

Notice 2015-16

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**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

May 15, 2015

The Honorable John Koskinen
Commissioner
Internal Revenue Service
CC:PA:LPD:PR (Notice 2015-16)
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Submitted via E-Mail to: Notice.comments@irs.counsel.treas.gov

RE: Notice 2015-16, Section 49801 — Excise Tax on High Cost Employer-Sponsored Health Coverage

Dear Commissioner Koskinen:

The Blue Cross and Blue Shield Association ("BCBSA") appreciates the opportunity to provide comments to the Internal Revenue Service ("IRS") on Notice 2015-16, Section 49801 — Excise Tax on High Cost Employer-Sponsored Health Coverage ("the Notice").

BCBSA is a national federation of 37 independent, community-based, and locally-operated Blue Cross and Blue Shield Plans ("Plans") that collectively provide health care coverage for 105 million – one in three – Americans. Blue Cross and Blue Shield Plans offer coverage in every market and every ZIP Code in America. Plans also partner with the Government in Medicare, Medicaid, the Children's Health Insurance Program, and the Federal Employees Health Benefits Program.

The Notice is an important first step to assist employers and health insurance issuers to understand how the excise tax on high cost employer-sponsored health coverage ("excise tax") will be implemented. BCBSA is concerned that the excise tax could have sweeping and unanticipated adverse impacts on plan designs that Congress likely did not believe were either high cost or overly generous, including high deductible plans offered with health savings accounts, as well as gold and silver level plans that issuers are required to offer to employers under the Affordable Care Act ("ACA"). BCBSA is also concerned issuers and administrators will be responsible for paying taxes on products that are not high cost or overly generous simply because an employer chooses to offer additional applicable coverage to their employees or because an employee chooses to enroll in an HSA. Issuers and employers must, at the least,

be afforded a credible opportunity to design and sell products that do not run afoul of the excise tax.

As such, BCBSA urges Treasury and the IRS to adopt, wherever possible, rules that alleviate the adverse impact of the excise tax on consumers. This approach is necessary to ensure that employers are not forced to adopt higher cost sharing plans (e.g., bronze plans) without HRAs, HSAs, or FSAs, or drop coverage altogether. In addition, BCBSA urges Treasury and the IRS to make administration of the excise tax as simple as possible and to provide alternatives for employers and health insurance issuers wherever possible.

Key Recommendations

Recommendation # I:

Ensure that Plans can avoid incurring the excise tax and still comply with all other applicable ACA requirements. In particular, gold and silver level plans that issuers are required to make available as a condition for participation on a SHOP Marketplace should not subject an insurer or employer to the excise tax (whether purchased on or off of the Marketplace). Additionally, Treasury and the IRS should exercise their regulatory authority to calculate the excise tax in reference to the lowest cost plan an individual is eligible to enroll in that meets the minimum value requirement (that is, the lowest cost plan “made available” to an individual).

Recommendation # II:

Allow employers to exclude contributions to HSAs and Archer MSAs, including employee salary reduction contributions to HSAs, from the definition of applicable coverage, to encourage employers to continue offering high deductible health plans and other consumer driven products long available to employees.

Recommendation # III:

Provide relief by excluding salary reduction and employer flex contributions to FSAs from the definition of applicable coverage, to encourage employers to continue offering consumer driven health funding vehicles long available to employees.

Recommendation # IV:

Permit the cost of coverage to be calculated based on standard population measurements, including geography. The costs of plans vary significantly from region to region and not permitting issuers to account for geographic variation will inevitably lead to inequitable results for insurers covering individuals in high cost areas.

We also ask that Treasury and the IRS develop clear guidance, in as timely a manner as possible, for determining COBRA applicable premiums that harmonize with the rules developed for the excise tax, including the ability to account for geographical variations in cost.

Recommendation # V:

Clarify that health insurance issuers providing administrative services are not “the person that administers the plan benefits” and thus cannot be liable for the excise tax.

Recommendation # VI:

Exclude from the excise tax any dental or vision coverage that meets the current excepted benefit standard, as modified in regulations finalized last year.

Recommendation # VII:

Permit self-insured plans to use either the actuarial basis method or the past cost method for computing the cost of coverage. However, Treasury and the IRS should clarify which factors may be taken into account by a self-insured plan using the actuarial method for estimating the cost of coverage. These factors should be enumerated with sufficient time for plans to comment on the contemplated factors prior to the issuance of final rules.

Recommendation # VIII:

Permit employers to determine the cost of coverage under an HRA by adding together all claims and administrative expenses attributable to the HRA for a particular period and dividing that sum by the number of employees covered for that period. Treasury and the IRS should adopt the other approaches outlined in the Notice as well, and to permit employers to choose between approaches. Allowing employers a choice would maximize flexibility and would avoid overvaluing HRA coverage, double counting HRA amounts, and other similarly inequitable outcomes.

Recommendation # IX:

Permit self-insured plans to determine the cost of applicable coverage by using actual costs paid by the plan to provide health coverage for the year. Treasury and the IRS should time the filing of returns and payment of the excise tax in such a way as to promote the feasibility of using actual costs.

Recommendation # X:

Permit a choice between both approaches outlined in the Notice for applying dollar limits to employees with both self-only and other-than-self-only applicable coverage.

Recommendation # XI:

Provide guidance on the timeframe in which the employer must give issuers and administrators information regarding their portion of the excise tax. Issuers and administrators will need sufficient time between receiving the information and filing due dates to address any disagreements with the employer as well as calculate rates adequate to take into account the

cost of the tax. Guidance should also clarify that an issuer or administrator will not be liable for any interest or penalties as a result of an employer's miscalculation of the excise tax owed.

Recommendation # XII:

Implement the approach discussed in the Notice that would exclude employee assistance programs ("EAPs") that qualify as an excepted benefit from the definition of applicable coverage for purposes of the excise tax.

Recommendation # XIII:

Exclude from the cost of applicable employer-sponsored coverage all costs associated with the excise tax. These costs should include amounts recouped from third parties by plans in order to make plans whole for payment of the excise tax (for example, amounts paid as tax "gross ups" to a plan by an employer). These costs should also include fees and taxes imposed on plans by the ACA, including the health insurance provider fee, the Patient-Centered Outcomes Research Institute fee, and transitional reinsurance program contributions, as well as state premium taxes.

Our additional recommendations and detailed comments are attached.

We appreciate the opportunity to provide comments regarding the Notice on the excise tax and look forward to continuing to work with Treasury and the IRS as they issue guidance on implementing this tax. If you have any questions, please contact Richard White at Richard.White@bcbsa.com or 202.626.8613.

Sincerely,

A handwritten signature in black ink, appearing to read "K. Haltmeyer", with a long horizontal flourish extending to the right.

Kris Haltmeyer
Vice President
Health Policy Analysis
Blue Cross Blue Shield Association

**BCBSA Detailed Comments and Recommendations on the Notice 2015-16, Section 4980I
— Excise Tax on High Cost Employer-Sponsored Health Coverage**

I. Safe Harbors for Determining the Cost of Coverage

Issue:

In the Notice, Treasury and the IRS invite comments on whether any alternative approaches to determining the cost of applicable coverage would be consistent with the statutory requirements and would be useful.

Recommendation:

Ensure that plans can avoid incurring the excise tax and still comply with all other applicable ACA requirements. In particular, gold and silver level plans that issuers are required to make available as a condition for participation on a SHOP Marketplace should not subject an insurer or employer to the excise tax (whether purchased on or off of the Marketplace).

Treasury and the IRS should exercise their regulatory authority to calculate the excise tax in reference to the lowest cost plan an individual is eligible to enroll in that meets the minimum value requirement (that is, the lowest cost plan “made available” to an individual), rather than looking at the coverage the individual actually enrolls in (as suggested by the Notice).

If Treasury and the IRS are unable to provide ongoing relief as requested, they should use their regulatory authority to provide transition relief or temporary limited enforcement. Treasury and the IRS could, for example, delay enforcement of the excise tax, for the first several years that the tax is effective base the determination of the tax on the lowest cost plan made available, or provide safe harbors based on metal levels or other objective and easily ascertainable factors.

Rationale:

Any requirement to determine the cost of coverage on an employee by employee basis will create tremendous administrative complexity at great cost to issuers, administrators and employers (and, ultimately, employees and other insureds). Treasury and IRS could reduce both the complexity and the cost of the provision by creating safe harbors or interim rules that allow issuers to determine the cost of coverage based on clear and easily ascertainable standards.

Creating a safe harbor from the excise tax for gold and silver level plans conforms to Congressional intent. Congress would not have required that these plans be offered on exchanges if it felt that these plans would be overly generous.

The statutory language in § 4980I, when read as a whole, appears to permit Treasury and the IRS to look at the cost of coverage made available to employees rather than looking at coverage in which an employee is actually enrolled. Looking at the cost of coverage for the lowest cost plan made available to employees in this context would not only comply with the statutory language of § 4980I but would also be consistent with the approach taken by Treasury

and the IRS in the context of the employer shared responsibility provision. Under the employer shared responsibility rules, whether an employer owes an assessable payment is determined in reference to the coverage offered, and not in reference to the coverage in which an employee actually enrolls. Consistency between information that needs to be collected and reported would be a welcome lessening of the already considerable administrative burdens placed on plans by the ACA.

We read the Notice, however, as indication that this is not the approach that Treasury and the IRS plan on taking in future guidance. One problem with the contemplated approach of looking at the plan in which an employee enrolls, however, is that in coming years small group plans in virtually every state will become subject to the excise tax.

Such an approach also will have disparate impacts on states depending on geographic variations in the cost of coverage. An additional problem with the proposed approach is that employers may soon be in a position where they will be unable to offer minimum value coverage, as required by the employer shared responsibility provisions, without also incurring the excise tax. Such outcomes would be deeply unjust for taxpayers simply trying to comply with applicable ACA requirements.

If permanent relief is not possible, Treasury and the IRS should provide safe harbors based on clear and easily ascertainable factors. For example, plans are required to calculate actuarial values under other provisions of the ACA so tying safe harbors to AV levels would both avoid duplicating administrative burdens and tie the determination of the cost of a plan to clear and available metrics.

II. HSAs and Archer MSAs

Issue:

The Notice states that Treasury and IRS anticipate future proposed regulations providing that (1) employer contributions to HSAs and Archer MSAs, including salary reduction contributions to HSAs, are included in applicable coverage and (2) employee after-tax contributions to HSAs and Archer MSAs are excluded from applicable coverage.

Recommendation:

Allow employers to exclude contributions to HSAs and Archer MSAs, including employee salary reduction contributions to HSAs, from the definition of applicable coverage, in order to encourage employers to continue offering high deductible health plans and other consumer driven products long available to employees.

If a permanent exclusion is not permitted given the statutory language of the provision, at a minimum, interim relief (such as a three year non-enforcement safe harbor) should be provided in order to assist employers who wish to still offer these services to their employees.

Rationale:

That applicable coverage will include salary reduction contributions to HSAs will be problematic for many plans. HSAs are vehicles for consumers to use to enhance their awareness of the cost of health care and to make them more judicious in spending health care dollars. The goal of HSAs and other similar products is to push health care costs down through provider competition and services selection based on value and quality – goals that are very much in keeping with the policy behind the excise tax. Including employee contributions for purposes of the excise tax will provide a disincentive to employees wishing to contribute to HSAs and to employers wishing to offer high deductible health plans.

Further, HSA contributions made on an after-tax basis and then deducted under § 223 are clearly not included in the statutory definition of applicable coverage. Including pre-tax employee contributions but excluding contributions made on an after-tax basis and then deducted is an artificial distinction that only adds more complexity to HSA administration and further discourages their use.

It is also problematic that employer contributions are taken into account for purposes of defining applicable coverage. HSAs are unique vehicles that permit account holders to exercise control over how the funds are used, as opposed to typical health plans where enrollees are only entitled to the benefits under the plan. If employer and employee contributions to HSAs are included in the definition of applicable coverage HSAs will hit the dollar limit imposed by § 4980I whereas plans with smaller deductibles and richer benefits will not. The result of this rule will be that employers will stop offering HSA plans to employees – an outcome that contradicts the purpose of the excise tax.

In stating that employer contributions, including salary reduction contributions, to HSAs will be included in applicable coverage the Notice does not distinguish between HSAs that are group health plans and those that are not. Under the plain language of § 4980I(a)(1) and (d)(1), however, the excise tax may only be applied to employer sponsored coverage provided under a group health plan. Treasury and the IRS must clarify that only contributions made to HSAs that qualify as group health plans can be included in the excise tax.

HSAs are typically not considered “group health plans.” Rather, HSAs are tax advantaged trust or custodial accounts established and maintained by individuals with an approved trustee or custodian. HSAs belong to the individual account holder, not the employer, and if an employer makes contributions to an employee’s HSA and the employee terminates employment, the employee is generally able to keep those contributions for future use. Funds in an HSA may be used for both medical and non-medical expenses (subject to additional tax).

Treasury and the IRS have not issued formal guidance addressing whether an HSA is a “group health plan” under Code § 5000. They have, however, stated in the preamble to the regulations on prohibitions on lifetime and annual dollar limits that “HSAs generally are not treated as group health plans because the amounts available under the plans are available for both medical and nonmedical expenses.” Similar treatment has been accorded by other agencies for purposes of HIPAA Administrative Simplification and COBRA.

It is possible for an HSA to qualify as a group health plan under ERISA. The Department of Labor has issued guidance describing situations in which an employer can cause an HSA to become a group health plan, including when the employer controls investment opportunities or informs employees that the HSA is an employee benefit plan maintained by the employer. The fact that an employer contributes to an HSA has never, on its own, been enough to qualify an HSA as a group health plan.

In light of the language in § 4980I(a)(1) and (d)(1) Treasury and the IRS should clarify that only contributions made to an HSA that qualifies as a group health plan will be included in calculating the amount of the excise tax. Such clarification would lend meaning to the language in § 4980I(a)(1) and (d)(1), which when read together provide that only group health plans can be subject to the excise tax, as well as to the language in § 4980I(d)(2)(C) which does seem to contemplate that certain contributions to HSAs should be included when determining the cost of applicable coverage. Making such a clarification will also largely avoid the needless complication, discussed above, of having individuals deduct contributions to an HSA under § 223 rather than simply make the contributions on a pre-tax basis.

We believe that Treasury and the IRS have the authority to provide relief for HSAs that are not group health plans even taking into account the statutory language in § 4980I(c) and (d). If Treasury and the IRS believe that their authority is constrained, however, it would certainly be well within their regulatory authority to create safe harbors for valuing HSA contributions or to provide other limited interim relief.

III. FSAs

Issue:

The Notice states that Treasury and the IRS anticipate future proposed regulations providing that both salary reduction and employer flex contributions to health FSAs will be included in determining the cost of applicable coverage.

Recommendation:

Provide relief by excluding salary reduction and employer flex contributions to FSAs from the definition of applicable coverage, in order to encourage employers to continue offering consumer driven health funding vehicles long available to employees.

If a permanent exclusion may not be possible given the statutory language of the provision, interim relief (such as a three year non-enforcement safe harbor) should be provided in order to assist employers who wish to still offer FSAs to their employees and to assist consumers — many of whom have chronic health needs — that rely upon health FSAs.

Rationale:

Like HSAs, FSAs increase consumers' awareness of their health spending and since amounts in an FSA can be rolled over from year to year participants have an incentive to spend the amounts in their FSAs wisely.

With passage of the ACA Congress signaled their approval of FSAs by encoding them in statute. If, however, FSAs are included in the definition of applicable coverage the effort involved in valuing the cost of each individual FSA, in addition to the complications inherent in determining the value of an FSA, would make the cost of administration prohibitive. If FSAs are included in the definition of applicable coverage we expect that most employers will simply stop offering FSAs altogether. This result would be in stark contrast to Congressional intent.

The Congressionally mandated cap on FSA contributions ensures that were such contributions excluded from the definition of applicable coverage, FSAs would not create an end-run around the purpose of the excise tax.

Even if Treasury and the IRS believe their authority is constrained in providing relief for FSAs given the statutory language in § 4980I(c) and (d), it would be well within their regulatory authority to create safe harbors for valuing FSA contributions or to provide other limited interim relief.

IV. Geographic Variation

Issue:

The cost of applicable coverage must be determined under rules "similar" to the rules for calculating COBRA applicable premiums. The statute provides two baseline per-employee dollar limits (for self-only and for other-than-self-only coverage) as well as several upward adjustments to increase the baseline amounts in various circumstances. There are, however, no explicit upward adjustments for geographic variation.

Recommendation:

Permit the cost of coverage to be calculated based on standard population measurements and permit an upward adjustment for geographic variation. The costs of plans vary significantly from region to region and not permitting issuers to account for geographic variation will inevitably lead to inequitable results for insurers covering individuals in high cost areas.

We also ask that Treasury and the IRS develop clear guidance, in as timely a manner as possible, for determining COBRA applicable premiums that harmonize with the rules developed for the excise tax.

Rationale:

Although the statute does not list geography as one of the specifically enumerated factors for an upward adjustment to the dollar limits specified in § 4980I(b)(3), it is within Treasury's and the IRS' regulatory authority to permit plans to account for geographic location in determining the underlying cost of coverage as described in § 4980I(d)(2). Section 4980I(d)(2)(A) clearly contemplates that it is within Treasury's and the IRS's sole authority to develop rules for determining the cost of applicable coverage. While those rules must be "similar" to the COBRA rules, the language of the statute instructs Treasury and the IRS to structure the requirements for determining the cost of coverage in such a way as to best carry out the intent of the section. See § 4980I(g). Under our recommendation the upward adjustments specifically enumerated in the statute for age and gender would continue to apply – the geographic variation would also come into play in determining the cost of the underlying coverage.

The cost of coverage varies significantly from region to region due primarily to differences in provider reimbursement rates. Not accounting for geographic variation in determining the cost of coverage will inevitably lead to inequitable results for insurers, employers, and consumers in high cost areas. It would make no sense for a gold level plan offered on a SHOP Marketplace in New York to be subject to the excise tax when an identical plan offered on a SHOP Marketplace in Alabama is not. Administering the excise tax without accounting for geographic variation in the cost of coverage would unfairly increase the cost of plans in already high cost areas. As a result, employers will likely impose more cost sharing on employees or drop coverage altogether in greater proportions in certain high cost geographic areas. Therefore, Treasury and the IRS should permit the cost of coverage to be calculated based on standard population measurements, normalizing the cost for the impact of geography in high-cost areas.

As noted by Milliman, the excise tax is supposed to be a tax on plans with overgenerous benefits. However, geographic location can drive the value of a plan over dollar limit thresholds regardless of the richness of the plan. Milliman, *What does the ACA excise tax on high-cost plans actually tax?* at 3 (December 9, 2014).

Treasury and the IRS could provide safe harbors, even if only on an interim basis, based on the costs plans would actually incur providing the plan's benefits to a standard population in a standard-cost region of the country. Such safe harbors would promote equity between employees, employers, and insurers in different markets. It would also allow distinctions that have traditionally been made in the group market thus causing relatively less disruption to the existing marketplace.

This approach could be grounded in the statute's direction to Treasury to determine the cost of coverage in a manner similar to COBRA, which specifically allows for the consideration of geographic variation in cost. This approach would essentially allow a national aggregation approach for determining the cost of coverage so that plans in high cost areas could adjust expected costs based on national averages using the standard population approach. This is not dissimilar from an employer with a large employee population that operates in 50 states and chooses to set COBRA rates for its self-insured plan based on its overall claims experience rather than setting rates based on geographic areas.

V. Person that Administers the Plan

Issue:

Section 4980I(c)(1) and (2) specifies that in the case of applicable coverage that is not insured and is not an HSA or Archer MSA "the person that administers the plan" is the entity that shall pay the excise tax. Neither the statute nor the Notice define which entity is "the person that administers the plan."

Recommendation:

Clarify that health insurance issuers providing administrative services are *not* "the person that administers the plan" and thus cannot be liable for the excise tax.

Rationale:

Treasury and the IRS should define the person that administers the plan in a way that most easily fits with current plan filing and reporting requirements under ERISA and the Internal Revenue Code and should thus look to the ERISA plan administrator. Using a procedure in which a one party determines the tax which must be paid by another party appears to be unique within the Internal Revenue Code. Treasury and the IRS should clarify that insurance issuers are not obligated to pay a tax that is actually the responsibility of the ERISA plan administrator.

VI. Dental and Vision Coverage

Issue:

Treasury and the IRS are considering whether to exercise their regulatory authority under § 4980I(g) to propose an approach under which self-insured limited scope dental and vision coverage that qualifies as an excepted benefit pursuant to the recently issued regulations under § 9831 would be excluded from applicable coverage for purposes of § 4980I.

Recommendation:

Exclude from the excise tax any dental or vision coverage that meets the current excepted benefit standard, as modified in regulations finalized last year (80 Fed. Reg. 59130 (October 1, 2014)).

Rationale:

Providing for consistent treatment of excepted benefits will further the uniform administration of group health plans and make it easier for employers to offer these benefits to employees.

VII. Valuation of Self-Insured Plans

Issue:

COBRA rules prescribe two methods for self-insured plans to compute the COBRA applicable premium – the actuarial basis method and the past cost method. The actuarial method must take into account “such factors as the Secretary may prescribe in regulations.” § 4980B(f)(4)(B)(ii). Treasury and the IRS have not issued regulations prescribing factors that must be taken into account.

Recommendation:

Permit self-insured plans to use either the actuarial basis method or the past cost method for computing the cost of coverage. However, Treasury and the IRS should clarify which factors may be taken into account by a self-insured plan using the actuarial basis method for estimating the cost of coverage. These factors must be actuarially justified and supported and should be enumerated with sufficient time for plans to comment on the contemplated factors prior to the issuance of final rules.

Rationale:

Permitting the use of both methods for purposes of determining the cost of coverage for self-insured plans is in keeping with the requirement that the cost of applicable coverage be determined “under rules similar to the rules of section 4980B(f)(4).” § 4980I(d)(2)(A). Since the cost of all applicable coverage will be aggregated for purposes of the excise tax, plans, administrators and employers all need to know what factors to take into account for purposes of calculating the cost of self-insured coverage.

VIII. HRAs

Issue:

The Notice states that Treasury and the IRS anticipate that HRAs will be applicable coverage and therefore guidance is needed on how to determine the cost of HRA coverage. The Notice observes that simply basing the cost of coverage on amounts that are available in an HRA may overvalue the HRA since all contributions might not be spent in a given year. Accordingly, Treasury and IRS are considering a rule that would permit an employer to determine the cost of coverage by adding together all claims and administrative expenses attributable to HRAs for a particular period and dividing that sum by the number of employees covered for that period. Several other approaches are also described in the Notice.

Recommendation:

Permit employers to determine the cost of coverage under an HRA by adding together all claims and administrative expenses attributable to the HRA for a particular period and dividing that sum by the number of employees covered for that period. Treasury and the IRS should adopt the

other approaches outlined in the Notice as well, and to permit employers to choose between approaches. Allowing employers a choice would maximize flexibility and would avoid overvaluing HRA coverage, double counting HRA amounts, and other similarly inequitable outcomes.

Rationale:

As discussed in the Notice, determining the cost of HRAs is difficult due to risks of overvaluing and double counting. While making available multiple methods for determining the cost of applicable coverage under an HRA runs the risk of increasing administrative complexity it also increases the chances of valuing an HRA fairly and thus not discouraging their use. Allowing employers to choose between approaches would maximize flexibility and would avoid overvaluing HRA coverage, double counting HRA amounts, and other similarly inequitable outcomes. We encourage Treasury and the IRS to maintain maximum similarity between rules under the excise tax and rules under COBRA.

IX. Determination Period

Issue:

In the Notice Treasury and IRS invite comments on the feasibility of a method for determining the cost of applicable coverage using actual costs.

Recommendation:

Permit self-insured plans to determine the cost of applicable coverage by using actual costs (determined in a manner that is actuarially justified and supported) paid by the plan to provide health coverage for the year. Treasury and the IRS should time the filing of returns and payment of the excise tax in such a way as to promote the feasibility of using actual costs.

Rationale:

Permitting the use of historical data to determine costs would allow for certainty and would also arguably provide the most accurate means of capturing actual costs for purposes of calculating any excise tax owed.

X. Treatment of Employees with Both Self-Only and Other-Than-Self-Only Coverage

Issue:

Section 4980I(b)(3) provides two annual dollar limits: one for an employee with self-only coverage and one for an employee with other-than-self-only coverage. An employee may, however, simultaneously have coverage to which the self-only dollar limit applies and coverage to which the other-than-self-only dollar limit applies. In such circumstances it is unclear which of

the two limits should apply to the employee. The Notice outlines two potential approaches to dealing with this issue.

Recommendation:

Permit a choice between both approaches outlined in the Notice for applying dollar limits to employees with both self-only and other-than-self-only applicable coverage.

Rationale:

Treasury and IRS should afford plans the maximum level of flexibility practicable to determine how to treat employees with both self-only and other-than-self only coverage.

XI. Liability for Miscalculations

Issue:

Section 4980I(c)(1) and (2) specifies that health insurance issuers are responsible for paying the excise tax for insured plans and that the person that administers the plan is responsible for paying the excise tax for self-insured plans. It is the employer, however, that must calculate the excise tax and notify the entity liable for the tax (and the IRS) of the amount of the tax that is owed. § 4980I(c)(4). If an employer miscalculates the excise tax neither an insurer nor the person administering the plan will be able to pay the correct amount owed, if any.

Recommendation:

Provide guidance on the timeframe in which the employer must give issuers and administrators information regarding their portion of the excise tax. Issuers and administrators will need sufficient time between receiving the information and filing due dates to address any disagreements with the employer as well as calculate rates adequate to take into account the cost of the tax. Guidance should also clarify that an issuer or administrator will not be liable for any interest or penalties as a result of an employer's miscalculation of the excise tax owed.

Rationale:

Issuers and administrators are unlikely to have access to all the information necessary to be able to fully understand their potential risk and the extent of any potential liability under the excise tax. Employers should be required to pass along the necessary information as quickly as practicable. Issuers and administrators should be permitted to rely upon information provided by employers, and should be held harmless with respect to errors in payment resulting from incorrect information provided by employers.

XII. Employee Assistance Programs

Issue:

Section 4980I(d)(1)(B)(i) generally excludes from the definition of applicable coverage excepted benefits listed in § 9832(c)(1). Treasury and the IRS have recently issued regulations under § 9831 adding certain EAPs to the definition of excepted benefits. These newly added excepted benefit programs are not listed in § 9832(c)(1), however, and would thus arguably be included in the definition of applicable coverage absent guidance to the contrary.

Recommendation:

Implement the approach discussed in the Notice that would exclude EAPs that qualify as an excepted benefit from the definition of applicable coverage for purposes of the excise tax. Treasury and the IRS should exercise their authority under § 4980I(g) to provide that all excepted benefits, including EAPs qualifying as excepted benefits pursuant to the recently issued guidance under § 9831, are excluded from the definition of applicable coverage. These types of programs do not provide significant benefits in the nature of medical care yet are valuable tools for employees and often serve to drive down the cost of major medical care.

Rationale:

Services provided by EAPs and other excepted benefits do not provide significant benefits in the nature of medical care. They are both limited in scope and tangential to major medical care, and as such should not constitute applicable coverage. These programs provide valuable services to employees and their dependents as well as flexibility to employers. They may also serve to lower costs associated with more comprehensive coverage by offering services that prevent minor issues from developing into major medical problems.

Excepted benefits are generally not subject to Affordable Care Act requirements. Treasury and the IRS have recently issued guidance under § 9831 adding EAPs to the list of excepted benefits. It would be in keeping with the intent of the statute, which generally recognizes that excepted benefits are not applicable coverage, as well as within the scope of Treasury and the IRS's regulatory authority to exclude from the definition of applicable coverage all benefits included in the recent guidance.

XIII. Taxes and Fees

Issue:

Section 4980I(d)(2)(A) provides that in determining the cost of applicable employer-sponsored coverage "any portion of the cost of such coverage which is attributable to the tax imposed under this section shall not be taken into account...." The Notice does not offer guidance on how Treasury and the IRS plan on interpreting the term "attributable to the tax".

Recommendation:

Exclude from the cost of applicable employer-sponsored coverage all costs associated with the excise tax. These costs should include amounts recouped from third parties by plans in order to make plans whole for payment of the excise tax (for example, amounts paid as tax “gross ups” to a plan by an employer). These costs should also include fees and taxes imposed on plans by the ACA, including the health insurance provider fee, the Patient-Centered Outcomes Research Institute fee, and transitional reinsurance program contributions. Finally, Treasury and the IRS should exclude from the cost of applicable employer-sponsored coverage all state premium taxes.

Rationale:

The excise tax is intended to lower the cost of health care. The statute provides that in calculating the amount of the tax it is appropriate to look at the cost of health care itself, and not at the cost of fees and taxes associated with health plans. The language of the statute provides that amounts “attributable to the [excise] tax” must be excluded from the cost of coverage. The word “attributable” means that the exclusion is broader than the amount of the tax itself. Amounts “attributable” to the excise tax should include amounts incurred as a direct result of the imposition of the excise tax, such as gross ups paid to make a plan whole after payment of the excise tax. Treasury and IRS should look to the calculation of the medical loss ratio, which excludes federal and state taxes as well as licensing or regulatory fees from its calculation, as an example of costs that are appropriately excluded from cost calculations.

The policy rationale that underpins the exclusion of amounts attributable to the tax from the cost of coverage also supports excluding amounts attributable to other taxes and fees imposed on health plans and insurers by the ACA. The excise tax should relate only to the cost of health care itself. Subjecting plans to the excise tax because they owe fees and taxes imposed by the ACA, rather than because they offer expensive health care, would be an inequitable result for the plans and would not further the policy goals of the excise tax. We understand that this is a complex issue and we look forward to working with you on reaching a reasonable solution.

XIV. On-Site Medical Clinics

Issue:

Section 4980I(d)(1)(B)(i) excludes from the definition of applicable coverage each of the excepted benefits listed in § 9832(c)(1) other than the § 9832(c)(1)(G) exception for on-site medical clinics. Accordingly, coverage provided through on-site medical clinics is generally counted as applicable coverage.

Recommendation:

Exclude from applicable coverage on-site medical clinics that offer only *de minimis* medical care to employees. However, Treasury and the IRS should adopt a more flexible rule than a *de minimis* standard. Clinics are a cost effective way for employers to deliver a range of

preventative benefits and clinic benefits could be excluded from the excise tax under the existing excepted benefit rules. If medical care in excess of the applicable standard is offered Treasury and the IRS should provide that only the incremental additional cost of that excess care will be included in determining the cost of applicable coverage.

Rationale:

The purpose of the excise tax is to drive down the cost of comprehensive health coverage. Services provided by on-site medical clinics that qualify as excepted benefits are limited in scope and in no way replace major medical care. They do, however, provide valuable services to employees. For example, such clinics often provide treatment such as screenings for obesity and hypertension and smoking cessation programs, vaccinations, and limited acute care for conditions such as urinary tract infections, ear aches and infections and insect bites. These clinics may also serve to lower costs associated with more comprehensive coverage by offering services that prevent minor issues from developing into full blown medical problems while also limiting the time an employee must spend away from work in order to receive relatively minor preventive care such as receiving routine shots or pain medication.

XV. Medicare Advantage Plans

Issue:

Neither the statute nor the Notice indicate whether group plans that are Medicare Advantage Plans will be included in the definition of applicable coverage.

Recommendation:

Clarify the treatment of group plans that are Medicare Advantage plans under the excise tax and should provide guidance on when, if ever, Medicare Advantage plans are applicable coverage potentially subject to the tax. We recommend that Treasury and the IRS clarify that Medicare Advantage plans are not group health plans that are subject to the excise tax, because Medicare Advantage plans are governmental insurance programs. At a minimum, government payments to Medicare Advantage plans should be excluded when determining the cost of coverage.

Rationale:

Medicare Advantage plans provide a managed care cost-effective alternative to fee for service Medicare. These plans are intended to reduce the overall cost of care and are subject to strict federal standards, including robust requirements regarding benefits. There is no indication in either the statutory language or the legislative history that Congress intended for Medicare Advantage plans to be included in the excise tax. Nor is there a policy rationale for including these plans in the excise tax, especially when individual Medicare Advantage plans would not be included. Accordingly, Treasury and the IRS should provide guidance excluding these plans from the definition of applicable coverage. In any event, the statute indicates that Government payments should not be included in the cost of coverage, so Government payments to group

health plans (either directly to the group health plan or through a Medicare Advantage Organization) for Medicare Advantage should be excluded.

XVI. Dollar Limit Adjustments

Issue:

It is unclear how the various dollar limit adjustments operate alone and in conjunction with one another.

Recommendation:

Clarify that dollar limit adjustments (including age, gender, and employment in high risk professions) are calculated in a multiplicative fashion (*i.e.*, the factors for each adjustment are multiplied instead of added. This is similar to the treatment of age and geographical factors used when an issuer develops its rates). The statute and Notice anticipate that employers will be permitted to adjust the applicable dollar limit based on several factors, including gender, age, and employment-type (*i.e.*, employees in high-risk professions). It is unclear, however, how the various dollar limit adjustments operate alone and in conjunction with one another. Specifically, Treasury and the IRS should make clear that these adjustments are multiplicative.

Treasury and the IRS should also clarify how employers should determine whether an individual is eligible for enrollment under Medicare for purposes of the adjustment for retirees and what constitutes a “majority” for purposes of the adjustment for high risk professions.

Regulations should establish criteria for an employee to be identified as being in a high-risk profession.

Lastly, the age and gender modifications should be applied benefit plan by benefit plan to provide fair adjustments.

Rationale:

Employers need to understand the dollar adjustments in order to design the most cost-effective benefit package they can offer and to properly manage their potential liabilities with respect to the excise tax.

There should be some criteria for an employee to be identified as being in a high-risk profession. While the statute identifies specific professions deemed high risk, it is unfair to exclude other professions that are also high-risk in that the characteristics of the work fit with professions named in the statute. There is no rational basis to exclude these other professions.

Age and gender modifications should be applied benefit plan by benefit plan to provide fair adjustments. Otherwise, there would be a mismatch: setting age and gender factors based on the entire employer, but tax is determined on a benefit plan by benefit plan basis. For example, a group of 800 21-year old males and one 90 year old male – that group would have a really

good age gender factor, but if that 90 year old were on his own plan, those age and gender factors would be applied to him as well. This would lead some benefit plans paying a tax just because they have an older person on them, which does not appear to be the intent of the law.

XVII. Limited Benefit Wraparound Coverage

Issue:

Section 4980I(d)(1)(B)(i) generally excludes from the definition of applicable coverage excepted benefits listed in § 9832(c)(1). Treasury and the IRS have recently issued regulations under § 9831 adding certain limited wraparound programs to the definition of excepted benefits. However, these newly added excepted benefit programs are not listed in § 9832(c)(1) and would thus arguably be included in the definition of applicable coverage absent guidance to the contrary.

Recommendation:

Clarify the treatment of benefits that meet the criteria to qualify as an excepted benefit providing “limited wraparound coverage” in accordance with the final regulations issued under § 9831.

Rationale:

Excepted benefits are generally not subject to ACA requirements. It is unclear whether these limited wraparound excepted benefits are included in or excluded from the definition of applicable coverage subject to the excise tax.

XVIII. Assistance to Employers in Allocating and Calculating the Tax

Issue:

Some employers may not have adequate resources to allocate and calculate the tax correctly.

Recommendation:

Clarify that employers may hire accountants or other appropriate experts to help them calculate and allocate the tax.

Rationale:

Some employers subject to the excise tax may be relatively small and may not have resources to allocate the tax among the various coverage providers and provide a correct calculation to insurance issuers and other coverage providers. The same problems may be faced by employers with large, complex employee benefit plans. Employers should be able, at their discretion, to hire accountants or other appropriate experts to assist them in allocating and

calculating the tax. This will help relieve the burden on employers as well as help insurance issuers and other coverage providers receive a fair and accurate allocation of the tax.