Notice 2015-16

THE COUNCIL

The Council of Insurance Agents & Brokers

May 15, 2015

VIA ELECTRONIC MAIL – notice.comments@irscounsel.treas.gov

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

RE: Notice 2015-16: Section 4980I—Excise Tax on High Cost Employer-Sponsored Health Coverage

To Whom It May Concern:

The Council of Insurance Agents and Brokers ("Council") appreciates this opportunity to respond to the Treasury Department/Internal Revenue Service's (simplified herein as "IRS") request for information on various issues related to calculation of the Affordable Care Act's ("ACA") "Cadillac tax."[1] The Council represents the largest and most successful property/casualty and employee benefits agencies and brokerage firms. Council member firms annually place more than $200 billion in commercial insurance business in the United States and abroad. Council members conduct business in some 30,000 locations and employ more than 120,000 people worldwide. In addition, Council members specialize in a wide range of insurance products and risk management services for business, industry, government, and the public.

Since 2008, Mercer has been surveying employers of all sizes about their concerns and experiences with healthcare reform, and the ACA's Cadillac tax has consistently been a top issue.[2] The tax stands to have a huge impact on employer-sponsored health coverage in this country. Without changes to their current plans, 42% of employers will be subject to the tax when it takes effect in 2018, and 55% will be subject to the tax by 2022. Even now, the looming tax is having an impact on how and to what extent employers offer health coverage to their employees. Approximately one-third of employers surveyed in February 2015 said that the threat of incurring the Cadillac tax influenced their 2014 health plan decisions. A substantial number of employers are already taking (and many more are considering taking) actions like raising deductibles and other cost-sharing provisions, and dropping high-cost plans altogether in order to minimize the impact of the tax.

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[1] *See* 26 U.S.C. § 4980I.

[2] A summary of Mercer's March 2015 survey results is attached as Exhibit 1 to these comments.

In other words, data shows that the Cadillac tax threatens to undermine a key policy goal of the ACA—to encourage employers to sponsor quality health coverage for their employees and their employees' families. Now, employers that do offer such coverage are legitimately concerned that they will be penalized for offering "excess" benefits. The Council urges the IRS to design implementing regulations that minimize this tension between ACA provisions and encourage retention of employer-sponsored plans. For example, the Council supports the creation of a safe harbor for employers that merely satisfy the ACA's minimum shared responsibility requirements.[3] A safe harbor of this nature would avoid the scenario—presumably not anticipated or intended by Congress—where employers satisfy the minimum requirements to avoid one ACA penalty, only to trigger another.

The Cadillac tax poses a significant financial penalty and substantial operational burden on employers, and will likely result in employers dropping health coverage and/or removing healthcare choices for employees—a race to the bottom in employer-sponsored coverage. Again, this dismantling of employer-sponsored coverage is contrary to the overarching goals of the ACA. The Council urges the IRS to consider these consequences when drafting any future rules, and to minimize any potential adverse effects of the tax by utilizing appropriate safe harbors and providing sufficient flexibility for employers.

Below are more detailed comments in response to the IRS's request for information.

Defining "applicable coverage"

Under the ACA's Cadillac tax provision, the term "applicable employer-sponsored coverage" is defined as: with respect to any employee, coverage under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under section 26 U.S.C. § 106, or would be so excludable if it were employer-provided coverage within the meaning of that section.[4] Section 106 generally excludes from an employee's gross income "employer-provided coverage under an accident or health plan."[5] And under the Cadillac tax provision, "group health plan" means "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."[6]

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[3] 26 U.S.C. § 4980H.
[4] 26 U.S.C. § 4980I(d)(1)(a).
[5] 26 U.S.C. § 106(a).
[6] 26 U.S.C. § 4980I(f)4); 26 U.S.C. § 5000(b)(1).

In keeping with the ACA's goals of encouraging meaningful employer-sponsored coverage and promoting the health and wellness of America's workforce, the Council urges the IRS to exclude from the definition of applicable coverage any benefits that are offered separately (or could be offered separately) from major medical coverage, including: employee assistance programs, wellness programs, on-site medical clinics, dental and vision coverage, and tax-preferred accounts or financing arrangements funded by employees. These secondary benefits, which are offered to supplement major medical coverage and/or help employees save for major medical expenses, were developed by the marketplace to reduce the overall cost of healthcare and keep members of major medical plans healthier. Including these secondary benefits only penalizes and discourages these kinds of positive, cost-saving market innovations.

The IRS has specifically requested comment on how on-site medical clinics should be treated for purposes of defining applicable coverage. The Council advocates excluding them from the definition of applicable coverage altogether. On-site clinics (much like wellness programs) have become increasingly popular with employers because they allow employers to meet the occupational health needs of their employees, emphasize wellness, keep overall healthcare costs down, and recruit and retain employees. These clinics are consistent with the policy goals underlying the Cadillac tax; namely, reducing unnecessary costs and over-utilization. If the IRS includes on-site clinics in the definition of applicable coverage, it is very likely that these popular and cost-saving services will disappear as employers seek to minimize their exposure to the tax.

To the extent on-site medical clinics are included at all under applicable coverage, the Council supports a carve-out for clinics that do not offer major medical care on a continuous basis. Most on-site clinics offer minimal services like immunizations, provision of non-prescription pain relievers and cold medicine, and treatment of injuries caused by accidents at work. Should the IRS adopt an approach that distinguishes between "minor" and "major" care at on-site clinics, it is encouraged to provide clear, simple guidelines on where that line is drawn so that employers can readily determine whether their clinics fall within or outside the applicable coverage definition.[7]

The Council also urges the IRS to exclude from the definition of applicable coverage all employee contributions to HSAs, Archer MSAs and FSAs. Inclusion of employee contributions to these types of accounts would discourage employees from saving for future medical expenses (savings that are particularly important to low- and

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[7] For on-site clinics that are considered applicable coverage, the Council recommends basing the cost of such coverage on the employer's cost of running the clinic. This method would allow employers to allocate cost between self-only and other-than-self-only coverage, and minimize the recordkeeping burden on employers. Further, this method would not require the employer to pay a tax on costs that were never incurred. If a clinic is run by an independent entity and the employer offers support only through free or reduced-cost rent, the clinic should be excluded from the definition of applicable coverage.

middle-income families), decrease the amount of control employees and their families have over financing their healthcare costs, and may cause employers to stop providing opportunities for such contributions altogether. Further, for FSAs and HRAs that only reimburse for dental and vision benefits, the Council encourages the IRS to exclude them entirely from the applicable coverage definition.

Determining the cost of applicable coverage

The ACA's Cadillac tax provision specifies that the cost of applicable coverage will be determined by rules "similar to" the rules for calculating COBRA applicable premiums.[8] The IRS suggests using COBRA's "similarly-situated" approach for calculating the cost of coverage, rather than basing the cost calculation on each individual employee. The Council strongly supports a group-based approach to calculating cost, instead of requiring individualized cost determinations, which would be overly burdensome for employers.

Under the IRS's proposal, the first step in the cost determination would be aggregation by benefits package or differences in health plan coverage. Then the groups would be disaggregated based on enrollment in self-only or other-than-self-only coverage. Next, the IRS proposes to permit, but not require, aggregation and disaggregation based on other factors that are common in the group insurance market (e.g., aggregation within other-than-self-only coverage, disaggregation based on bona fide employment criteria like nature of compensation and job categories). While this proposed framework does give employers some flexibility to develop an approach that suits their needs, aggregation and disaggregation rules are generally cumbersome and complicated for employers to implement. Consequently, the Council urges the IRS to provide employers with the maximum amount of flexibility in making aggregation and disaggregation decisions.

For self-insured plans, the IRS proposes to use the two methods available for calculating COBRA applicable premiums: the actuarial basis method and the past cost method. The IRS is considering requiring plans to use the same valuation method for at least five years. As a general matter, the past cost method is difficult for employers to implement because many employers find it necessary (in order to control escalating healthcare costs) to make significant changes to their plans every few years, or in some cases, every year. This also makes it difficult for an employer to select one calculation method for multiple years. Again, the IRS is encouraged to afford the maximum amount of flexibility to employers by allowing them to change methodologies as they see fit.

Given the challenges associated with the past cost method, an actuarial basis method based on a reasonable estimate of the actual cost the plan would expect to incur during the determination period presents a more workable approach for both COBRA and Cadillac tax purposes. More specifically, the Council supports an actuarial basis approach based on broad, flexible standards, rather than on a fixed list of specific

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[8] *See* 26 U.S.C. § 490B(f)(4).

actuarial factors. To the extent specific factors are used, the Council believes it is best to incorporate flexibility in selecting trend factors, instead of limiting trend factors to medical care inflation indexes. Such indexes are not designed to accurately predict future costs because they fail to account for things like the leveraging effect of deductibles and copayments, the impact of new techniques and medicines, or unpredictable shifts in market forces that affect the cost of care.

Additionally, any actuarial basis method should accommodate employers of different sizes. For a very large business, a single year of claims experience may be sufficient to calculate or estimate the expected cost of the plan. For smaller employers, on the other hand, two or three years of claims experience may be necessary to make a reasonable cost determination.

Finally, the Council urges the IRS to refrain from imposing accreditation requirements on individuals making cost determinations under an actuarial basis method. Such a requirement could have an adverse impact on cost and would not necessarily improve the accuracy of cost determinations. Third parties (e.g., TPAs, brokers, consultants) who typically calculate rates for group health plans have not historically been accredited, but they employ actuaries to develop rate models and for special situations where rate models may not be appropriate. Requiring individuals who make cost determinations to be accredited could also create capacity problems (i.e., a limited number of individuals eligible to assist a large number of employers that operate on calendar plan year).

Applying annual dollar limits to the cost of coverage

The IRS seeks comments on the various dollar-limit adjustments available under the Cadillac tax provision, including the adjustment for age and gender.[9] The calculation of that adjustment is dependent upon the age and gender characteristics of the employer population and the characteristics of the national workforce. In order to facilitate employers' calculation of the adjustment, it would be helpful for the IRS to specify and publish as soon as practicable, and then on an annual basis, the age and gender data sets that should be used in calculating this adjustment.

Conclusion

The Council commends the IRS on its thoughtful and thorough approach to implementing the ACA's Cadillac tax provision, and its commitment to gathering stakeholder input. As this process moves forward, the Council urges the IRS to keep in mind the overarching policy goals of the ACA, the potential adverse consequences of the tax for employees and their families, and the potential financial and administrative challenges for employers that seek to comply with the various (and sometimes competing) pieces of the ACA. In sum, we hope the IRS will endeavor to maximize flexibility for and minimize the burden on employers in any future rule-making.

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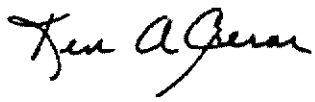
[9] 26 U.S.C. § 4980I(b)(3)(C)(iii).

Thank you for your consideration.

Respectfully submitted,



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