July 31, 2017

Submitted Electronically Via Federal Rulemaking Portal: www.regulations.gov

Department of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, DC 20220

RE: Request for Information: Executive Orders 13771 and 13777, Review of Regulations

To Whom It May Concern:

The U.S. Chamber of Commerce (the "Chamber") submits these comments to the Department of Treasury (the "Department" or "Treasury") in response to the Proposed Rule's Request for Information on the Review of Regulations, generally, and on recommendations for Treasury Department regulations that can be eliminated, modified or streamlined in order to reduce burdens, specifically ("RFI"). This RFI was published in the Federal Register on June 14, 2017 by Treasury in furtherance of Executive Order 13771 Reducing Regulations and Controlling Regulatory Costs and Executive Order 13777 Enforcing the Regulatory Reform Agenda.[1] Through our comments, the Chamber hopes to inform the Department and its regulatory reform task force in the ongoing efforts to evaluate existing regulations and make recommendations to prioritize repeal, replacement, or codification, consistent with applicable law. We commend the administration's endeavors to achieve the goals of the Executive Orders 13771 and 13777 and share the interest in identifying for repeal, replacement or modification regulations that eliminate jobs or inhibit job creation; are outdated, unnecessary or ineffective; impose costs that exceed benefits; create a serious inconsistency or otherwise interfere with regulatory reform initiatives and policies. These comments focus on Treasury regulations promulgated and finalized to implement provisions of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as "ACA").[2]

[1] Proposed Rule's Request for Information, 82 Fed. Reg. 27,217-27,218. (June 14, 2017) (to be codified at 5 C.F.R. Chapter XXI; 12 C.F.R. Chapters I, V, XV, and XVIII; 17 C.F.R. Chapter IV; 19 C.F.R. Chapter I; 26 C.F.R. Chapter I; 27 C.F.R. Chapter I; 31 C.F.R. Subtitle A and Chapters I, II, IV, Through VIII, IX, and X; and 48 C.F.R. Chapter XX) [hereinafter referred to as the "RFI"] https://www.gpo.gov/fdsys/pkg/FR-2017-06-14/pdf/2017-12319.pdf

[2] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (2010)

INTRODUCTION

The Chamber is the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector and region, with substantial membership in all 50 states. More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. Therefore, we are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large. Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business – manufacturing, retailing, services, construction, wholesaling, and finance – is represented.

The Chamber is committed to working with the administration and members of Congress to strengthen and further reform our nation's health care system through regulatory and legislative action. With input from our members, we have identified a series of regulatory changes that could provide significant assistance to businesses struggling to comply with the ACA and related regulations promulgated by Treasury.

OVERVIEW

This comment letter highlights changes to existing regulations within Treasury's authority to repeal and modify. However, in addition to this letter, we encourage you to also review and consider the contents of three other items submitted with this comment letter:

- 5-page chart on "Health Care Regulatory Work";
- 10-page chart on "Important Regulatory Steps;" and
- 21-page document on "2017 Health Care Policy Recommendations."

These three documents detail in several different ways the extensive regulatory and legislative changes that we believe are necessary to improve our current health care system. This may be informative as you delve further into the substance of prior rules and look for ways to alleviate burdens.

The "Health Care Regulatory Work" chart includes hyperlinks to the litany of comment letters that we have submitted as regulations were being promulgated by the past administration. As you also pursue efforts to roll back problematic and improper regulations, we encourage you review these comment letters detailing our substantive and procedural concerns.

The "Important Regulatory Steps" chart details specific regulatory changes that we believe will help achieve several of the RFI's goals. The recommendations in this chart are divided into three categories based on our priorities and the critical outcomes that we believe the proposed changes can accomplish: stabilize insurance markets, provide relief to employers, and return regulatory authority to the states.

The "2017 Health Care Policy Recommendations" document includes a thorough discussion of several ACA provisions and non-ACA policy priorities along with our "steps requested." While the document is comprised of four sections, we call your attention to the first two sections which detail opportunities to correct bad policy and flawed ACA reforms, and promote private sector innovation, respectively.

RECOMMENDATIONS

The Chamber shares the Department's priorities and goals of assessing which regulations can be eliminated, modified or streamlined in order to reduce burdens. There are three specific ACA provisions for which Treasury has promulgated particularly problematic and unnecessarily limiting regulations: the health insurance tax; the employer reporting of minimum essential coverage, and; narrow interpretation of preventive services. Therefore, we encourage you to issue clarification:

- Revising the tax treatment of funds collected to pay the health insurance tax to avoid double taxation;
- Simplifying the burdens on employers associated with the mandated minimum essential coverage reporting requirements;
- Permitting greater flexibility in the coverage of preventive services under HSA-HDHPs;
- Providing that health care coverage offered to avoid the 4980H penalty ("employer mandate") should not be subject to the 4980I penalty ("Cadillac tax"); and
- Rolling back unnecessary regulatory restrictions on certain coverage offered by U.S.-based issuers.

We look forward to working with the Department as it reviews these burdensome regulations and stand ready to provide additional guidance and clarification.

I. HEALTH INSURANCE TAX: REVISE TAX TREATMENT TO MITIGATE PREMIUM INCREASES

Funds Collected to Pay the Tax Should Be Excluded from Gross Income for Reporting Purposes

Under the ACA, the annual tax on health insurance providers (or covered entities) is treated, for tax purposes, as a tax under Section 9010(f), which cannot be taken as a deduction for federal income tax purposes. In 2013, the Congressional Budget Office ("CBO") recognized and informed the Congress and President Obama that a large portion of the tax will be passed through to policy holders in the form of higher premiums. We believe, based on long-standing federal income tax principles, the final regulations should have recognized the application of well-established tax policy, case law and rules that may apply and permit any funds recovered

from policy holders for purposes of paying the tax to be excluded from the health insurance companies' gross income if the conditions of the tax policy and rules are met.[3]

Specifically, as the attached legal analysis explains, because there is a direct connection between the tax paid to the government by the insurance providers and the amounts recovered to pay this tax, the payment and the recovery of the tax funds should be considered a single integrated transaction. Under the well-established "tax benefit rule," since the tax is not deductible by the insurance company, the tax recovered from policy holders should not be included in the insurance company's gross income. In short, the ACA's specific reference to the deductibility of the tax is a distinct and different concept under tax principles than how the tax is treated for reporting of gross income.

From a broader policy perspective, excluding the recovered fees from the insurers' gross income would help minimize the impact of the fee on premium costs. The current regulations require insurance providers to include the recovered funds collected to pay the tax in gross income. As a result, the total cost of the fee and the additional federal income tax is included in the premium charged to affected employers and consumers.

Taxing the Health Insurance Provider Tax will Increase Premiums Even Further

The final rule's ill-advised tax treatment of the tax will not only *further* exacerbate premium increases that will result from the health insurance providers tax, but will collect more federal revenues than required under the ACA's provision:

> If the Treasury Department determines that the recovery of the fee from policyholders is gross income of the Covered Entities, the additional costs to the Covered Entities of the federal income taxes on that gross income is also expected to be passed on to policyholders. Thus, it is the policyholders, rather than the Covered Entities, that have the largest stake in this issue. Excluding the recovered fee amounts from the Covered Entities' gross income will still result in the Covered Entities paying the full amount of the health insurance providers fee imposed by ACA, but will also result in policyholders paying less for health insurance coverage than they will pay otherwise.[4]

In addition to Skadden's legal analysis, which outlines case law supporting the exclusion of the health insurance providers tax from gross income for reporting purposes, the Chamber cites a report done by Quantria Strategies, which qualified the effect that the proposed tax treatment of the tax would have on premium increases. By choosing to "tax the tax," Treasury's interpretation likely caused consumer and employer premiums to increase from $45 to $70 billion dollars *more*

[3] See attached legal analysis from Skadden, Arps, Slate, Meagher & Flom which provides a thorough explanation of the extensive case law that supports this rationale. This opinion was written by a team including Ken Gideon, former Assistant Secretary of the Treasury for Tax Policy and Chief Counsel for the Internal Revenue Service.
[4] Skadden, Arps, Slate, Meagher & Flom, "Annual Fee Imposed on Health Insurance Providers under Section 9010 of the Patient Protection and Affordable Care Act: Exclusion from Gross Income of Recoveries of the Fee from Policyholders," page 1

than the health insurance providers fee statutory provisions require, according to an analysis done by Quantria Strategies.

> To cover Federal income taxes due, taxable health insurers will need to collect $1.54 from customers for each $1 owed and paid to the Treasury.[5]

A similar analysis was done by Milliman, which estimated that "the Federal government will collect an additional $61 billion from increased corporate taxes related to the fee's implementation."[6] This excess taxation will occur because Treasury has applied federal income tax to the health insurance provider tax premiums that insurers collect and then forward to the Internal Revenue Service ("IRS"). This excess taxation represents around one-third of the total premium impact of the tax and is not required under the statute.

Treasury has the Authority to Reduce the Harm

The Treasury Department has the authority to save consumers and employers $45 to $70 billion in premium costs over the next ten years by clarifying there is no need to "tax the tax." Numerous IRS rulings and court cases establish the recovery of costs is not taxable, provided no tax deduction was claimed for the cost, which it is not for the health insurance providers fee. The Skadden opinion also analyzes precedent to conclude, "Similarly, when a taxpayer is reimbursed for costs that primarily benefit another person [as the health insurance provider will be by premium payers for the health insurance provider fee it will then pay to the federal government], the reimbursements are not included in the taxpayers' gross income, notwithstanding an incidental or indirect economic benefit to the tax payer."

II. REPORTING REQUIREMENTS: REDUCE THE BURDEN OF REPORTING MINIMUM ESSENTIAL COVERGE

Reduce Mandated Reporting of Social Security Numbers

Employers do not generally collect or have access to the Social Security numbers ("SSN") of their employees' dependents and spouses. While employers may have the SSN for their employees, it has been exceedingly difficult for many employers to report the SSNs for all individuals to whom coverage is offered or provided. Instead, we recommend the Treasury, IRS and Social Security Administration use the data provided to them by employers to determine the SSNs of covered dependents and spouses.

Employers should be permitted to provide only the SSN of the employee subscriber and not the Social Security number of every relevant family member. With this information, Treasury and the IRS are able to identify and determine the proper Social Security numbers of covered dependents listed based on income tax returns and, alternatively with the assistance of the Social

[5] Quantria Strategies, LLC, Prepared by Mary M. Schmitt and Judy Xanthopoulos, "Effect of the Health Insurer Fee in the Affordable Care Act (ACA) on Health Insurance Premiums" June 3, 2013.
[6] Milliman Research Report, Prepared by Mathieu Doucet and Julia Yahnke, "ACA Health Insurer Fee: Estimated Impact on the U.S. Health Insurance Industry," April 2013.

Security Administration based on other information provided by employers such as the name and date of birth of the covered family members.

Facilitate Electronic Delivery

Although Treasury and the IRS have acknowledged that "electronic methods are a simpler and more efficient method to supplying employees with required information," the requirement that consent be obtained for each employment-related tax or benefit information electronic delivery is arcane. Given the frequency with which electronic delivery is used to provide employees compensation, tax and benefit information, employers should be afforded greater flexibility. If an employee has consented on the record to receive other employment related tax or benefit information via electronic delivery, an employer should be permitted to rely on that consent and provide the Section 6056 statement to that employee via electronic delivery. The Treasury should work with the Department of Labor to develop a uniform common sense standard for electronic delivery of materials to employees.

In addition employers should be permitted to provide employees information on their W-2 statement that coverage was offered to the employee (same as with Section 6055), in addition to a generic electronic communication that these data elements were provided to the IRS. Employers should be permitted to report in this manner rather than be required to provide individualized statements.

III. PERMIT GREATER BENEFIT DESIGN FLEXIBILITY

Allow HSA-HDHPs to More Generously Cover Additional Preventive Services

To be paired with a Health Savings Account, High Deductible Health Plans ("HSA-HDHPs") are required under the Internal Revenue Code ("Code") to have defined minimum deductibles and are restricted from providing benefits in a given year until the annual deductible is satisfied. Under the ACA, HSA-HDHPs, like other health plans, must cover certain preventive services (such as those given an "A" or "B" recommendation by the U.S. Preventive Services Task Force) on a pre-deductible basis at zero dollars in cost sharing. Coverage of these services on a pre-deductible basis is permitted as they fall within a "safe harbor," allowing HSA-HDHPs to cover certain preventive care prior to the deductible being met.

Beyond the preventive services that must be covered on a pre-deductible basis by all plans, current interpretation of the scope of the HSA-HDHP preventive care safe harbor is narrow and increasingly problematic and disconnected. Generally, plans lack the regulatory flexibility to cover services that help patients manage chronic conditions because the guidance regarding the safe harbor excludes services or benefits meant to treat "an existing illness, injury or condition." Previously, this exclusion has been read quite literally to suggest services to manage or prevent exacerbation of a chronic condition are not "preventive" within the meaning of the safe harbor as the illness or condition already exists. This interpretation contravenes informed understanding of the importance of prevention, which reflect that in addition to improving outcomes and enhancing productivity, management of chronic conditions prevents adverse, costly, and often

avoidable acute exacerbations. We recommend Treasury permit HSA-HDHPs to cover additional services and benefits under the preventive care safe harbor, if they so choose.

Treasury Has the Authority to Reduce this Harm

The Secretary of the Treasury has flexibility under Section 223(c) of the Code to define the scope of preventive care for purposes of the safe harbor. In relevant part, the Code refers to "preventive care (within the meaning of Section 1871 of the Social Security Act, *except as otherwise provided by the Secretary*)."[7] The phrase "except as otherwise provided by the Secretary" is an explicit delegation of authority to Treasury and the IRS, acting on the Secretary's behalf, to define the scope of "preventive care" for purposes of Code Section 223. While the Social Security Act's definition is a starting point, it is not the end of the inquiry *if the Secretary so provides.*

The authority granted to the Secretary in Code Section 223 is in addition to the Secretary's general authority to prescribe rules and regulations as necessary to enforce the Internal Revenue Code. Code Section 7805(a) states that "…the Secretary shall prescribe all needful rules and regulations for the enforcement of this title…" Since the preventive care safe harbor is part of the enforcement of Code Section 223, any expansion of that safe harbor is governed by the general regulatory authority of Section 7805. Therefore, it appears clear as a matter of law that the Secretary has the authority to expand the definition of preventive services for purposes of the safe harbor.

IV. COVERAGE OFFERED TO AVOID THE 4980H PENALTY ("EMPLOYER MANDATE") SHOULD NOT BE SUBJECT TO THE 4980I PENALTY ("CADILLAC TAX")

Clarify that in Acting to Avoid One Statutory Fine, an Employer Cannot Trigger and be Subject to Another.

The Chamber is very concerned about the potential for employers to find themselves in the unenviable (and unfair) position of having to decide between paying an excise tax by reason of Code Section 4980I (the "Cadillac tax"), or alternatively paying an excise tax by reason of Code Section 4980H ("the employer mandate"). Therefore, Treasury should establish a safe harbor to assure employers that are complying with the shared responsibility requirements in Code §4980H and offering minimum value coverage, in order to avoid facing a "free-rider" penalty, that such compliance with this tax provision will not then trigger another tax liability for offering "excess benefits." The Chamber recommends that Treasury and the IRS exempt employers that offer a plan that covers the minimum benefits including preventive services required to avoid triggering a §4980H tax from the Excise Tax.

Under §4980H(a), an "applicable large employer [that] fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage" may be subject

[7] Code Sec. 223(c)(2)(C) (emphasis added).

to a significant tax. Further, under §4980H(b) and §36B, the ACA stipulates that for applicable large employers to avoid a secondary tax penalty, the minimum essential coverage offered to all full-time employees must be both affordable and provide "minimum value." The statute further explains what constitutes minimum value in §36B(2)(C)(ii) and sets the floor at 60 percent actuarial value.[8] This value also corresponds with the lowest cost option offered in the small group market. Additionally, under §2713, all group health plans must also provide coverage of preventive services with no cost-sharing, perhaps in recognition of the contribution that prevention makes to health care efficiency. These services include screenings for cancer and many other medical conditions, a wide range of immunizations, and tobacco cessation counseling and interventions, among others.

These minimum levels of coverage were floors set by the ACA as to what health care coverage must constitute in the small group and employer-sponsored arenas. In setting this floor, the ACA set minimum levels for health coverage and insurance under the auspices of ensuring that individuals purchasing health care coverage would have access to health care services. Unless this safe harbor is created, employers and issuers complying with these base level coverage requirements will be taxed due to the provision's inconsistencies and poor indexing.

Therefore, it is critical to create a safe harbor exempting all employer-sponsored plans that are merely offering the minimum required coverage for a variety of reasons. First, failure to exempt these plans would mean that, due to the inadequate indexing methodology, all employers offering coverage will at some time in the future (and depending on geographic location, sooner for many) be placed in the position of not being able to offer satisfactory coverage for purposes of the employer shared responsibility requirements without triggering a corresponding Excise Tax liability under Code §4980I. Any effort to reduce a plan's costs for purposes of Code §4980I has a corresponding adverse effect of negatively affecting a plan's minimum value status. It would be inconsistent to require that employers provide such benefits and then effectively penalize them when these mandated benefits and coverage levels drive plan spending above the Excise Tax thresholds. Certainly this dilemma could not have been intended by Congress, nor does it seem appropriate from the perspective of tax equity.

To ensure that employers are able to continue to comply with their employer shared responsibility requirements without fear of triggering a Code §4980I Excise Tax, we urge Treasury and the IRS to promulgate a safe-harbor rule that would exempt employers that offer plans with minimum value status from Excise Tax liability.

V. ROLL BACK UNNECESSARY REGULATORY RESTRICTIONS ON CERTAIN COVERAGE OFFERED BY U.S.-BASED ISSUERS

The Chamber requests that Treasury eliminate and modify certain guidance addressing the application of provisions of the ACA to expatriate health insurance issuers, expatriate health

[8] (ii) Coverage must provide minimum value. Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in Section 5000A(f)(2)) and the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

plans, and employers in their capacity as expatriate health plan sponsors, as defined in the Expatriate Health Coverage Clarification Act of 2014 ("EHCCA"), as incorporated in the Consolidated and Further Continuing Appropriations Act, 2015 (Dec. 16, 2014). [9, 10]

There are several problematic and unnecessary regulatory requirements included in Notice 2015-43 and the proposed rule that are inconsistent with the statutory language and legislative intent of the EHCCA and would harm U.S. business interests and expatriates. [11, 12] Specifically, we recommend the four modifications to the guidance issued to date.

Remove the Proposed 12-Month Travel/Length-of-Stay Limit for U.S. In-bound Expatriates

Treasury should remove the 12-month travel/length-of-stay limitation for U.S. in-bound expatriates (i.e., Category C individuals), which appears both in Notice 2015-43, as well as in the subsequent proposed rule. Notice 2015-43 and the proposed rule would unnecessarily require that, in order for an individual to be considered to be a member of a group of similarly-situated individuals for purposes of EHCCA Section 3(d)(3)(C) (i.e., Category C individuals), the individual must be expected to travel or reside in the U.S. for no more than 12 months. This regulatory limitation goes beyond the legislative intent of the EHCCA in determining which similarly-situated individuals are qualified expatriates; it undermines the purpose of the EHCCA Section 3(d)(3)(C) and impairs the ability of U.S. insurance companies to compete with their foreign competitors in covering similarly-situated groups. Plan sponsors of similarly-situated groups, including foreign governments, make significant purchasing decisions on a multi-year basis and, because of these requirements, would likely place their business with foreign insurers that could provide coverage for more than 12 months. This shift would leave U.S. insurers of expatriate health plans no choice but to move their plans offshore as well, resulting in the loss of U.S. jobs and U.S. revenue.

Remove the Proposed Limitation that Requires Category B Qualified Expatriates be U.S. Nationals

A Category B qualified expatriate is statutorily defined as a primary insured who is working outside the U.S. for a period of at least 180 days in a consecutive 12-month period that overlaps with the plan year.[13] However, the proposed rule further inappropriately narrows this definition by requiring that Category B expatriates be U.S. nationals, a specificity not included or required by the EHCCA. This additional specific qualification would result in harmful unintended consequences. For example, if Category B qualified expatriates must be U.S. nationals, third-country nationals ("TCNs") working outside the U.S. (e.g., a German national working in Spain) would not qualify and therefore would not count for purposes of the "substantially all" calculation, resulting in the disqualification of TCN plans.

[9] https://www.govtrack.us/congress/bills/113/hr4414/text
[10] https://www.congress.gov/113/plaws/publ235/PLAW-113publ235.pdf
[11] https://www.irs.gov/pub/irs-drop/n-15-43.pdf
[12] https://www.gpo.gov/fdsys/pkg/FR-2016-06-10/pdf/2016-13583.pdf
[13] EHCCA Section 3(d)(3)(B)

Expatriate health plans cover individuals of all nationalities, and U.S. nationals may not be the primary demographic group on a particular plan. In fact, some expatriate health plans have no U.S. nationals enrolled in the plan. If TCNs are not counted as qualified expatriates, plans covering primarily TCNs would be disqualified as expatriate health plans under the EHCCA. This requirement could lead to an absurd result, whereby U.S.-issued plans covering only or primarily TCNs could be required to comply with the ACA the same way as a U.S. domestic health plan. The nationality of the individual should make no difference as to whether he or she can be covered on an expatriate health plan, as long as he or she meets the travel requirement for Category B.

Adopt a Good-faith Standard or Lower the Numeric Threshold for "Substantially All" Enrollment Requirement

Under the statute, "substantially all" of the primary enrollees of an expatriate health plan must be qualified expatriates.[14] The proposed rule further specifies that a plan satisfies this "substantially all" enrollment requirement if, "on the first day of the plan or policy year, less than 5 percent of the primary enrollees (or less than 5 primary enrollees, if greater) are not qualified expatriates." This regulatory numeric definition of "substantially all" would impose an arbitrary and restrictive requirement on U.S. insurance companies that doesn't apply to foreign health insurers. As a result, U.S. insurance companies would not be able to provide coverage for groups that do not meet this threshold, while foreign insurers could cover them without adhering to a threshold. Plan sponsors that are not able to administer the threshold would place their business with foreign insurers not subject to the rule. Consequently, U.S. insurers of expatriate health plans would be forced to move their plans offshore to compete for this business.

We urge the Department to instead allow plan sponsors and issuers to make a good-faith effort to meet the statutory requirement. Alternatively, if the Department includes a definition of "substantially all" in the final rule, we request that the Department adopt the following definition: *"A plan satisfies the requirement of this paragraph (f)(3)(i) if 15 percent (or less) of the primary enrollees or 15 (or less) primary enrollees, whichever is greater, are not qualified expatriates."*

Eliminate the Regulatory Travel Condition on Category A Qualified Expatriates

The Proposed Rule would deny access to health care coverage for services in multiple countries for individuals that are not expecting to travel outside the U.S. at least one time per year during the coverage period. A qualified expatriate requires expatriate health plan coverage and services for various reasons, including: coverage for dependents residing outside the U.S., coverage for expatriates and their families when they travel internationally or visit their home country; and coverage for medical evacuation. Plan issuers, administrators, and plan sponsors cannot control whether an individual travels outside of the U.S. at least once per year, and they will not know if an individual expects to or actually does so. The individual's decision to access care

[14] EHCCA Section 3(d)(2)(A)

would depend on a variety of subjective factors such as availability of care, cultural preferences, support system, and cost.

The statute states that to be considered a qualified expatriate, the individual must be "*reasonably determined by the plan sponsor* to require access to health insurance and other related services and support in multiple countries . . ." (emphasis added).[15] In the proposed rule, the Department appears to be making a determination Congress clearly intended for plan sponsors to make. This determination should remain the responsibility of the plan sponsor.

CONCLUSION

The Chamber appreciates the ongoing work of the Department to identify regulations that: are outdated, unnecessary, or ineffective, and; impose costs that exceed benefits. To the extent that regulatory changes alone are not sufficient, we hope you will join us in calling on Congress to make additional legislative changes quickly to reduce unnecessary costs, alleviate administrative burdens on employers that inhibit investment and job creation and preserve the choice and plan variety in health insurance and coverage options.

Sincerely,

Randel K. Johnson
Senior Vice President
Labor, Immigration, & Employee Benefits
U.S. Chamber of Commerce

Katie Mahoney
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[15] EHCCA Section 3(d)(3)(A)(ii)