exchanges. However,

Congress needs time to consider and advance such legislation. If Congress fails to act, there are also means to address the verification of coverage offers issue using the existing regulatory processes, but doing so will require more time and additional regulatory action.

The existing IRC Section 6055 and 6056 employer reporting process is the logical source of the data the exchanges will need to make effective and accurate subsidy verifications, but more time is necessary to make it all work. Modifying the existing Form 1094/1095 C and disclosure statements to require employers to report on the cost of family coverage would be a way to facilitate accurate exchange-based coverage determinations for both employees and related individuals using existing channels. However, doing so would require modifications to employer reporting forms and directions, as well as new sub-regulatory guidance. To allow employers, vendors that assist with the reporting process, and your agency to prepare and implement these changes for 2022 information reporting of employer-sponsored coverage offers, this proposed rule would need to be finalized on a near-immediate basis. Then your agency would need to make almost immediate changes to reporting process and related guidance in time for all involved to be ready for the upcoming reporting season, which will begin in the late fall of 2022 and extend into the winter of 2023. It may be too late already to implement such a change for the 2023 coverage year since 2022 reporting will not be complete until the winter of 2023. A year's delay would allow your agency and the Centers for Medicare and Medicaid Services to develop an effective coverage offer verification and enforcement mechanism and create all needed guidance and reporting form and procedural changes that will be needed by applicable large employers and their reporting compliance vendors.

For all these reasons, NAHU urges the IRS and the Biden administration to delay finalizing this measure until at least 2023. We are grateful for the IRS's consideration of our feedback, as well as the feedback of other stakeholders. If you have any questions about our comments or need more information, please do not hesitate to contact me at (202) 595-0639 or jtrautwein@nahu.org.

Sincerely,

Janet Stokes Trautwein
Executive Vice President and CEO
National Association of Health Underwriters