Notice 2015-16

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**VIA ELECTRONIC SUBMISSION TO Notice.comments@irscounsel.treas.gov**

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Internal Revenue Service
P.O. Box 7604
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RE: **Notice 2015-16**
**Section 4980I – Excise Tax on High Cost Employer-Sponsored Health Coverage**

Thank you for the opportunity to provide comments on Notice 2015-16 regarding the Excise Tax on High Cost Employer-Sponsored Health Coverage.

Cigna Corporation, together with its subsidiaries (either individually or collectively referred to as "Cigna"), is a global health services organization dedicated to helping people improve their health, well-being and sense of security. Our subsidiaries are major providers of medical, dental, disability, life and accident insurance and related products and services.

Our previous comments on the implementation of Affordable Care Act (ACA) regulations and guidance have reflected our commitment to expanding access to a breadth of quality, affordable health care options for all individuals. As a leading provider of health insurance services, Cigna has a keen interest in the implementation of the ACA and we are pleased to provide the following comments on Notice 2015-16 related to Section 4980I – Excise Tax on High Cost Employer-Sponsored Health Coverage. The Excise Tax on High Cost Employer-Sponsored Health Coverage ("excise tax") will have a significant impact upon the Cigna companies and the clients and customers we serve. We therefore appreciate the Department of the Treasury's and the Internal Revenue Service's ("Department" or "Treasury") willingness to receive comments on this very important subject.

We understand that the excise tax is intended to discourage employers from sponsoring group health plans that provide "rich" benefits which promote high levels of utilization of health care services and provide little incentive to shop for health care services based upon cost and value. However, the premise in Section 4980I that a high cost plan is necessarily a "rich" benefit plan is uncertain. It ignores the fact that the cost of a group plan can be influenced significantly by the risk profile of the covered population and geography, for example. Using a statutory dollar limit on plan cost rather than benefit design to determine whether the excise tax applies can, for example, result in one plan being subject to the excise tax because it covers a less healthy population and/or it is located in a high-cost geographic area, whereas an employer with an identical plan will not be subject to the tax simply because it has a healthier enrollee population and/or is located in a low-cost geographic area. Similarly, a plan with cost-sharing and other benefit features designed to discourage unnecessary utilization of health care

services and promote wellness could well be subject to the excise tax while a "richer" plan would not be subject to the excise tax simply because of enrollee demographics and geography. The fact that a questionable premise underlies Section 4980I's use of a statutory dollar amount to determine whether a plan is a "high cost" plan, makes it all the more necessary that the implementing regulations for Section 4980I attempt to exclude from the cost calculation those cost factors over which the issuer or plan sponsor have no control. We address our specific concerns with Notice 2015-16 below.

**Non-deductibility of Tax to Insurers**

The fact that the excise tax is non-deductible means that issuers will necessarily include the anticipated excise tax in their premium. This will further increase the cost of the plan, resulting in greater liability under the excise tax (in effect, a double penalty), even if the actual value of the plan benefits does not increase.

We urge the Department to consider excluding from the determination of plan cost, costs attributable to the excise tax itself as well as all other taxes (e.g., state premium taxes), or fees or assessments (e.g., the Patient Centered Outcomes Research fee, the transitional reinsurance contribution, and the health insurance issuer fee) from the determination of the cost of a plan.

**Primary Insured Individual**

We concur with the comments submitted by America's Health Insurance Plans (AHIP) regarding the term, "primary insured individual." "Primary insured individual" should only embrace those individuals who have an independent right to elect coverage under an applicable employer-sponsored group plan. We recommend the Department add clarifying language to define this term appropriately.

**Excess Benefit**

Section 4980I(b)(1) states, "The term, 'excess benefit,' means, with respect to any applicable employer-sponsored coverage made available by an employer during any taxable period..." (emphasis added). We believe the excise tax calculation should be based on the cost of the lowest cost plan made available to employees. Employers should be able to offer their employees multiple plan choices without penalty. We note, in this regard, that individuals obtaining individual coverage on the Federal or State Marketplaces have access to Gold and Platinum metal tier plans (both of which provide rich benefits)without an imposition of an excise tax on the issuer. Individuals with access to group coverage should likewise have such an option if offered by their employer. But employers may cease offering a choice of richer plans if the excise tax is imposed based upon which plan option an employee elects.

There are several other references within Section 4980I that suggest the excise tax could be determined by looking at the coverage offered or made available to the employee (rather than enrolled). Specifically, Section 4980I(b)(1) defines "excess benefit" with respect to "coverage made available" to an employee. Similarly, 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 Section 106. Lastly, we note that

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 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. We believe the language of Section 4980I can be read to encompass not only enrolled coverage but also offered coverage.

Employers 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. The administrative difficulty of determining the aggregate cost of coverage would be aggravated if employers are required to look to the cost of the coverage in which an employee is actually enrolled. Requiring employers to look to actual enrollment means that there would be 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 expenditures of time and money.

Determining excise tax liability based only on enrolled coverage could discourage employers from offering multiple plan options or multiple benefit packages in order to prevent adverse selection among the options. Employers could 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.

**Applicable Dollar Limit**

As noted above, using a statutory dollar amount to determine whether a plan is a high cost plan does not account for differences in plan costs that may be attributable to geography or the health profile of the insured group. While age and gender are important and should be basis for adjustments, geography and health risk are equally significant drivers of the cost of medical care. In some areas of the country, the statutory dollar amount does not afford plan sponsors much ability to benefits to meet their employees' needs. We note a Milliman Client Report for the National Education Association (NEA): "...the adjustment accurately reflects the age and gender characteristics of the employer versus the national labor force and does so equally well in all age and gender combinations, but does so **only for employers with average costs** (emphasis added)."[1] There are many areas of the country where the combined effect of premium-driving factors will make it unlikely that the threshold could be exceeded, regardless of how rich the benefit plan.[2] Therefore, we strongly encourage the Department to consider adjusting the threshold for geography and health risk.

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[1] Dobson, R.H. & Rachlin, S. D. (9 December 2014). What does the ACA excise tax on high-cost plans actually tax? *Milliman Client Report* prepared for National Education Association.
[2] Ibid.

The difficulty with using premium as the basis of the tax is that the premium paid for an employer-sponsored health plan is subject to many variables. Typically, in the large employer market a manual rate is used, which is based on an insurer's overall book of business. Insurers start with a base rate that applies to a certain rating period and benefit package. This base rate would already reflect the insurer's provider reimbursement levels and the effect of its utilization management program. The following adjustment factors would then be applied to determine the manual rate for a given employer-sponsored group health plan: trend factor, product or plan type (sometimes called network adjustment factor), benefit adjustment factor, age/gender factor, geographical area factor, industry factor, and a factor to reflect administrative expenses, taxes, licenses and fees, and risk or profit margin. All of the factors are intended to represent the insurer's best estimate of the future experience of the particular employer-sponsored health plan based on characteristics that have been shown to affect future experience. There are other factors that are thought to affect claims, but are not typically reflected in manual rating (e.g., lifestyle, income level, catastrophic claims, etc.).

We also recommend that the dollar limit adjustments for age, gender, geography and health risk, be treated similar to adjustments for qualified retirees and high-risk professions, i.e., that they should be additive, or "stacked," to provide maximum relief.

Furthermore, we are concerned that the dollar limits are indexed to the rate of consumer inflation (CPI-U) rather than medical inflation. Limits based on the CPI-U will be inadequate to keep pace with the cost of medical inflation as the elements factored into each metric are different, and history has shown that growth in medical inflation outpaces CPI-U. Over the past twenty-five years inflation has generally risen 99% whereas medical inflation has risen 227%.[3]

Additionally, the indexed thresholds should be released well in advance of a plan year so employers and insurers can make fully-informed decisions as they consider and prepare group plan coverage options for the next plan year. So, we encourage Treasury to consider the timing of indexing as well.

In light of all the problems with using a dollar threshold, we ask the Department to consider an alternative approach using the actuarial value of the plan. We suggest the Department consider relying on actuarial value as it is less prone to variation based on health status or geography, for example, and it provides a better sense of the true value of the plan.

We urge the Department to consider that the ACA establishes four metal level plans for the individual and small group markets, which represent actuarial values between 60 and 90 percent. None of those plans are deemed so rich that they

[3] Bureau of Labor Statistics, Consumer Price Index Databases, All Urban Consumers, available at http://www.bls.gov/cpi/data.htm

trigger a penalty under the law. However, similar offerings by employers are projected to trigger the excise tax. As the excise tax stands today, plans with a 70 percent actuarial value – a silver plan under the ACA – will reach the thresholds soon after 2018.[4] Small employers on the SHOP will be impacted by the excise tax if an employee selects a silver tier plan. Employees of large employers would unfairly be impacted because large employers could be compelled to offer plans that are below a 70 percent actuarial value in order to avoid triggering the excise tax. Therefore, Treasury should develop an alternative approach based on actuarial value that represents the actual value of the plan rather than the cost.

**Qualified Retiree**

We understand a qualified retiree to mean an individual who is receiving coverage, at least age 55, not entitled to benefits or eligible for enrollment under Medicare, and retired. We do not believe that an employer would be able to track an individual's eligibility for Medicare because employers do not typically have this information.

We request clarification on how retirees eligible for Medicare and continuing under employer's retiree coverage will be impacted.

**Employer or Employee Paid Coverage**

We recommend the Treasury exclude the cost of preventive care in determining the cost of employer-sponsored coverage because the coverage of preventive care is required by law and the associated cost of such coverage is beyond the control of the employer. The statutory framework of the excise tax, coupled with the Treasury's aggressive definition of "minimum value," means there will come a point where an employer cannot both avoid excise tax liability and also comply with all benefit mandates and assessments under the ACA, putting employer-sponsored coverage in peril.

**Health Reimbursement Account (HRA) and Health Savings Account (HSA)**

For purposes of calculating the costs of the plan, the HSA and HRA contributions should be treated in a manner consistent with how they are treated in other ACA regulations (such as the MLR, the MV or AV calculations). Only current year employer contributions (or a percentage of them) should be considered in the calculation and any carryover balance from prior year contributions are excluded from the calculation.

Employee contributions to any account should not be considered in the calculation as they are not representative of a value an employee is receiving for the premiums they have paid for their benefit plan. Rather, they represent additional voluntary contributions in excess of the premium paid from their paychecks; and therefore, should not be included in determining the value of the plan.

After tax employee contributions into an HSA do not appear to be taken into

[4] Reynolds, L. (29 October, 2014). As Employers Try to Avoid ACA Excise Tax, Lower-Cost Health Plans Face Biggest Test. *Benefits & Compensation Management Update*. Retrieved from: http://www.bna.com/employers-try-avoid-n17179910733/

account for purposes of the excise tax. There is no apparent policy basis to treat employee pre-tax salary reduction contributions differently. As currently written, we believe that this inconsistency will result in employers ceasing to afford employees the opportunity to make pre-tax contributions into their HSA. This will result in lower overall savings that would be available to help employees pay for the out of pocket expenses incurred in plans with higher employee cost sharing. Lower and moderate income families could be left without the financial resources to satisfy their out of pocket expenses, which is not aligned with the overarching goal of the ACA to improve affordability and access to care.

We suggest Treasury exclude Health Savings Account (HSA) contributions made by the employee from the cost of the employer-sponsored coverage. Employee contributions to an HSA are voluntary and there are opportunities for the employee to contribute to their HSA without the knowledge of the employer.

We note Section 4980I appears to make an important distinction with respect to HSAs between contributions made by an employer versus by an employee. Specifically, in determining the cost of coverage with respect to an HSA, Section 4980I(d)(2)(C) states that "the cost of coverage **shall be equal to the amount of employer contributions under the arrangement**" (emphasis added). While employer contributions have often been interpreted for purposes of federal tax law to include employee pre-tax contributions, other statutory language in Section 4980I strongly suggests the reference to employer contributions in Section 4980I(d)(2)(C) must be read to exclude employee pre-tax contributions. Specifically, the language at Section 4980I(d)(2)(B) 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).

Given the reference to "employer contributions" in Section 4980I(d)(2)(B)(i), the only amounts remaining that could potentially be encompassed by the statutory language of Section 4980I(d)(2)(B)(ii) are employee pre-tax contributions via salary reduction. Accordingly, if the reference to "employer contributions" is read to include employee pre-tax salary reduction contributions, then the language of Section 4980I(d)(2)(B) would be rendered meaningless.

We believe when Congress enacted Section 4980I, Congress intended for any

references to "employer contributions" – at least for purposes of Section 4980I – to be limited to non-elective employer contributions and, thus, to exclude contributions made by employees on a pre-tax basis via salary reduction. Section 4980I(d)(2)(C), when read in this light, can then be construed rightly to only apply to non-elective employer contributions and to exclude employee pre-tax contributions from valuation.

Finally, with regards to HSAs, we note HSAs generally have not been treated as group health plans for purposes of ERISA as well as for certain purposes under the Code, including federal continuation coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). Accordingly, we think there is a very reasonable basis to at least exclude employee pre-tax contributions from the scope of the excise tax.

As to HRAs, they can take many forms and serve many purposes. Some employers sponsor 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 made by an employer – should be excluded from the excise tax. A contrary rule would inappropriately magnify the extent of coverage available to the "employee" at issue would likely result in an inaccurate and exaggerated excise tax liability. We request that any proposed or final rule make clear that an HRA is excluded from valuation if it only reimburses premiums with respect to coverage that is already subject to valuation under Section 4980I.

Deposits into a dormant retiree reimbursement account should not be counted against the value of the plan until the account becomes active. If the deposits were rolled over from an active HRA they should not be factored into the calculation since those contributions would already have been taxed once.

**Flexible Spending Account (FSA)**

We suggest Treasury consider how FSA carryovers will be taken into account when determining the cost of health FSA coverage and how the amounts available in the two and a half month administrative grace period will be counted. Additionally, Treasury should also consider how amounts that were forfeited will be addressed in the cost calculation.

For purposes of calculating the costs of the plan, the FSA contributions should be treated in a manner consistent with how they are treated in other ACA regulations (such as the MLR, the MV or AV calculations). Only current year employer contributions (or a percentage of them) should be considered in the calculation and any carryover balance from prior year contributions should be excluded from the calculation. We request guidance with respect to (i) how FSA carryovers will be taken into account when determining the cost of health FSA coverage, (ii) how the amounts available in the two-and a-half month administrative grace period will

be treated, and (iii) how amounts that were forfeited will addressed in the cost calculation.

**Governmental Plans**

The statute does not clearly identify how employer-sponsored retiree health plans that incorporate Medicare benefits for Medicare-eligible retirees are to be treated for purposes of the excise tax. Specific guidance is needed on whether such plans are subject to the provisions of Section 4980I, or whether, because the benefits provided under such plans are largely defined by Title XVIII of the Social Security Act, they are excluded from Section 4980I. If such plans are subject to the excise tax, additional guidance is needed to understand how employers calculate the value of such plans. Calculating the value of such plans raises some unique issues, such as how to treat the value of required Medicare benefits incorporated into such plans for purposes of determining whether the plans are subject to the excise tax.

In considering whether Section 4980I should apply to employer-sponsored retiree health plans for Medicare-eligible retirees, we would encourage you to consider the vastly different spending and cost patterns of Medicare beneficiaries versus others. Because of age or disability, expected spending for Medicare beneficiaries is much higher than for the under-65 population. The thresholds for the tax established in the law are based on spending patterns for younger, healthier individuals. Expected spending for the Medicare population may exceed the threshold based solely on expected spending for core Medicare benefits, which have been found to be considerably less generous than most private coverage (Kaiser Family Foundation, 2012).

An additional scenario involving employer-sponsored retiree plans is that of retiree plans that include benefits for both Medicare-eligible retirees and retirees who are not yet Medicare eligible. Such plans offer both Medicare eligible and under 65 retirees the same benefit plan design understanding that those eligible for Medicare will have Medicare as the primary payer. Premiums for these bundled retiree offerings do not create separate premium amounts for Medicare eligible and under 65 retirees, thus creating premium subsidization from the Medicare eligibles. Because these plans must account for both Medicare and non-Medicare covered services and the expected costs of those age 65 and over and those under 65, their expected value may be higher than if such plans did not include all Medicare-covered services or did not include Medicare-eligible retirees. We are concerned that if such plans are subject to Section 4980I, employers will be less likely to offer such plans to retirees, forcing many retirees who are under age 65 to the marketplace to purchase coverage.

**Employee Assistance Plans (EAPs)**

We are supportive of excluding EAPs as excepted benefits from the excise tax as these programs do not provide significant medical care. EAPs help employees identify and resolve personal issues before they have serious medical, family, and/or workplace consequences.

**On-site Medical Clinics**

We are concerned with the Department's intention to include on-site medical clinics in the value of employer-sponsored coverage for purposes of the excise tax. If Treasury continues to include on-site medical clinics in calculating the excise tax, then we recommend using a *de minimus* threshold based on extent of care where any such threshold excludes preventive and primary care services. As noted in the Notice, the Joint Committee on Taxation indicated in its technical explanation that Congress did not intend to subject on-site medical clinics providing only *de minimus* medical care to the excise tax.

**Stand-alone Dental or Vision Coverage**

We are supportive of excluding both insured and self-funded limited scope dental and vision plans from the excise tax. Cigna agrees with the position set forth in the Notice. A contrary rule could result in disparate treatment of self-funded coverage and could disadvantage employers who sponsor such self-funded limited scope coverage as well as the third party administrators and other providers associated with such coverage.

**Determining Cost of Coverage**

The cost of the coverage is determined on a monthly basis and is generally determined under rules similar to the rules to determine the applicable COBRA premium under Section 4980B(f)(4). The COBRA rules look to the cost of the coverage for similarly situated beneficiaries, and thus, it seems that the cost of coverage for the tax will employ a similar concept. It is unclear what "rules similar to the rules of Section 4980B(f)(4)" means and we request clarification.

It is also unclear how an insurer will determine its share of coverage provided for all applicable coverages if the employee has coverage from multiple insurers, in particular FSAs, but other plans as well. We request the Department provide guidance on how it expects this calculation to be made.

**Liability**

The fact that health insurers are liable for a *pro rata* share of the tax with respect to total insured coverage provided by the employer raises a host of legal and business issues for insurers. Insurers may not have full and accurate information about the nature and extent of the employer-sponsored coverage being offered. Thus, insurers may find it difficult to understand the full extent of their potential excise tax liability which is necessary to anticipate when establishing premium rates.

The fact that the employer is responsible for determining the insurer's liability is concerning. We request the Department consider whether the insurer must rely on the employer's information and what happens if the employer determines or allocates the excise tax incorrectly.

The difficulty in using premium as the basis of the tax is that the premium paid for an employer-sponsored health plan is subject to many variables: cost of state and federally mandated benefits, administrative expenses, taxes, licenses and fees, etc.

While it is beyond the authority of the Department to address concerns around the statute itself, the Department can consider these factors as it prepares to issue regulatory guidance. Thought should be given to whether the amounts paid to an insurer could give rise to unintended or adverse consequences regarding medical loss ratio, the annual fee on health insurance providers under Section 9010 of the ACA, state premium taxes, or financial and statutory accounting and other state and federal rules. We recommend all fees and taxes, at least, be excluded from calculating the excise tax.

Finally, for self-insured group health plans, we recommend clarification that the person that "administers the plan" for purposes of paying the excise tax is the "plan administrator" as defined in ERISA rather than its third party administrator.

**Responsibility for Determining, Apportioning and Noticing Tax Liability**

We have a number of questions about the responsibility for determining, apportioning, and noticing tax liability we would encourage the Department to address. For example, what will the timeframe be during which the employer must give the issuers/administrators information regarding their *pro rata* liability under the excise tax? We note that issuers need adequate time between receipt of such notice and the tax due date so that they can resolve any disputes regarding the calculations with the employer.

Other questions we have are:

- What notice and appeal rights may the insurer have regarding the employer's excise tax determination?
- Will an insurer be liable for interest and penalties if it relies on the employer's determination but such determination turns out to be incorrect?
- What obligations will insurers have if an employer fails to calculate and provide the excise tax information?
- How is the amount of the tax calculated and reported in the case of self-employed individuals?

Insurers will need certain information well in advance of the deadline for paying the excise tax and, in some cases, well in advance of the beginning of the tax year in which the applicable coverage is provided. For example, insurers will need information from Treasury regarding the annual indexing of thresholds far enough in advance of the relevant tax year to price their products accordingly. In addition, carriers will need employers to inform them of excise tax liability so that carriers can satisfy income tax obligations, statutory accounting reporting deadlines, and NAIC reporting deadlines.

Again, we request that Treasury issue additional guidance that addresses these and other questions about the mechanics underlying the excise tax.

**Penalty for Failure to Properly Calculate the Excess Benefit**

As mentioned above, the employer is responsible for determining the extent to which an excise tax is owed with respect to an "employee." However, the statutory language appears to require that a health insurer pay any additional excise taxes owed (but no penalties) in the event the employer understates the tax liability owed.

It is not clear whether the insurer could be liable for statutory interest (even though not subject to the penalty) but this result appears likely. It is also unclear what happens in the event a coverage provider makes an overpayment of excise tax. The Department should resolve these issues.

If there is a penalty imposed for inaccurate reporting by the employer, then the insurer should not be responsible for any accrued interest.

As a large employer sponsoring a group health plan for its thousands of employees and their dependents, Cigna offers the following comments on the Notice:

**Rules Similar to COBRA**

Generally, we support harmonizing the COBRA and Section 4980I valuation rules so long as the rules do not disadvantage employer plans for purposes of the excise tax. Thus, we would not support the development of a single set of valuation rules if that resulted in excess cost determinations or that reduced employer flexibility with respect to the excise tax. It is important that employers such as Cigna end up with a set of rules that provide for sufficient flexibility and administrative ease to calculate both the cost of COBRA, 4980I valuation and the excise tax, and at the same time, do not result in excess cost determinations or other unfavorable results for purposes of the excise tax.

**12-Month Measurement Period**

We support the Notice's flexibility in allowing self-insured plans that choose the past cost method to use a 12-month measurement period not ending more than 13 months before the beginning of a current determination period to calculate the cost of coverage during such determination period. We believe this allows employers flexibility while ensuring greater consistency in how the past cost method is applied. Further, we believe that this approach provides employers with sufficient time to calculate cost for purposes of the excise tax without putting significant additional strain on their resources.

**Benefits Taken into Account in Determining Cost of Coverage**

Pursuant to the ACA, plans are now required to cover certain benefits (e.g., preventive care and in the small group market, essential health benefits). Given that coverage of these benefits is required by the ACA, the Department should consider allowing plans to exclude the costs attributable to providing such mandated benefits for purposes of the excise tax. To tax the benefits required by the ACA seems counterintuitive and not what Congress could have intended. The excise tax is aimed at "excess benefits," which cannot include those benefits required by law. Thus, we think the better approach would be to only tax those benefits offered beyond those required by law in the market in which the plan is

offered.

**Costs Taken into Account Under Past Cost Method for Self-Funded Plans**

We generally support the Treasury's proposed inclusion of claims in determining costs under the past cost method. However, employers, in determining cost of coverage, should be free to use either claims incurred or claims submitted so long as they are consistent in how they calculate costs for purposes of COBRA valuations.

The Notice provides that Treasury is contemplating including administrative expenses and reasonable overhead expenses of the employer in computing costs under the past cost method. The Notice further provides that reasonable overhead expenses are to be ratably allocated to the cost of administering the employer's health plans. We think this approach is reasonable with respect to expenses that are charged back to the plan by the employer or otherwise factored into the COBRA rate. However, if expenses are borne solely by the employer and not charged back to the plan or are not factored in for purposes of determining the cost of coverage under COBRA, we believe that such expenses should not be included in the calculation of cost for purposes of the excise tax.

When valuing their major medical plans, employers should be permitted to exclude any health-related savings accounts (such as HRAs or HSAs) that relate to these plans to the extent that such accounts are properly valued by the employer independent of the plan. Otherwise, there is a risk of double counting and over-valuation of plan costs.

**Aggregation**

Employers should be given greater flexibility in aggregating coverage for purposes of the excise tax. Specifically, employers should be permitted to aggregate coverage on a controlled group basis, member company basis, or an ERISA plan basis. Moreover, employers should not be required to disaggregate based upon like benefits packages. Employers currently structure benefits to employees within controlled groups in a myriad of ways. We believe that providing employers flexibility in how they aggregate coverage will allow them to calculate excise tax liability taking into account the realities of how they structure benefits, rather than requiring them to create artificial distinctions in coverage solely for purposes of this new tax liability.

**Measuring Cost Against the Threshold**

Based on the Notice, it seems like the comparison of cost to the threshold may be made on an individual-by-individual basis. However, this may result in significant administrative burden for employers. As such, we suggest allowing employers the option to compare cost against the threshold by using a random and independently validated sampling of employees and then using this amount to determine per capita tax liability. For example, for an employer with 25,000 covered lives, it would be permitted to perform an excise tax calculation with respect to a random, but significant sample of its population of covered lives (e.g., 400 lives) and then multiply the average per capita excise tax by the number of

covered lives to determine the total excise tax liability.

**Health Reimbursement Arrangements**

In terms of valuing HRAs, for ease of administration, employers should be permitted to value HRA coverage based only upon the additional amounts (notional or otherwise) that are contributed to the HRA for the tax year at issue. Additionally, amounts contributed before January 1, 2018 should be excluded from valuation.

**Retiree Coverage**

We support the allowance for plans to treat pre-65 and post-65 retirees as similarly situated beneficiaries. However, we think that retiree-only plans should not be subject to the excise tax. The excise tax generally applies to "employer-sponsored coverage" and references are made throughout Section 4980I to "plan." Generally, for purposes of ERISA, a "group health plan" is defined as an employee welfare benefit plan that provides medical care to employees (including current and former employees) and their dependents. However, ERISA also provides that the requirements of Section 7 (into which many of the ACA's requirements applicable to ERISA plans are incorporated) do not apply to plans with less than two participants who are current employees (e.g., retiree-only plans). Given that retiree-only plans are exempt from most of the ACA's requirements, we think there is a valid policy argument to exempt retiree-only plans from the excise tax.

Thank you for your consideration of these comments.

Respectfully,

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