

**America's Health
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Notice 2015-16

MAY 19 2015

May 15, 2015

CC:PA:LPD:PR (Notice 2015-16)
Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Submitted Electronically: notice.comments@irs.counsel.gov

Dear Sir/Madam:

America's Health Insurance Plans (AHIP) is submitting comments in response to Notice 2015-16 regarding the excise tax on high cost-employer-sponsored health coverage (the "Excise Tax") imposed by the Affordable Care Act (ACA) through Code section 4980I. The Excise Tax takes effect in 2018 and is equal to 40 percent of the cost of coverage under an employer-sponsored health plan above the statutorily established benchmarks of \$10,200 for individual coverage and \$27,500 for family coverage. The Notice requests input on a number of issues related to implementation of the Excise Tax by health insurers and employers.

Structural Problems with the Excise Tax

Specific issues and recommendations regarding the Notice are discussed in the attached appendix. At the same time we remain concerned with certain inherent structural problems arising from imposition of this tax on employer provided health coverage.

(1) The Excise Tax Does Nothing to Address the True Costs of Health Care and Limits Employers' Ability to Design Benefit Structures Appropriate for their Workforces – The Excise Tax is calculated based on the "costs" paid by employers and employees for health coverage. The true cost of health coverage is driven by underlying factors, such as costs for physician and hospital services, growing provider consolidation, sharply increasing prices for prescription drugs and medical devices, greater utilization of health care services by certain populations, and the high prices of new specialty drugs and other new technologies and treatments. As a result, the Excise Tax forces employers to reduce coverage, potentially leaving employees without the options they want, without addressing the underlying reasons why that coverage is becoming more expensive.

(2) The Excise Tax Reduces Employer Decision Making on Benefits by Narrowing Health Coverage Options – Employers offer a wide variety of health options to employees that will be affected by the Excise Tax. For example, many employers offer employees the opportunity to

May 15, 2015

Page 2

enroll in either a health maintenance organization (HMO), preferred provider organization (PPO), point-of-service option (PPO) or high-deductible health plan (HDHP) paired with a health savings account (HSA) or health reimbursement arrangement (HRA). These different options give employees the opportunity to select the provider network and cost-sharing that best meets their needs. The Excise Tax is designed to force employers – and their employees – into the lowest cost option thereby reducing the ability of employees to access and choose certain types of health coverage.

(3) The Excise Tax Does Not Recognize a Crucial Cost Factor Affecting Certain Employers – While the statutory benchmarks used to calculate the Excise Tax may be adjusted upward based on certain factors, such as whether the employer is a high-risk profession or if the age and gender characteristics of the employer's workforce substantially differs from the characteristics of the "national workforce" – it does nothing to adjust for one of the key reasons for cost differentials across the country. A significant factor affecting health costs is the geographic location of the employer. Costs for the same service or procedure may be dramatically different from state to state and between urban and rural locations within a state. The Excise Tax will fall disproportionately on employers in higher-cost locations of the country, thus negatively impacting their employees.

(4) Over Time the Excise Tax will Capture a Greater Number of Employers – The benchmarks used to determine whether an Excise Tax is owed will be adjusted over time based on the Consumer Price Index – Urban (CPI-U). Historically, medical inflation has increased at an annual rate of 5 to 10 percent, while the CPI-U has seen an annual increase in the range of 2.5 to 3 percent. Due to excessive medical cost growth versus the CPI-U and other factors, a recent analysis by the American Health Policy Institute concluded that coverage sponsored by 17 percent of American businesses (38 percent of large employers) will be subject to the excise tax in 2018.¹ The medical cost inflation rate is a more accurate reflection of the underlying factors affecting the cost of employer provided health coverage, and the decision to use CPI-U means that more and more employers will find themselves potentially subject to the Excise Tax.

Key Recommendations

Our recommendations regarding implementation of the Excise Tax address a number of concerns, including the following:

- Employers that offer minimum essential coverage in order to comply with the employer "pay or play" provisions of Code section 4980H should not be penalized – otherwise

¹ American Health Policy Institute, "The Impact of the Health Care Excise Tax on U.S. Employees and Employers," accessed at: http://www.americanhealthpolicy.org/Content/documents/resources/Excise_Tax_11102014.pdf

May 15, 2015

Page 3

employers are faced with a stark choice of either offering coverage and paying the excise tax or not offering coverage and paying the employer shared responsibility fee.

- The agency should assist employers and health insurers with implementation and compliance responsibilities by clarifying how the tax benchmarks will be adjusted for certain categories of workers (e.g., "high-risk" professions) and for inflation in future tax years.
- The IRS should provide clear guidance on what types of employer coverage is subject to – and exempt from – the Excise Tax.
- Employer activities aimed at improving the well-being and health outcomes of employees and their family members, including wellness programs and on-site clinics, should be excluded from the Excise Tax
- Employers should be given flexibility in determining the cost of self-funded group health plan coverage.

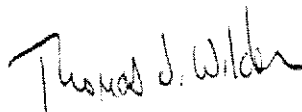
We also strongly urge you to act promptly in issuing guidance, regulations, and informational reporting requirements. Although the Excise Tax does not begin until 2018, employers and health insurers are already considering changes in benefit designs in response to potential tax liability. As you are aware, complying with the Excise Tax will be an extremely complex and challenging undertaking and it is critical that stakeholders have the information they need as soon as possible to implement this new tax.

AHIP appreciates the opportunity to provide comments on the Excise Tax and to offer recommendations on ways to streamline tax compliance. We look forward to working with the Department of the Treasury and the Internal Revenue Service on the regulations implementing Code section 4980I.

Sincerely,



Matthew Eyles
Executive Vice President
Policy and Regulatory Affairs



Thomas J. Wilder
Senior Counsel

Attachment:

**America's Health Insurance Plans
Comments Regarding Notice 2015-16
Section 4980I – Excise Tax on High Cost Employer-Sponsored Coverage
May 15, 2015**

America's Health Insurance Plans ("AHIP") is writing to provide comments and recommendations in response to Notice 2015-16, which provides initial guidance regarding the excise tax on high cost employer-sponsored coverage imposed by Internal Revenue Code ("Code") section 4980I ("Excise Tax"). This provision was enacted by the Affordable Care Act ("ACA").

A. Providing Employers with Flexibility in Offering Health Coverage Options

Issue A1: Providing a safe harbor rule to ensure that employers will not be subject to Excise Tax liability solely because they offer the minimum level of plan benefits needed to comply with the employer shared responsibility requirements of Code section 4980H.

Recommendation

Treasury and the Internal Revenue Service ("IRS") should establish a safe harbor rule that would ensure that employers are not subject to a Code section 4980I Excise Tax liability solely for offering a plan that is comprised only of the minimum benefits needed to avoid triggering a corresponding excise tax with respect to Code section 4980H.

Discussion

AHIP is concerned that some employers may, at some point, incur an Excise Tax liability under Code section 4980I solely because of their offer of qualifying coverage for purposes of the employer shared responsibility requirements of Code section 4980H. Code section 4980H generally requires that "applicable large employers" offer qualifying coverage to full-time employees and their dependents or be subject to a significant excise tax. Code section 4980H(a) generally requires that the employer offer coverage consisting of "minimum essential coverage," within the meaning of Code section 5000A, to at least 95% of their full-time employees and non-spouse dependents. Code section 4980H(b) generally requires that an applicable large employer offer minimum essential coverage that is both affordable and provides "minimum value" within the meaning of Code section 36B.

In interpreting "minimum value" for purposes of Code sections 36B and 4980H, the Treasury rule requires an employer to determine the plan's minimum value status based not on its own cost-sharing, but rather by reference to a third party "benchmark" plan. *See* 26 C.F.R. §1.36B-2(c)(3)(vi) (referencing ACA §1302(d)(2), which states, in relevant part, "the level of coverage of a plan shall be determined on the basis that . . . essential health benefits . . . shall be provided to a standard population . . ."). Very generally, the rule requires an employer to compare the aggregate expected claims costs under its plan (*i.e.*, the numerator) against that of a typical self-

funded employer-sponsored plan (*i.e.*, the denominator). This interpretation seems at odds with the express statutory language of Code section 36B(c)(2)(C)(ii), which, on its face, determines a plan's "minimum value" status based only upon the plan's own cost-sharing and not in reference to any third party plan. Specifically, Code section 36B(2)(C)(ii) states:

(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.

(Emphasis added). The practical effect of Treasury's current interpretation regarding the "minimum value" standard is that many employers will at some time in the future 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 section 4980I. This is because any effort to reduce a plan's costs for purposes of Code section 4980I has a corresponding adverse effect of negatively affecting a plan's minimum value status. 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 section 4980I Excise Tax, we urge Treasury and the IRS to promulgate a safe harbor rule that would provide that employers could not incur an Excise Tax liability solely by offering a plan with the minimum level of benefits needed to comply with the employer shared responsibility requirements.

Issue A2: Providing a safe harbor methodology for determining the aggregate cost of applicable employer-sponsored coverage.

Recommendation

In reliance on principles of tax certainty and efficiency, Treasury and the IRS should provide a safe harbor methodology for determining aggregate cost based upon a plan's actuarial value (as opposed to its monetary cost).

Discussion

Code section 4980I determines the extent of any Excise Tax liability based upon the "cost" of the aggregate applicable employer-sponsored coverage with respect to a given employee. Cost is to be determined using rules "similar to" those that apply for purposes of Code section 4980B(f)(4) (*i.e.*, COBRA). AHIP and its members are very concerned that a taxing regime that looks at actual plan costs will be incredibly difficult to administer and could result in massive tax inefficiencies, as well as significant tax uncertainty and inequity, for our members and various other stakeholders.

First, we note that Code section 4980I provides no specific adjustment for geographical differences. As a result, two identical plans could have significantly different cost valuations for purposes of the Excise Tax solely by reason of the fact that one of the plans provides coverage to participants in a higher-cost area. Many commentators have noted this fact and, in support, have cited employers with workforces in major metropolitan areas as those likely to be adversely affected. But these are not the only employers who could be unjustly discriminated against by this rule. Many American families reside in rural areas where there may be fewer medical providers and/or less market competition. As a result, the cost of coverage for employers in some rural areas may be markedly higher as well. Unless Treasury and the IRS create an alternative safe harbor methodology, for example, one based upon actuarial value versus monetary cost, employees working for employers in higher-cost geographic areas may have reduced coverage options.

Second, AHIP is concerned that the age adjustment mechanism will not adequately account for differences in coverage costs for older and younger workforces. Code section 4980I provides for an adjustment generally based on the age and gender characteristics of an employer's workforce as compared to the age and gender characteristics of the national workforce. Specifically, an upward adjustment to the dollar thresholds may apply, equal to the excess (if any) of (i) the premium cost of the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for the type of coverage provided to an individual in a taxable period if priced for the age and gender characteristics of all employees of the individual's employer, over (ii) that premium cost for the provision of such coverage under such option in such taxable period if priced for the age and gender characteristics of the national workforce.

While this statutory adjustment is helpful, AHIP is concerned that it does not go far enough in terms of smoothing age differences in the small group market. This is because, in the small market, plans are subject to limits on the extent to which they may adjust rates based on age (specifically, they are limited to adjusting rates for age within a ratio of 3:1 for most adults). AHIP is concerned that the adjustment mechanism for age as detailed in the statute will not sufficiently correct for employers that have elderly workforces, resulting in the tax disproportionately applying to coverage offered to older individuals in comparison to younger individuals with identical benefits, which could not be what Congress intended.

Third, the current rule does not provide for any specific adjustment based upon health risk or claims experience. As a result, and similar to the hypothetical above, two identical large group plans could incur significantly different cost valuations solely by reason of the fact that one plan covers a relatively unhealthier population. This fact is highly problematic and unless it is cured through the establishment of an appropriate adjustment or alternative safe harbor methodology, there is the possibility that individuals with the greatest need for comprehensive health care may find themselves with relatively less coverage (because employers would need to reduce coverage to reduce Code section 4980I "cost" so as to avoid or reduce Excise Tax liability). It is conceivable that the current cost-based methodology could cause some plan sponsors to undertake actions to minimize plan "costs," such as reducing and/or eliminating special programs intended to provide employment to special needs or disabled individuals.

Fourth, as enacted, Code section 4980I includes no exception for small employers. As a result, employers with as few as potentially one employee could be subject to the Excise Tax. Small employers, like all employers, may lack the financial resources or access to providers and experts, to comply with a complicated taxing regime. Accordingly, it is imperative that any resulting rules with respect to Code section 4980I take into account the role of the small employer as well as the inherent limitations employers may face in complying with rules that are too complicated or costly to administer. AHIP believes that the establishment of simpler safe harbor methodologies will assist small employers in complying with the Excise Tax calculations.

AHIP and its members believe a methodology based upon actuarial value ("AV"), such as a 90 percent or higher AV, is appropriate in light of the concerns discussed above. Such a methodology will ensure that taxpayers are not disadvantaged based upon age, geography or because of the specific health factors of enrollees, and would simplify the calculation of the excise tax by eliminating the need for any adjustments. Additionally, making such a methodology available as an alternative means to determine compliance with Code section 4980I will help minimize any disincentives for employers to continue to offer multiple benefit options for their employees. Lastly, such a methodology would be welcome news for smaller employers who may already be struggling with the growing set of regulations applicable to their businesses and would facilitate compliance by both small and large employers with Code section 4980I.

Per the terms of the ACA and related tri-agency guidance, issuers of small group coverage on the "Small Business Health Options Program ("SHOP") generally must agree to offer silver and gold level plans. *See* 45 C.F.R. §156.200 (imposing requirements on QHP issuers). These plans are likely to have higher costs because of their higher actuarial value. It seems highly illogical that Congress would have required issuers to offer silver and gold level small group insured plans on the SHOP, only to have such plans trigger an Excise Tax liability. Accordingly, AHIP believes a safe harbor methodology based on actuarial value would not only be helpful in terms of reducing the burdens associated with administering the Excise Tax, but is required to make sure the ACA is applied in a consistent and appropriate manner with respect to its stated goals and intentions.

Lastly, in part because of Treasury's interpretation of "minimum value" for purposes of Code sections 36B and 4980H (which looks not only at the extent of a plan's given cost-sharing, but at an external benchmark), there will come a point in time where a given employer will not be able to avoid an excise tax under both Code sections 4980I and 4980H. Certainly, this result was not intended by Congress. We strongly urge Treasury and the IRS to adopt a rule that makes clear that an employer will never be found liable for an excise tax under Code section 4980I with respect to the offering of coverage to the extent that such coverage is needed to avoid an excise tax under Code section 4980H. However, we note that a safe harbor methodology based on actuarial value could resolve this issue so long as the actuarial value threshold for purposes of Code section 4980I is set sufficiently high so as to permit employers to offer "minimum value" coverage for purposes of Code section 4980H.

For the foregoing reasons, AHIP recommends the establishment of a safe harbor methodology for determining aggregate cost based upon a plan's actuarial value (as opposed to its monetary cost).

B. Timing of Information Regarding Dollar Limits and Adjustments

Issue B1: Providing a timely estimate of and safe harbor for the “health cost adjustment percentage.”

Recommendation

Treasury and the IRS should collaborate with the Office of Personnel Management (“OPM”) provide an estimate of any “health cost adjustment percentage” that could apply for purposes of Code section 4980I(b)(3)(C)(ii) sufficiently in advance of the time health insurers and employers are designing benefit options for 2018.

Discussion

Code section 4980I imposes a 40% nondeductible excise tax on any “excess benefit.” The “excess benefit” is equal to the aggregate cost of all “applicable employer-sponsored coverage” with respect to an “employee” in excess of the “applicable annual limitation” of Code section 4980I, after certain adjustments, as relevant, per Code section 4980I(b)(3)(C)(iii) and (iv).

Code section 4980I(b)(3)(C)(ii) provides for a possible upward adjustment to the applicable annual limitations in 2018 based on the health cost adjustment percentage as defined in Code section 4980I(b)(3)(C)(ii). The “health cost adjustment percentage” is equal to 100% plus the excess (if any) of the percentage by which the per employee cost of coverage for the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan (FEHB) for plan year 2018 (using the benefit package for such coverage in 2010) exceeds such cost for the 2010 plan year, over 55 percent.

In order to effectively plan for 2018, the first year of the Excise Tax, coverage providers such as our members must have information regarding whether the applicable annual limitations will be increased based upon the health cost adjustment percentage. Based on the prior experience of our members that participate in the FEHB program, the cost for the Blue Cross/Blue Shield standard benefit option for 2018 will be finalized by OPM in late July or early August of 2017 and will be publically announced in late September or early October of that year. However, at that point, it may be too late for health insurers, other coverage providers, and employers to effectively utilize this information in the design of their 2018 coverage offerings. Absent timely information about the extent of any upward adjustment by reason of the health cost adjustment percentage, employers and issuers will likely be forced to assume that there will be no increase in the base annual applicable limitations.

Information regarding the health cost adjustment percentage is also needed because our members, as well as their employer clients, generally are required to make certain disclosures for financial and tax accounting purposes. Absent reliable information (including safe harbor estimates that could be relied upon by taxpayers), our members may be left in the very unfortunate position of having to make financial disclosures to the markets based upon little or no information. Additionally, our members might find themselves having to amend or correct

state and federal disclosures based upon new information, which could be disruptive to the markets as well as their business value and operations.

For the foregoing reasons, AHIP urges Treasury and the IRS to work with OPM and provide an estimate of the 2018 health cost adjustment percentage during 2016 and permit issuers and other coverage providers to rely on that estimate in good faith for purposes of Code section 4980I.

Issue B2: Providing safe harbor projections of the indexed “applicable annual limitations” and adjustments thereto.

Recommendation

Treasury and the IRS should provide safe harbor projections of the indexed “applicable annual limitations” and adjustments thereto with respect to qualified retirees and high risk and other designated professions at least 18 months in advance of the beginning of the applicable year.

Discussion

Code section 4980I provides for certain upward adjustments to the applicable annual limitations, including with respect to qualified retirees and high risk and other designated professions. These adjustments are set forth in Code section 4980I(b)(3)(C)(iv). Both the applicable annual limitations and the adjustments with respect to qualified retirees and certain high risk professions are subject to annual indexing per Code section 4980I(b)(3)(C)(v), based upon the change in the Consumer Price Index (Urban). It is imperative from a planning perspective that stakeholders be provided with timely information regarding the dollar thresholds that will apply for purposes of the Excise Tax and safe harbor projections that can be relied upon.

AHIP understands that Treasury and the IRS may not know until as late as the end of August of a given year what the indexing rate will be for purposes of the next year. Given that some issuers and employers typically finalize their plan offerings and/or products at least twelve to fifteen months prior to the start of a plan year, it would be nearly impossible for issuers and employers to take into account any increase in the dollar thresholds by reason of the annual indexing given that the information will be made available so late in time relative to the start of the corresponding tax year.

Additionally, as noted, our members, as well as their employer clients, generally are required to make certain disclosures for financial and tax accounting purposes. Absent reliable information (including safe harbor estimates that could be relied upon by taxpayers) regarding the dollar thresholds that will apply with respect to a given tax year, our members may be left in the very unfortunate position of having to make financial disclosures to the markets based upon little or no information. Some health insurers might find themselves having to amend or correct disclosures based upon new information, which could be problematic as discussed above.

For the foregoing reasons, AHIP urges Treasury and the IRS to provide a projected index as a safe harbor at least 18 months in advance of the respective tax year for purposes of Code section 4980I(b)(3)(C)(v) that could be relied upon by issuers and employers in designing their plan

offerings and/or products. The offering of such a safe harbor index will ensure that issuers and employers are best able to maximize the benefits available to their plan participants or insureds without triggering Excise Tax liability.

Issue B3: Clarifying how the adjustments to the applicable dollar limits are applied.

Recommendation

Treasury and the IRS should clarify in regulations how the adjustments to the applicable dollar limits are collectively applied.

Discussion

Code section 4980I(b)(3)(C) provides that the dollar limit thresholds are potentially subject to adjustment by one or more of the following factors:

- In 2018, by a “health cost adjustment percentage”;
- In 2018 and later years, by an “age and gender adjustment”;
- In 2018 and later years, by a specified dollar amount (indexed for inflation) with respect to qualified retirees and certain high risk professions; and
- In 2019 and later years, by an indexing factor.

AHIP appreciates that Congress included certain adjustment factors that recognize inflation effects and the unique composition of certain workforces. However, it is not entirely clear how these adjustments work together or in what order they apply. AHIP encourages Treasury and the IRS to issue rules that clearly set forth how these adjustments work and, more specifically, to make clear employers that may use more than one adjustment may take all of them into account (e.g., permit an employer to “stack” the age and gender and adjustments for certain designated professions, if appropriate).

C. Determining Coverage Based on Offer or Enrollment

Issue C1: Determining an employee’s aggregate cost of coverage based either on the coverage “offered” or the coverage in which employees enroll.

Recommendation

Employers should be permitted to determine the aggregate cost of applicable employer-sponsored coverage based either on coverage in which the employee is actually enrolled or on coverage made available to the employee.

Discussion

Code section 4980I(a) provides that if an employee is covered under any applicable coverage of an employer during a taxable period and there is an excess benefit with respect to the coverage, then the Excise Tax will apply. Read by itself, this language would seem to indicate that in determining the extent of any Excise Tax liability, an employer must look to the coverage in which an employee is actually enrolled. Notice 2015-16 indicates that Treasury and the IRS are inclined to adopt this position.

Notwithstanding this language, there are several other references within Code section 4980I that suggest that the Excise Tax could be determined by looking at the coverage that is offered or made available to the employee (rather than just enrolled). Specifically, Code section 4980I(b)(1) defines “excess benefit” with respect to “coverage made available” to an employee. Similarly, Code section 4980I(d)(1)(A) defines “applicable employer-sponsored coverage” to mean “coverage under any group health plan made available” to an employee which is excludable (or would be excludable) under Code section 106. Lastly, we note that Code section 4980I(b)(3)(B) provides that the annual limitation that applies to an individual for a month is determined based on the type of coverage “provided” to the employee. Given the language contained in Code subsections (b)(1) and (d)(1)(A), this reference to “provided” coverage could certainly be construed to mean the coverage that is offered or otherwise made available to the employee.

Employers will face significant administrative challenges in determining the aggregate cost of applicable coverage, calculating the amount of any Excise Tax liability, and allocating any such liability among the appropriate coverage providers. In many respects, the administrative difficulty of determining the aggregate cost of coverage would be augmented if employers are required to look to the cost of the applicable coverage in which each employee is actually enrolled. Requiring employers to look to actual enrollment means that there are no administratively simple ways to calculate the cost of applicable coverage across an employee population; rather, individual calculations must be done for each employee. For many employers, such individual calculations would result in significant operational challenges.

Moreover, determining Excise Tax liability based only on enrolled coverage could discourage employers from offering multiple plan options or multiple benefit packages because adverse selection among those options could cause higher claims or higher risk individuals to enroll to a relatively greater extent in the plans with increased benefits. Employers may be discouraged from offering benefit options that are most suitable for individuals that are sicker, chronically ill, or otherwise in greater need of increased coverage.

Determining Excise Tax liability based upon offered versus enrolled coverage would alleviate both of these very important concerns. First, employers would be permitted to utilize a simpler methodology for determining any Excise Tax liability based upon the suite of benefits offered across a workforce, rather than having to engage in employee-by-employee calculations. Additionally, determining Excise Tax liability based upon offered versus enrolled coverage will help ensure that disabled or chronically ill Americans have access to the most suitable coverage. We believe such a rule is supported by the statute as well as public policy and that a limited

reading of the statute based only upon enrollment should be avoided.

D. Defining Subject Enrollees

Issue D1: Determining who is a “primary insured individual.”

Recommendation

“Primary insured individual” for purposes of Code section 4980I should include anyone who has an independent right to elect coverage under an applicable employer-sponsored plan.

Discussion

Code section 4980I applies to applicable employer-sponsored coverage with respect to an “employee.” “Employee,” in turn, is defined in Code section 4980I(d)(3) to include “any former employee, surviving spouse, or other primary insured individual.” It is not clear based on the statutory language who may qualify as a “primary insured individual” other than employees, former employees, or surviving spouses. Guidance is needed on this issue so that coverage providers can clearly delineate who is, and is not, an employee for purposes of the Excise Tax. We urge Treasury to clearly set forth in guidance who is an “employee,” including who is a “primary insured individual.” In this regard, we think it would be reasonable to define the term to include anyone with an independent right to elect coverage (which would, for example, include individuals with an independent right to elect COBRA coverage).

Issue D2: Application of the Excise Tax to individual insurance policies purchased by self-employed persons.

Recommendation

Individual insurance policies purchased by self-employed persons should in all circumstances be excluded from the scope of the Excise Tax.

Discussion

Based upon the statutory language of Code section 4980I, it appears that the Excise Tax applies to some types of group coverage provided to self-employed persons. As noted above, Code section 4980I imposes the Excise Tax if the aggregate cost of applicable employer-sponsored coverage provided to an “employee” exceeds a stated dollar limit. Code section 4980I defines “applicable employers-sponsored coverage” by reference to a “group health plan,” which is in turn defined in Code section 5000(b)(1) to be a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

With respect to the treatment of self-employed individuals, Code section 4980I(d)(1)(D) states:

In the case of an individual who is an employee within the meaning of section 401(c)(1), coverage under any group health plan providing health insurance coverage shall be treated as applicable employer-sponsored coverage if a deduction is allowable under section 162(l) with respect to all or any portion of the cost of the coverage.

Code section 401(c)(1) provides that, for purposes of section 401, “[t]he term ‘employee’ includes, for any taxable year, an individual who is a self-employed individual for such taxable year.”¹

Based upon the express reference to self-employed persons in Code section 4980I(d)(1)(D), it appears Congress intended for at least some group health plans covering self-employed persons to be subject to the Excise Tax provisions of Code section 4980I. For example, it seems reasonable to believe that Congress intended the provisions to apply to plans covering multiple partners in a partnership (such as medical or law firm practices).

AHIP does not believe, however, that Congress could have intended for Code section 4980I to apply to individual (*i.e.*, non-group policies sold in the individual insurance markets to self-employed persons). This is due, in part, to the fact that health issuers underwriting individual insurance will have no way of knowing with any real certainty whether an individual insurance policy is being purchased by a self-employed person. This is in contrast to policies sold or marketed in the group insurance market where the issuer will be aware of the potential for the Excise Tax provisions of Code section 4980I to apply to such policies.

Additionally, with respect to self-employed individuals who are employees under Code section 401(c)(1), the Excise Tax applies to coverage under any group health plan providing health insurance coverage only if a deduction is allowable under section 162(l) with respect to all or any portion of the cost of coverage. Again, the issuer will have no knowledge of the extent to which the self-employed person has sufficient earnings from self-employment to claim a Code section 162 deduction.

Lastly, we note that, in other contexts with respect to the Affordable Care Act, the Department of Health and Human Services (“HHS”) has concluded that plans covering only a sole proprietor are not group health plans. *See* CCHIO Technical Guidance (CCHIO 2012-002): Questions and Answers Regarding the Medical Loss Ratio Regulation, Centers for Medicare and Medicaid Services (April 20, 2012) (hereinafter “CMS Q&As”) and Plan Management Webinar Frequently Asked Questions #3, Centers for Medicare and Medicaid Services (April 11, 2013) (hereinafter “QHP FAQs”). Specifically, with respect to the Medical Loss Ratio (“MLR”), HHS

¹ Code section 401(c)(1) goes on to state that “[t]he term ‘self-employed individual’ means, with respect to any taxable year, an individual who has earned income . . . for such taxable year.” It also includes “an individual who would be a self-employed individual . . . but for the fact that the trade or business . . . did not have net profits for the taxable year” and “an individual who has been a self-employed individual . . . for any prior taxable year.”

stated, “. . . where a sole proprietor and/or a spouse-employee are the only enrolled employees, the health plan would not be considered to be a group health plan.” Q&A 27, CMS Q&As. Similarly, with respect to the SHOP Exchanges, HHS provided, “States, State-based SHOPs, and FF-SHOPs must use ERISA/PHS Act provisions that prevent a business without at least one common law employee from forming a group benefit plan (sole proprietors, certain S-corp shareholders, and family members of either are not common law employees).” Q&A 18, QHP FAQs.

To subject an issuer to Excise Tax liability in this instance seems contrary to principles of tax equity and certainty. Accordingly, and in light of the foregoing, we urge Treasury and the IRS to issue rules that make clear that, in all instances, individual insurance policies providing coverage to a self-employed person are excluded from the scope of the Excise Tax.

E. Applicable Employer-Sponsored Coverage

Issue E1: Excluding employee assistance programs that qualify as excepted benefits within the meaning of Treas. Reg. section 54.9831-1(c)(3)(vi) from the Excise Tax.

Recommendation

Treasury and the IRS should use their regulatory authority to exclude employee assistance programs (“EAPs”) that qualify as excepted benefits pursuant to Treas. Reg. section 54.9831-1(c)(3)(vi) from the definition of “applicable employer-sponsored coverage.”

Discussion

The Notice proposes to exclude from the definition of subject coverage employee assistance programs or “EAPs” that qualify as excepted benefits within the meaning of Treas. Reg. section 54.9831-1(c)(3)(vi). The apparent rationale for this treatment is that EAPs that qualify for the exclusion must, in part, (i) not provide significant benefits in the nature of medical care, (ii) not coordinate benefits with any other group health plan, and (iii) not charge any employee premium or employee contribution.

AHIP believes that EAPs that qualify as an excepted benefit should be excluded from the scope of subject coverage. These types of EAPs, by definition, cannot provide significant medical care. Moreover, EAPs typically provide a range of support services to employees (e.g., legal or financial counseling) and the costs of valuing any medical care provided by the EAP would be time-consuming and likely would result in material financial expense. AHIP believes federal policy should support employer sponsorship of EAPs and other types of arrangements designed to ensure the health of the American worker.

AHIP recommends that EAPs that qualify as excepted benefits should be excluded from the scope of the Excise Tax.

Issue E2: Excluding employer activities aimed at improving employee well-being and health outcomes, including wellness programs, from the Excise Tax.

Recommendation

In addition to excluding EAPs as set forth above, Treasury and the IRS should use their regulatory authority to exclude employer activities aimed at improving health outcomes, including wellness programs, from the definition of “applicable employer-sponsored coverage.”

Discussion

Many employers are taking steps to improve the general health as well as the health outcomes of their employees. These steps include sponsorship of wellness programs, as well as the offering of biometric screenings, health coaching, chronic disease management, and expanded on-site clinic services, among others. In fact, according to the Kaiser Family Foundation’s annual survey of employer health benefits, approximately 98 percent of large employers (with 200 or more workers) and 73 percent of smaller employers (with between 3 and 199 workers) offer at least one wellness program. Kaiser Family Foundation, *Employer Health Benefits: 2014 Annual Survey*. 2014, The Kaiser Family Foundation, Menlo Park, CA; Health Research & Educational Trust, Chicago IL.

The ACA created numerous incentives for stakeholders to undertake actions to improve health outcomes. These include the introduction of preventive care requirements, the medical loss ratio (“MLR”) accounting for expenditures for activities that improve health care quality, flexibility in rating based on tobacco use, and quality of care reporting.

Section 2718 of the Public Health Service Act (“PHSA”) generally requires that a minimum percentage of the premium charged with respect to individual and group insurance coverage be utilized for the provision of benefits. However, for purposes of PHSA section 2718, expenditures for activities that improve health care quality are excluded from the denominator as part of the MLR calculation. “Activities that improve health care quality” were construed by the agencies to mean, *inter alia*, “activities designed to implement, promote, and increase wellness and health activities,” including “(1) wellness assessments;[and] (2) wellness/lifestyle coaching programs designed to achieve specific and measurable improvements”

In recognition of Congress’s intentions, and to help ensure that employers remain encouraged to undertake these activities, AHIP recommends that the final rule implementing Code section 4980I include a broad exception for any plan, arrangements, or other activities that are intended to improve the general health or well-being or health outcomes of participants. Under such a rule, the activities listed above would be excluded for purposes of the Excise Tax.

If Treasury and the IRS feel wellness programs cannot be excluded from the definition of “applicable employer-sponsored coverage” altogether, then they should at least exclude wellness programs that do not provide health coverage for a broad range of services and treatments in various settings from the definition of “applicable employer-sponsored coverage.”

Issue E3: Excluding certain on-site clinics from the Excise Tax.

Recommendation

Treasury and the IRS should use their regulatory authority to exclude on-site clinics from the definition of “applicable employer-sponsored coverage” if the clinic only provides de minimis medical care per the safe harbors described below.

Discussion

A growing number of employers have established on-site clinics for their employees. These clinics may provide a range of services from general first-aid for workplace injuries, to occupational safety and health programs such as diagnostic screening for job-related ailments. Many employers have added services to their on-site clinics such as flu shots because they have realized that such services improve employee health and reduce costs.

Notice 2015-16 requests comments whether on-site clinics should be excluded from applicable employer-sponsored coverage. The Notice acknowledges that when Congress enacted Code section 4980I, it appeared to pull in certain on-site clinics. However, as also noted in the Notice, the Joint Committee on Taxation (“JCT”) indicated in its technical explanation that Congress did not intend to subject on-site clinics providing only de minimis medical care to the Excise Tax.

We recommend that on-site clinics providing only de minimis medical care be excluded from the Excise Tax. For purposes of determining what constitutes “de minimis,” we recommend the establishment of several safe harbors for use by employers, in the alternative, as appropriate. These safe harbors could include the following tests:

- An on-site clinic provides only “de minimis” medical care and thus is excepted if the annual marginal costs of providing any benefits consisting of Code section 213 medical care do not exceed 15% of the overall costs of any related group health plan.
- An on-site clinic provides only “de minimis” medical care if it provides medical care consisting of no more than the following services: (1) immunizations; (2) injections of antigens (for example, for allergy injections) provided to employees; (3) provision of a variety of aspirin and other nonprescription pain relievers; and/or (4) treatment of injuries caused by accidents at work (beyond first aid).

Issue E4: Excluding self-funded limited-scope dental and vision coverage from the Excise Tax.

Recommendation

Treasury and the IRS should use their regulatory authority to exclude both insured and self-funded limited-scope dental and vision coverage from the definition of “applicable employer-sponsored coverage.”

Discussion

Code section 4980I excludes from applicable coverage “any coverage under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye.”

On its face, the statutory exclusion appears to apply only to insured limited-scope dental or vision coverage. However, as Notice 2015-16 observes, there is no apparent policy reason for treating self-funded coverage differently from insured coverage. AHIP agrees with the position set forth in the Notice. In fact, recent rules from Treasury and the IRS treats fully insured and self-funded limited scope dental and vision coverage as similar “excepted benefits.” (*see* 26 C.F.R. §54.9831-1(c)(3)(i)). A contrary rule would result in disparate treatment of self-funded coverage. AHIP recommends that self-funded limited-scope dental or vision coverage be excluded from the scope of the Excise Tax along with similar insured coverage.

Issue E5: Excluding employee pre-tax salary reduction contributions to medical savings accounts and health savings accounts from the Excise Tax.

Recommendation

Treasury and the IRS should use their regulatory authority to exclude employee pre-tax salary reduction contributions to Archer medical savings accounts (“MSAs”) and health savings accounts (“HSAs”) from the definition of “applicable employer-sponsored coverage.”

Discussion

Code section 4980I includes several express references to MSAs and HSAs, including Code section 4980I(c) (regarding liability to pay tax) and Code section 4980I(d)(2)(C) (regarding valuation). AHIP believes these references are to any funds deposited into an account by the employer and not pre-tax contributions by an employee. As a result, we recommend that employee pre-tax salary reduction contributions to such accounts should be excluded from the scope of the Excise Tax. In support of this recommendation, we note that Code section 4980I appears to make an important distinction with respect to MSAs and HSAs between “employer contributions” and “employee contributions” or “employer contributions under any salary reduction election.”

While employer contributions have often been interpreted for purposes of other federal tax provisions to include employee pre-tax contributions, other statutory language in Code section 4980I suggests an unqualified reference to “employer contributions” in Code section 4980I(d)(2)(C) should be read to exclude employee pre-tax contributions to MSAs and HSAs. For example, with respect to health flexible spending arrangements (“FSAs”), Code section 4980I(d)(2)(B) specifically states:

In the case of applicable employer-sponsored coverage consisting of coverage under a flexible spending arrangement (as defined in section 106(c)(2)), the cost of the coverage shall be equal to the sum of—

(i) the amount of employer contributions under any salary reduction election under the arrangement, plus

(ii) the amount determined under subparagraph (A) with respect to any reimbursement under the arrangement in excess of the contributions described in clause (i).

(Emphasis added).

In marked contrast to the language regarding FSAs, Code section 4980I(d)(2)(C) – which is located immediately below the FSA language – states as follows:

In the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of employer contributions under the arrangement.

(Emphasis added). As the highlighted language indicates, with respect to MSAs and HSAs, the contributions subject to valuation for purposes of Code section 4980I are “employer contributions.” This is in contrast to the language of Code section 4980I(d)(2)(B)(i), which refers to “employer contributions under any salary reduction election.”

The fact that Congress chose only to refer to “employer contributions” with respect to MSAs and HSAs, but referred to “employer contributions under any salary reduction election,” suggest to us that the statute could be read to indicate that Congress intended to subject to the Excise Tax only those amounts contributed by an employer in the form of non-elective employer contributions – and that pre-tax employee contributions (i.e., “employer contributions under any salary reduction election”) are disregarded with respect to HSAs.

Several other aspects of the statute, as well as past practice and precedent, support this reading of the statute. First, as noted in the Notice, after-tax employee contributions to MSAs and HSAs do not appear to be taken into account for purposes of the Excise Tax. This appears to be the case even if an individual later deducts such contributions on his or her annual Form 1040, as permitted by Code sections 220 and 223. Subjecting employee pre-tax salary reduction contributions to these accounts would create an odd tax result in that an individual could make his or her MSA or HSA contributions excludable from federal income tax if they make contributions outside of the workplace on a post-tax basis (and take a corresponding deduction on their annual Form 1040), but not if they make the same contributions at work via their employer’s Code section 125 cafeteria plan. There is no apparent policy basis for treating these two types of contributions differently.

In addition, if employee pre-tax contributions to MSAs and HSAs are counted for purposes of the Excise Tax, it should be expected that employers may cease to make available to employees the opportunity to make pre-tax contributions to the accounts. This is not because employers want to deny employee access to MSAs or HSAs. Instead, it would be part of a strategy to keep their applicable employer-sponsored coverage below the applicable dollar thresholds so as to avoid an Excise Tax liability.

It should also be noted that under ACA Section 1302(d)(2)(B) and regulations implementing that provision, the amount of “employer contributions to a health savings account (within the meaning of section 223 of the Internal Revenue Code)” may be taken into account when determining the actuarial value of coverage. In this context “employer contributions” are the amounts contributed into an HSA by an employer and not the employee’s pre-tax contributions. Although this provision amends the PHSA and not the Code, it evidences Congress’ intention to distinguish between amounts employers and employees contribute into such accounts on a pre-tax basis.

For the foregoing reasons, AHIP urges Treasury and the IRS to use their regulatory authority to exclude employee pre-tax salary reduction contributions to MSAs and HSAs from the definition of “applicable employer-sponsored coverage.”

Issue E6: Excluding limited scope flexible spending accounts and limited scope health reimbursement arrangements from the Excise Tax.

Recommendation

Treasury and the IRS should use their regulatory authority to exclude limited scope FSAs and limited scope health reimbursement arrangements (“HRAs”) from the Excise Tax.

Discussion

As discussed in the Notice, per the express statutory language of Code section 4980I, Congress intended to exclude from the Excise Tax stand-alone dental and vision coverage. Accordingly, AHIP requests that the final rules exclude from the Excise Tax FSAs or HRAs that only reimburse dental or vision benefits as set forth in Revenue Ruling 2004-45. Such a rule aligns with congressional intent and will ensure that limited scope dental or vision benefits, regardless of whether provided through an FSA, HRA or otherwise, receive equal treatment under federal tax law.

Issue E7: Excluding HRAs that only reimburse premiums for applicable employer-sponsored coverage from the Excise Tax.

Recommendation

Treasury and the IRS should use their regulatory authority to exclude from the definition of “applicable employer-sponsored coverage” HRAs that may only be used to reimburse premiums for other coverage that constitutes applicable employer-sponsored coverage.

Discussion

As acknowledged in the Notice, HRAs can take many forms and serve many purposes. Employers may choose to offer HRAs that are limited to reimbursing premiums with respect to employer-sponsored major medical group coverage (whether insured or self-funded). To the extent that the major medical coverage is already subject to valuation for purposes of the Excise Tax, the HRA – and the contributions thereto by an employer – should be excluded for purposes of the Excise Tax. A contrary rule would result in an inaccurate and exaggerated Excise Tax liability.

Issue E8: Excluding employer-sponsored Medicare plans and Employer Group Waiver Programs (EGWPs) from the Excise Tax.

Recommendation

Treasury and the IRS should use their regulatory authority to exclude employer-sponsored Medicare plans and EGWPs from the definition of applicable employer-sponsored coverage. In the event such plans are not wholly excluded from the Excise Tax, AHIP recommends that amounts paid by the Center for Medicare and Medicaid Services (“CMS”) with respect to such plans should be excluded from the Code section 4980I cost determination.

Discussion

Many employers sponsor Medicare plans or EGWPs for their retirees and may provide significant employer-paid premium subsidies with respect to this coverage, which reduce the costs for the retirees enrolled in the coverage. Employer-sponsored Medicare plans and EGWPs should be excluded from the scope of the Excise Tax to ensure that retirees continue to have access to these plans as well as related employer premium subsidies. A contrary rule could cause some employers to cease offering these plans, which in turn, would increase costs on many aged individuals because of the lost employer premium assistance from their former employers. Moreover, excepting these plans from the Excise Tax is desirable because individual Medicare Advantage policies and traditional Medicare Part D coverage are not subject to the Excise Tax. .

For these reasons, AHIP recommend that Treasury and the IRS exclude all employer-sponsored Medicare plans and EGWPs from the scope of the Excise Tax. To the extent that such plans are not wholly excluded from the Excise Tax, AHIP recommends that amounts paid by CMS with

respect to such plans should be excluded from the cost determination for purposes of Code section 4980I.

Issue E9: Excluding employee post-tax contributions for specified disease coverage and fixed indemnity coverage from the Excise Tax.

Recommendation

Treasury and the IRS should use their regulatory authority to exclude employee post-tax contributions to specified disease coverage and fixed indemnity coverage from the definition of applicable employer-sponsored coverage notwithstanding that there may also be employer contributions to that coverage that is excludible from the employee's gross income.

Discussion

Code section 4980I(d)(1)(B)(iii) excludes coverage only for a specified disease or illness and hospital indemnity or other fixed indemnity insurance from the definition of "applicable employer-sponsored coverage" if the payment for the coverage or insurance is not excluded from the gross income of the employee.

This exclusion was not specifically discussed in the Notice, but based on the statutory language, it seems clear that the specified disease or indemnity coverage would: (1) be subject to the Excise Tax if it is paid for solely by employer contributions that are excluded from an employee's gross income and (2) not be subject to the Excise Tax if it is paid for solely by employee after-tax contributions. AHIP requests that if that type of coverage is paid for with both types of contributions, that only the portion of the coverage that is paid for by the employer's contributions be included within the scope of the Excise Tax.

Specified disease and indemnity coverages are fairly inexpensive coverages that some employers purchase for all their employees. In addition to this employer-purchased base coverage level, some employers provide their employees the optional opportunity to buy higher coverage levels at their own expense through post-tax payroll deductions. If the higher coverage levels must be counted for purposes of the Excise Tax merely because the employer pays for the base coverage level, it should be expected that employers may cease to make available to employees the opportunity to buy those higher levels.

For these reasons, AHIP and its member companies urge Treasury and the IRS to include within the scope of the Excise Tax for specified disease coverage and fixed indemnity coverage only employer contributions that are excludible from the employee's gross income.

F. Determining Cost of Applicable Employer-Sponsored Coverage

Issue F1: Valuation of HRAs.

Recommendation

To the extent HRAs are considered applicable employer-sponsored coverage, AHIP encourages Treasury and the IRS to develop clear and easy-to-administer rules for valuing such arrangements.

Discussion

As discussed above, AHIP encourages Treasury and the IRS to exclude certain HRAs from applicable employer-sponsored coverage altogether. To the extent HRAs are considered applicable employer-sponsored coverage, principles of equity and fairness dictate that only amounts that become available on or after January 1, 2018 (*i.e.*, when the Excise Tax becomes effective) should be subject to the Excise Tax, as proposed in Notice 2015-16. In addition, after the Excise Tax becomes effective, AHIP urges Treasury and the IRS to specify that employers may value HRA coverage using only the amounts that are contributed to the HRA with respect to the tax year at issue.

Given the complexity of valuing HRAs, AHIP believes it would be appropriate to provide flexibility to employers in calculating the value of an HRA. AHIP would be supportive of Treasury and the IRS providing multiple methodologies for employers to select from in deciding how to value HRAs. Given the complexity of the Excise Tax as a whole, any ways to provide flexibility to coverage providers are welcome.

Issue F2: Valuing FSAs.

Recommendation

With respect to FSAs that are considered applicable employer-sponsored coverage, AHIP encourages Treasury and the IRS to allow coverage providers to exclude amounts that remain in an account due to a carryover provision or a grace period provision.

Discussion

As discussed above, AHIP encourages Treasury and the IRS to exclude limited scope FSAs from applicable employer-sponsored coverage. To the extent an FSA is considered to be applicable employer-sponsored coverage, AHIP urges Treasury to adopt a rule that would permit coverage providers to value the FSA based on the contributions made to the account for a given year and to exclude from valuation amounts that are in an account solely due to a carryover provision or a grace period provision associated with such FSA (so long as they were previously taken into account for purposes of valuation in the year in which they were actually contributed to the account). Allowing coverage providers to exclude such amounts would facilitate valuation. In addition, AHIP urges Treasury and IRS to adopt an optional rule whereby coverage providers

may, in their sole discretion, value FSAs based on amounts actually used by the account holder during the year, since it is often the case FSA account holders do not fully use the amounts contributed to their accounts during a year.

Issue F3: Retaining stakeholder flexibility with respect to the eventual harmonization of the valuation rules for COBRA and the Excise Tax.

Recommendation

Treasury and the IRS should prioritize maintaining flexibility for stakeholders as they implement valuation rules for the Excise Tax. Given the significant burdens posed by the administration of the Excise Tax, AHIP recommends that entities be permitted to continue to utilize their current good faith interpretation of the COBRA rules for purposes of COBRA as well as the Excise Tax.

Discussion

The Notice indicates that Treasury and the IRS are considering issuing proposed rules with respect to COBRA valuation and that these rules might also apply for purposes of determining “cost” of applicable employer-sponsored coverage for purposes of the Excise Tax.

AHIP is concerned that stakeholders will face significant administrative challenges in attempting to comply with the requirements of Code section 49801. Requiring stakeholders to understand and implement new valuation rules for purposes of COBRA will result in additional administrative burden and confusion. Employers are currently permitted to use a good faith, reasonable interpretation of the COBRA statute for purposes of compliance. The preamble to the final COBRA regulations provides, “For any period beginning on or after the effective date of the final regulations with respect to topics not addressed in the final regulations, such as how to calculate the applicable premium, the plan and the employer must operate in good faith compliance with a reasonable interpretation of the requirements in section 4980B.” Preamble to 1999 Final IRS COBRA Regulations, 64 Fed. Reg. 5160, 5161 (Feb. 3, 1999).

To ensure that stakeholders are not even more burdened by the administrative aspects of the Excise Tax, AHIP strongly recommends that stakeholders be permitted to continue to administer COBRA in a manner that is consistent with their existing reasonable good faith interpretation of the statutory language of COBRA. This will help minimize the implementation challenges posed by the Excise Tax and ensure that employers can focus all of their attention on implementing the Excise Tax.

Issue F4: Providing employers with broad flexibility in aggregating coverage so long as the aggregation does not result in a valuation higher than the total premium for such.

Recommendation

Treasury and the IRS should provide employers with broad flexibility in aggregating coverage for purposes of the Excise Tax so long as the method of aggregation does not result in a

valuation with respect to any insured coverage that exceeds the total premium charges with respect to such insured coverage.

Discussion

The Notice sets forth a contemplated methodology regarding aggregation. Specifically, it provides that each group of similarly situated employees would be determined by starting with all employees covered by a particular benefit package (e.g., a health maintenance organization or preferred provider organization) provided by the employer, then subdividing that group based on mandatory disaggregation rules, and allowing further subdivision of the group based on permissive disaggregation rules (as explained below).

- Aggregation by benefits package. The initial groups of similarly situated employees would be determined by aggregating all employees covered by a particular benefit package provided by an employer. The employees enrolled in each different benefit package would be grouped separately.
- Mandatory disaggregation (self-only coverage and other-than-self-only). After aggregating all employees covered by a particular benefit package, the employer would be required to disaggregate the employees within the group covered by the benefit package based on whether an employee had enrolled in self-only coverage or other-than-self-only coverage.
- Permissive aggregation within other-than-self-only coverage. Employers would not be required to determine the cost of applicable coverage for employees receiving other-than-self-only coverage based on the number of individuals covered in addition to the employee.
- Permissive disaggregation. Treasury and the IRS are considering allowing, but not requiring, an employer to further subdivide the group of employees that would be treated as similarly situated. Specifically, they are considering whether disaggregation should be permitted based on a broad standard such as bona fide employment-related criteria, or a more specific standard, such as a list of limited specific categories for which permissive disaggregation would be allowed.

AHIP is concerned that the contemplated methodology may be unduly restrictive and has the potential to result in less choice for enrollees and potentially increased “cost” valuations for plans with greater participation by individuals who may be sicker, have chronic conditions, or experience higher claim costs. This is because the contemplated methodology would appear to require employers to value coverage not on a plan-level or at the level of the employer, but at the level of each benefit package (such as low-deductible, mid-deductible, and high-deductible coverage). To the extent individuals incurring relatively higher claims enroll in one of the benefit packages, this would seem to result in a higher “cost” valuation for purposes of the Excise Tax. As a result, employers may choose to eliminate benefit packages in order to achieve lower average “costs” and, in doing so, individuals could lose access to coverage that is relatively better suited to their medical needs.

As an alternative to the contemplated methodology, AHIP recommends a rule that would provide employers with broad discretion in determining how best to aggregate their plans and/or benefit packages. However, in no event should the “cost” of an employer’s coverage be determined to be greater than the total premiums charged for the insurance by the issuer.

G. Certain Additional Issues Related to the Excise Tax

Issue G1: Determining the amount attributable to the Excise Tax.

Recommendation

Amounts “attributable to the tax” should include amounts charged by a covered entity to recoup the Excise Tax and any taxes or fees applied to such amounts.

Discussion

Code section 4980I(d)(2)(A) provides that the cost of applicable coverage does not take into account “any portion of the cost of such coverage which is attributable to the tax imposed under this section” (emphasis added).

We urge Treasury and the IRS to issue rules interpreting this language to encompass not only the amount of the Excise Tax itself, but also amounts charged by an issuer to recoup costs “attributable to the tax.” Amounts attributable to the Excise Tax should include amounts resulting from the fact that the Excise Tax is nondeductible for the issuer, any premium cost attributed to recoupment of the Excise tax, and any additional state and federal tax liability, such as the health insurer fee imposed by Code section 9010. A contrary rule could disadvantage issuers relative to self-insured coverage and should be avoided.

Issue G2: Clarifying that the “person that administers the plan benefits” with respect to other coverage is the ERISA plan administrator.

Recommendation

Treasury and the IRS should define the term “person that administers the plan benefits” to be the entity listed as the “plan administrator” on the Form 5500, or that would be so listed if the annual reporting requirement were applicable to the plan.

Discussion

Code section 4980I(c)(2)(C) states that, with respect to applicable employer-sponsored coverage other than insured coverage and MSA and HSA contributions, the “person that administers the plan benefits” is liable for any Excise Tax owed. The term “person that administers the plan benefits” is not defined in the statute itself, nor are we aware of any existing definition elsewhere in the Code or regulations. AHIP urges Treasury and the IRS to define the term in regulations to

be the entity listed as the “plan administrator” on the Form 5500, or that would be so listed if the annual reporting requirement were applicable to the plan.

ERISA provides an existing and well-established definition of “administrator” that is an appropriate source for determining who is the person that administers the plan benefits. Specifically, ERISA section 3(16) defines an “administrator” of a plan to be “(i) the person specifically so designated by the terms of the instrument under which the plan is operated; (ii) if an administrator is not so designated, the plan sponsor; or (iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the secretary may by regulation prescribe.” This definition is well-established and the product of significant administrative rulemaking and federal common law.

For several reasons, third party administrators (TPAs) – as opposed to ERISA plan administrators - are ill-positioned to be the “person that administers the plan benefits.” They generally have limited knowledge regarding the extent of other coverage that is made available to a given employee, beyond the coverage with respect to which they provide services. Additionally, they may only charge a small per month or per contract administrative fee for their services and thus generally will not have an avenue to collect and/or charge additional amounts with respect to any Excise Tax liability, especially since they might not become aware of an Excise Tax liability until after the close of a plan year or contract termination.

For the foregoing reasons, AHIP strongly recommends that the “person that administers the plan benefits” be defined to be the entity listed as the “plan administrator” on the Form 5500, or that would be so listed if the annual reporting requirement were applicable to the plan.