ecfc EMPLOYERS COUNCIL
ON FLEXIBLE COMPENSATION

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LEGAL PROCESSING DIVISION
PUBLICATION & REGULATIONS BRANCH

Notice 2015-16

MAY 19 2015

May 15, 2015

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

Re: Comments on IRS Notice 2015-16

Dear Sir or Madam:

This letter is submitted on behalf of the Employers Council on Flexible Compensation ("ECFC") with respect to the issues addressed in IRS Notice 2015-16 (the "Notice") concerning the excise tax under Section 4980I of the Internal Revenue Code (the "Excise Tax"). This Excise Tax was added to the Internal Revenue Code (the "Code") by the Affordable Care Act (the "ACA").[1] ECFC would like to ensure that, as the U.S. Department of the Treasury and Internal Revenue Service (the "Agencies") promulgate regulations to implement the Code §4980I Excise Tax, the continued use of employer-sponsored consumer-directed benefit arrangements (including health savings accounts (HSAs), health flexible spending arrangements (FSAs), and health reimbursement arrangements (HRAs) will not be overly restricted or limited in such a way as to deter the adoption of such arrangements. This letter outlines the various ways in which such arrangements promote the efficient use of healthcare in a post-ACA world and provide suggestions on how the Agencies' guidance regarding the Excise Tax could avoid unnecessarily limiting the use of consumer-directed health plans.

ECFC is a membership association dedicated to maintaining and expanding private employee benefit programs with a particular interest in arrangements that provide employees a choice among employer-sponsored benefits (so-called consumer-directed benefit arrangements). ECFC's members include employers who sponsor employee benefit plans, including FSAs, HRAs, and HSAs, as well as insurance, accounting, consulting, and actuarial companies that design or administer employee benefit plans. ECFC member companies assist in the administration of cafeteria plan and health benefits for over 33 million employees. Providing benefits of choice for a significant portion of the 103.5 million Americans that benefit from consumer-directed arrangements[2] encourages the efficient and effective use of tax-advantaged healthcare funds.

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[1] The Affordable Care Act refers to the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

[2] FSA counts extrapolated from U.S. Census Bureau statistics on number of employed, number of employers who offer FSAs, average enrollment statistics, and Visa research (conducted by C+R Research, July 2012). HRA statistics based on "U.S. Consumer-Driven Healthcare: Health Benefit Account Market Sizing", Aite Group, November, 2013. HSA statistics from "2014 Year-End Devenir HSA Research Report", February, 2015 (http://www.devenir.com/research/2014-year-end-devenir-hsa-market-research-report/). These counts aggregated and multiplied by 2.35, (HHS PCORI fee multiplier that determines the average number of lives covered under the plan for the plan year [169 Treas. Reg. §§ 46.4376-1(c)(2)(iv)(B) and (C)].

The Affordable Care Act and the Excise Tax

The primary objectives in the implementation of the ACA were to (i) expand the number of Americans covered by health insurance, (ii) reform insurance laws by mandating certain standards that will apply to health insurance coverage and (iii) address the increasing costs of insurance coverage. The Excise Tax was intended to provide a means to address overly rich employer-provided benefit plan designs as well as to provide a revenue source to finance the other objectives of the ACA.[3]

The Excise Tax imposes a nondeductible 40 percent excise tax on health benefit coverage provided by an employer in excess of a statutorily determined amount. The Excise Tax applies to taxable years beginning after December 31, 2017. In IRS Notice 2015-16, the Agencies address (i) the definition of coverage subject to the tax ("applicable coverage"); (ii) how the cost of that coverage is determined; and (iii) the application of the statutory dollar limit to the cost of coverage.

Section 4980I of the Code provides detailed instructions on the manner in which the Excise tax is imposed; however, the Agencies were specifically provided the authority to "prescribe such regulations as may be necessary to carry out...[the] section.[4]" The Code states that the coverage subject to the Excise Tax is "coverage under any group health plan made available to...[an] employee by an employer which is excludible from the employee's gross income under section 106, or would be so excludible if it were employer-provided coverage (within the meaning of such section 106.[5]" Certain types of coverage were specifically excluded from applicable coverage.[6] Certain excepted benefits described in Code §9832 are excluded from applicable coverage as is dental and vision coverage under a separate policy, certificate, or contract of insurance. The Notice states that the Agencies are considering whether to exercise their regulatory authority to exclude self-insured limited scope dental and vision coverage that is considered excepted benefits under recently issued regulations under Code §9831 from the definition of applicable coverage. ECFC appreciates the Agencies' consideration of this issue and supports such an exercise of the Agencies' regulatory authority to eliminate the unnecessary distinction between insured and self-funded offerings of limited scope dental and vision coverage as there is no tax or health policy justification for such a distinction.

The Agencies noted that other types of health coverage may be considered applicable coverage subject to the Excise Tax, including Heath FSAs and HSAs. The Notice stated that the Agencies anticipate that employer contributions, including salary reduction contributions to an employee's FSA or HSA, would be considered applicable coverage and employee after-tax contributions to an HSA would not be considered applicable coverage.

Importance of Consumer-Directed Health Plan in an ACA Environment

Many employers are moving toward higher deductible health plans or plans that increase the amount of cost sharing borne by employees.[7] In addition, many employers are taking action to reduce the costs of their health coverage by moving to account-based, consumer-directed benefit arrangements.[8] This trend is echoed on the state and federally-facilitated exchanges, where much of the coverage available will have high deductibles and cost-sharing.[9] Consequently, consumer-directed benefit arrangements, such as FSAs, HRAs, and HSAs, will increase in importance in this ACA environment.

Employers also offer wellness programs in an attempt to provide a means for employees to stay healthy and prevent avoidable healthcare costs. Not surprisingly, these wellness programs work in tandem with consumer-directed benefit arrangements to reduce the overall health expenditures of employers and employees. As an incentive under these wellness programs, funds may be credited to the account in a consumer-directed benefit arrangement of an employee who meets certain health goals or takes certain steps toward good health. Congress recognized the desirability of employers offering wellness programs and the ACA provides both special exemptions

3 American Health Policy Institute, The Impact the Health Care Excise Tax on U.S. Employees and Employers (November 2014).
4 Code §4980I(g).
5 Code §4980I(d)(1)(A).
6 Code §4980I(d)(1)(B).
7 National Business Group on Health, "Large Employers' 2015 Health Plan Design Survey," August 13, 2014. According to this survey 42 percent of employers are increasing employee cost-sharing.
8 National Business Group on Health, "Large Employers' 2015 Health Plan Design Survey," August 13, 2014. According to this survey, 57 percent of employers are implementing or expanding account-based consumer-directed benefit arrangements.
9 Kev Coleman, Deductibles, Out-Of-Pocket Costs, and the Affordable Care Act, HealthPocket.com. (December 12, 2013). http://www.healthpocket.com/healthcare-research/infostat/2014-obamacare-deductible-out-of-pocket-costs#.

from the group health plan nondiscrimination provisions for certain wellness programs as well as increased incentive limits for wellness initiatives.

If consumer-directed benefit arrangements are swept under the definition of applicable coverage subject to the Excise Tax, employers are likely to cease offering those options to the detriment of employees. In making the determination of the mix of options for health coverage, employers will first determine the level of primary health coverage to be offered. This determination will necessarily take into account whether the coverage offered will allow the employer to meet its shared responsibility requirements under Code §4980H – minimum essential coverage that meets the affordability requirements. The Agencies are doubtless aware of studies that find that 48 percent (or more) of employers are likely to trigger the Excise Tax in 2018, and 82 percent could reach that level by 2023.[10] As the cost of providing this level of health coverage gets close to reaching the statutory dollar limit after which the Excise Tax is imposed, employers will be less likely to offer consumer-directed benefit arrangements. This is a particular concern where an employee is able to choose the amount provided under such plans, such as through a salary reduction arrangement, since the employer is unable to preliminarily discern whether its total health coverage offering will exceed the limit.

Consumer-directed benefit arrangements, including HRAs, FSAs, and HSAs provide a means of financing healthcare costs incurred under health plans, and particularly under high deductible health plans. Indeed, an important function of these account-based arrangements is to provide a ready source of funds to use for initial high cost expenses and enable employees (who might otherwise be forced into bankruptcy) an opportunity to amortize such costs throughout the calendar year. These accounts also provide a source of funds to provide coverage for benefits (*e.g.*, dental, vision, wellness, and otherwise) not covered under the high deductible or higher cost-sharing plans that employers may offer. Excise Tax regulations that sweep these consumer-directed healthcare arrangements into the calculation of the tax will result in fewer employers offering the plans. This means that at a time when employees will be required to finance more of their healthcare costs under these higher deductible or high cost-sharing plans, employers will be less likely to offer the means of paying those costs through consumer-directed benefit arrangements due to the inclusion of the employer and employee contributions, which likely create an unmanageable risk for the employer, especially due to the calculation and tax assessment being applied at an individual level. The burden is particularly heavy for lower-paid employees; without these consumer-directed benefit arrangements, such employees will need to pay these amounts out of other take-home pay creating previously unforeseen economic hardship.

In addition, there are practical considerations with how the Excise Tax applies to consumer-directed benefit arrangements. The Excise Tax is determined on a month-by-month basis with a determination in any given month of whether the coverage offered exceeds 1/12 of the statutory dollar limit.[11] In many consumer-directed benefit arrangements, the entire amount available may be credited to an employee's account at the beginning of the year (*e.g.*, to help the employee cope with a high deductible) or in installments (*e.g.*, as wellness program requirements are completed). Guidance will be needed to ensure that such annual contributions are calculated on a monthly basis in order to determine whether the employer's coverage exceeds the monthly statutory limit. A similar issue exists with account-based plans where amounts can be rolled over on a year-to-year basis (such as an HRA or HSA) or where there can be a carryover of unused amounts (or a grace period) in an FSA. We favorably note that the Agencies have considered some of these issues by suggesting that future guidance may provide that carried-over amounts in an HRA available in 2018 may not be counted toward the statutory limit. We believe that the Agencies can also provide practical guidance so that amounts credited at the beginning of a year will not trigger a monthly Excise Tax.

[10] "2014 Health Care Changes Ahead Survey Report", Towers Watson, September 2014. http://www.towerswatson.com/en-US/Press/2014/09/nearly-half-us-employers-to-hit-health-care-cadillac-tax-in-2018-with-82-percent-by-2023

[11] Code §4980I((b)(2).

Suggested Approaches on Application of the Excise Tax to Consumer Directed Benefit Arrangements (aka account-Based Plans)

ECFC recognizes that Code §4980I is a detailed statute that specifically prescribes how the Excise Tax is to be calculated and imposed. Nevertheless, Congress has given the Agencies broad authority to carry out the intentions of the provision. Because consumer-directed benefit arrangements have an important place in the world of employer health plans after the enactment of ACA, we think that the Agencies should use their broad interpretive authority to provide a means for employers to continue to offer these plans. We suggest that the Agencies consider providing the following when developing the guidance to implement the Excise Tax.

I. The Agencies should confirm in final guidance that limited scope vision and/or dental coverage is exempt from the Excise Tax when self-funded; confirm the application of this exemption to consumer-directed benefit arrangements (FSAs and HRAs); and expand application of the exemption to exclude any HSA-compatible (*i.e.*, limited purpose) FSA or HRA.

Code §4980I excludes from applicable coverage "any coverage under a separate policy, certificate, or contract of insurance, which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye." The Agencies indicated in the Notice that this exception should also apply to such excepted benefit coverages when offered on a self-funded basis. We agree with this approach as it eliminates an unintended consequence of providing such coverage on a fully-insured versus self-funded basis. We encourage the Agencies to formally extend this reasoned approach to consumer-directed benefit arrangements that provide excepted benefit only coverage (*e.g.*, vision and dental coverage) to ensure there is no confusion on the issue. In addition, we believe (given the nominal amount of additional coverage allowable under HSA rules) that this exception should be extended to any HSA-compatible, limited scope vision/dental/preventive care arrangement as described in Prop. Treas. Reg. §1.125-5(m); Rev. Rul. 2004-45, 2004-22 I.R.B. 971.

II. The guidance should clarify that employer contributions to an HSA are not included in the Excise Tax determination unless the HSA is a group health plan.

The Notice indicates that an employer's contributions to an HSA are categorically included in the Excise Tax determination, in accordance with Code §4980I(d)(2)(C); however, neither the statute as a whole nor Code §4980I(d)(2)(C) supports this conclusion. The literal language of the statute and Code §4980I(d)(2)(C) only supports one of two conclusions with respect to an employer's contributions to an HSA, both of which are limited in scope to HSAs that qualify as group health plans. HSAs qualify as group health plans only to the extent that they fail to satisfy the safe harbor prescribed by the Department of Labor in FAB 2004-1 and 2006-2. We request that the regulations clarify that employers need only include its contributions to an HSA that is a group health plan in its excess benefit determination.

What is applicable employer-sponsored coverage?

As a threshold matter, Code §4980I (a)(i) imposes an excise tax on the excess coverage benefit of only *applicable employer sponsored coverage.* It doesn't impose an excise tax on applicable employer sponsored coverage plus other types of employer provided benefits that are not applicable employer sponsored coverage. Code §4980I(d)(1) describes applicable employer-sponsored coverage as coverage made available by an employer to an employee *under a group health plan* (except a group health plan that is specifically exempted) that is excluded from income under Code Section 106. Thus, there are two elements to the applicable employer sponsored coverage definition: (i) the coverage must be provided under a *group health plan* and the (ii) coverage must be excluded from income under Code §106. Code §4980I(f)(4) defines a group health plan for purposes of 4980I by reference to definition of group health plan in Code §5000. Code §5000 defines a group health plan as an arrangement that provides medical care that is "of or contributed to by the employer".

Is an HSA applicable employer-sponsored health coverage?

Although an employer's contributions to an HSA are excluded from income tax under Code Section 106(d), HSAs are typically not considered "group health plans", even where the employer contributes to them. HSAs, which are established and maintained primarily in accordance with Code §223 (not Code §5000), are tax-advantaged trust or custodial accounts established and maintained *by individuals* with a bank or approved non-bank trustee or custodian. Even if an employer contributes to an HSA, the HSA belongs to the individual—not the employer. Contributions may be made to an individual's HSA on a pre-tax basis by the employer (including pre-tax salary reductions made through a cafeteria plan) or they may be made on a tax deductible basis by the accountholder or others on behalf of the accountholder. In all cases, the contributions to an individual's HSA are non-forfeitable. If an employer makes contributions to an employee's HSA, and the employee terminates, the employee is able to keep those contributions for future use. The individual accountholder dictates the manner in which the funds in the HSA will be used—not the employer who contributed to the HSA—and the funds in the HSA may be used for both medical and non-medical expenses.

To date the IRS has not issued any formal guidance addressing whether an HSA is a "group health plan" under Code §5000; however, the tri-agencies, including the IRS, clearly indicated the following in the preamble to the regulations on prohibitions against lifetime and annual dollar limits:

> Both MSAs and HSAs generally are not treated as group health plans because the amounts available under the plans are available for both medical and nonmedical expenses.[12]

Notwithstanding the general treatment of HSAs (and MSAs), it is possible for HSAs to qualify as "group health plans". The Department of Labor has issued guidance in both 2004 and 2006 describing situations in which an employer could cause the HSA to become a group plan subject to ERISA's group plan requirements. For example, an HSA would qualify as a group health plan under ERISA if an employer exerted control over the investments offered through the HSA or the employer communicated the HSA to employees as an employee benefit plan maintained by the employer—just to name a few. Under no circumstances, however, does an HSA qualify as a group health plan under the DOL's guidance solely because the employer made contributions to the HSA. In the preamble to the special enrollment regulations issued in 2006, the tri-agencies, including the IRS, noted that the special enrollment rules do not apply to HSAs unless and to the extent the HSA is a group plan under ERISA's rules. Presumably, it would appear that the IRS would follow the DOL's lead when making a determination whether an HSA is a group health plan.

Does the language in §4980I (d)(2)(c) extend the definition of applicable employer-sponsored coverage to HSAs that are not group health plans?

Although Code §4980I(d)(2)(c) is awkwardly worded, there is no reasonable reading of it that would operate to extend the reach of the Excise Tax to contributions to HSAs that are NOT group health plans. Code §4980I(d)(2) identifies various methods for calculating the cost of *applicable employer sponsored coverage*, which we note above is limited to coverage under a group health plan. Code §4980I(d)(2)(c) specifically indicates the following with respect to coverage under an HSA or MSA:

> In the case of applicable employer sponsored coverage [group health plan coverage] consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of Section 106, the cost of the coverage shall be equal to the amount of the employer contributions under the arrangement.

One interpretation of this rather unclear language is that this provision refers to coverage under a group health plan (e.g., an HDHP) that consists of employer HSA contributions. The only way that the contributions to the HSA could be considered coverage under the group health plan is if the HSA were integrated into the group health plan, which would make the HSA a group arrangement under the DOL's rules. The other reasonable interpretation of this provision, which we believe is the most appropriate interpretation, is that this language is referring to the portion of an HSA that is "applicable employer sponsored coverage" (*i.e.,* a group health plan) that is attributable to

[12] Similar treatment has been accorded by other agencies for purposes of HIPAA Administrative Simplification and COBRA.

an employer's contributions and not any contributions made by the accountholder on an after-tax basis. In either case, Congress is clearly not referencing an HSA that is not a group health plan.

Moreover, to conclude that Congress meant anything other than one of the two interpretations set forth above would completely change the meaning of Code §4980I(a)(1), which limits the tax to the excess benefit of "applicable employer sponsored coverage", which is coverage through a group health plan.

III. The guidance should clarify that voluntary supplemental excepted benefit coverage should not be included (even when funded on a pre-tax basis) unless the arrangement would be part of a Section 5000 group health plan.

As noted in the Notice, in order for coverage to be subject to the Excise Tax, the coverage must be provided under a "group health plan" as defined in Code §5000(b)(1). As noted with regard to HSAs above, arrangements that are not Code §5000 group health plans should not be subject to the Excise Tax.

Further, however, since enactment of the ACA, the Departments of Treasury, Labor, and Health and Human Services (collectively, the "Departments") have issued guidance that adopts a new term "employment payment plan". See Notice 2013-54 and related guidance which defines certain types of arrangements for the purchase of individual market coverage that are considered to be group health plans subject to the ACA. Consistent with Department of Labor (DOL) regulations and the guidance relating to employer-payment plans, arrangements that facilitate the purchase of individual market supplemental policies and that meet DOL requirements regarding voluntary arrangements should not be considered group health plans subject to the tax.

Specifically, under DOL regulations[13], an insurance program offered to employees is not an employer provided benefit covered by ERISA if:

(i). No contributions are made by the employer;

(ii). Employee participation in the program is completely voluntary;

(iii). The employer does not endorse the arrangement, and the employer's role is limited to:
- (a) allowing the insurer to publicize the program,
- (b) collecting premiums through payroll deductions, and
- (c) remitting contributions to the insurer; and

(iv). The employer receives no consideration in connection with the arrangement, other than reasonable compensation for its administrative expenses.

Further, under the employer payment plan guidance, to be considered an employer payment plan subject to the ACA, the arrangement must be both a group health plan under ERISA and provide major medical coverage.

We note that this guidance has evolved in an environment where the Agencies have been carefully differentiating between coverage that is group health plan coverage subject to the ACA and coverage that truly should be treated as an excepted benefit (for all ACA purposes).[14] We recommend that the same approach be followed for purposes of the Excise Tax. Thus, consistent with DOL regulations regarding voluntary arrangements and Notice 2013-54, an arrangement would not be a group health plan subject to the Excise Tax if the arrangement facilitates the purchase of individual market coverage, meets the requirements in the DOL regulations cited above, and the plan does not provide major medical coverage, *i.e.*, is an excepted benefit (as further redefined by the agencies). This exclusion should apply regardless of whether the employee contributions are made on a pre- or post-tax basis. This approach is entirely consistent with the post-ACA guidance relating to application of the ACA to employer payment plans.

IV. Salary reduction contributions to consumer-directed arrangements FSAs and HSAs should not be counted for purposes of determining the Excise Tax.

As noted above, it is our understanding that a primary purpose of the Excise Tax is to slow the growth of healthcare costs by capping what was perceived to be overly generous health plans. To accomplish this, the Excise

[13] 29 C.F.R. § 2510.3-1(j)

[14] See HHS Reg. § 148.220(b)(4).

Tax operates to lower the value of employer-provided, tax-free health coverage, which appears to be intended to result in lesser but wiser consumption of healthcare. As discussed in our general comments above, the Excise Tax is poorly designed to achieve this purpose and will have many unintended consequences. One of these is that employers will be less inclined to utilize consumer directed arrangements (FSAs and HSAs) funded by salary reduction even though such arrangements have been effective in promoting more efficient utilization of healthcare dollars. While we understand that the Service has traditionally treated salary reductions as an employer contribution, we believe that such treatment is inappropriate for the Excise Tax.

Treating coverage under Health FSAs funded solely with pre-tax salary reductions as applicable employer-sponsored coverage will do nothing to help achieve the goals set by Congress when it drafted 4980I. As a result of the ACA, pre-tax salary reductions for Health FSAs are limited by statute to $2,500 each year (adjusted for inflation). Thus, Health FSAs funded solely with pre-tax salary reductions are too limited in scope to contribute in any significant way toward the growth of healthcare costs and/or the financing of nationwide healthcare. Moreover, FSAs enable employees (especially lower wage employees) to better budget (and pay) for unanticipated spikes in healthcare expenses that might occur during the year. Consequently, we request the IRS to exercise its regulatory authority to exclude Health FSAs that are funded solely with pre-tax salary reduction contributions.

We also note that there is some ambiguity as to whether "employer contributions" in this context should include salary reduction contributions made by employees to an HSA (assuming the HSA is a group health plan as discussed above). We recommend that HSA salary reduction contributions be excluded. This is evidenced by the specific reference made to such amounts in Code Section 4980I(d)(2)(B). Congress made a clear distinction between employer contributions and employee pre-tax salary reductions, which clearly indicates that Congress intended to treat them separately within the statutory framework of 4980I. Further, given the tax structure governing HSAs, if salary reduction HSA contributions are included in the Excise Tax contribution, employees may obtain a similar tax benefit by making the contributions directly the HSA on an after-tax basis, and then deducting the contribution in accordance with section 223. This approach would be more cumbersome for employees, and some employees might forgo the HSA contribution in this situation, leaving the employee potentially further exposed to medical expenses. We recommend that individuals should not be required to go through additional administrative hoops to obtain similar tax benefits and that salary reduction contributions to HSAs (assuming the HSA is a group health plan) should also be excluded from the tax.

V. Extended transitional relief is appropriate in light of the disproportional impact of the Excise Tax on small employers and employers with consumer-directed benefit health arrangements.

Special consideration should be given to the impact of the Excise Tax on small employers, *i.e.*, employers with no more than 100 employees. While the tax will impose new burdens on all employers that offer health coverage, new legal requirements and the associated technical and administrative burdens typically fall hardest on small employers. Congress has long recognized this fact; for example, since 1988, the Code has included a process for the Chief Counsel for Advocacy of the Small Business Administration to review proposed regulations.

In adopting rules under the ACA, the Treasury Department has also recognized that this group of employers faces special circumstances. For example, employees with less than 100 employees were provided an additional year of transition relief from the 4980H employer penalties in order to "assist these employers with transitioning into compliance." The current exemption from Form W-2 reporting of the value of health coverage for small employers (fewer than 250 W-2s) is another example.

The Excise Tax involves both planning issues (as employers try to design plans so as to avoid the tax) as well as potentially complex calculations (particularly in the event the tax is triggered). It is often difficult for small employers to take on such tasks, including planning ahead, while there is regulatory uncertainty. Often, the practical reality is that small employers find it difficult to plan for a variety of possible outcomes, and must wait until the law is more certain and third parties have developed the necessary systems to address the new legal requirements. As the Excise Tax comes into play, these employers will also be just adjusting to the employer penalty regime and the change in small group size from 50 to 100 employees. Both of these provisions will result in significant changes in benefit offerings for some employers.

Indeed, it is anticipated that insurers will merely charge back the cost of any Excise Tax as a premium surcharge for small employers. For many small employers (with between 50 and 100 employees) whose experience has been better than normal and has not previously been pooled because of their prior "large group" status, application of small group rating rules in 2016 (unless further delayed), may result in a significant unexpected cost

increase and a migration away from offering health coverage to employees. The imposition of an additional punitive excise tax at the same time that rates are rising (due to redefining small group status) will force many small employers to reconsider offering coverage at all. Allowing such employers transition relief until the full impact of the Excise Tax on the small group market can be assessed should help enable such entities to better plan for its impact and prepare employees (where necessary) for the additional potential out of pocket exposure. In many cases plan adjustments (*e.g.*, offering dental or vision coverage as a stand-alone benefit or moving to a high deductible plan but adjusting pre-tax HSA contributions) will enable these employers to budget for and continue to offer quality benefits without excise tax exposure.

As the Treasury and IRS develop rules under section 4980I, special consideration should be given to the burdens on small employers, the extent to which the rules give sufficient time for such employers to transition to compliance, and whether additional transition rules are needed for such employers. We believe that, consistent with prior agency guidance, transition relief should be extended to employers with 100 or fewer employees until the full impact on small employers can be carefully examined.

Likewise, extended transition relief should be provided for sponsors of FSA and HRA arrangements with regard to the inclusion of such coverage for purpose of the Excise Tax. The Notice provides the first substantive guidance with regard to valuation issues for FSAs and HRAs. As noted in the Notice, many issues remain as to how such arrangements should be valued (and whether they should even be considered) for purposes of the Excise Tax. Given the lack of substantive guidance with respect to valuations issues for FSAs and HRAs, additional transition relief should be provided to the sponsors of such arrangements to allow them to ensure compliance prior to application of the Excise Tax.

VI. An exception should be provided for wellness plan incentives directed to consumer-directed benefit arrangements.

In those instances where an incentive under a wellness plan maintained by an employer would be an additional credit under a consumer-directed benefit arrangement sponsored by the employer (such as an FSA or an HRA), this additional credit should not be counted as applicable coverage for purposes to determining the Excise Tax. Benefits provided under the employer's group health plan are already counted as applicable coverage. By providing an incentive under the wellness program, the employer is attempting to reduce utilization of medical benefits under the group health plan in the current and future years. Including that incentive as an additional health benefit essentially treats the incentive as an increased health cost rather than recognizes that the incentive is aimed at reducing health costs of the employer. The Agencies should determine in future regulations that these wellness plan incentives are not additional healthcare spending and should not be considered applicable coverage for purposes of determining the Excise Tax.

VII. Additional considerations as regulations are developed

In addition to the discussion above related to the scope of applicable coverage for purposes of the Excise Tax, we would like the final regulations to address the following additional administrative considerations:

A. Need for "smoothing" of consumer-directed benefit arrangement contributions

As noted above, in many cases, contributions for consumer-directed benefit arrangements are made on an advance basis to ensure that employees have funds available to offset higher deductibles associated with ACA compliant coverage. Likewise, lump sum contributions associated with wellness programs are made as certain wellness goals are achieved. Special consideration should be provided with regard to such arrangements to enable contributions to be "smoothed out" across the entire taxable year for purposes of the Excise Tax.

B. Flexibility is required with regard to the determination of cost for HRA purposes

The Agencies have suggested a number of possible methods for determining the value of HRA (and FSA) arrangements for purposes of the Excise Tax, and we believe that the Agencies have correctly concluded that rollover amounts should not be included for purposes of valuing applicable coverage since such amounts were included at the time an accrual or account deposit was made. However, we also believe that flexibility should be allowed (*e.g.*, as evidenced by the smoothing issue above) to enable plan sponsors a number of reasonable

methods to determine the value of coverage provided. While more options may make calculation of the tax more complicated, such flexibility is necessary to accommodate the wide variety of HRA arrangements (*e.g.*, where some are funded in lump sums, an actuarial equivalency approach may be needed to smooth the impact of the single contribution).

C. Amounts contributed to a coverage only HRA or employer payment plan should be ignored as the Excise Tax would apply to the actual coverage elected

Many employers have adopted or are considering adoption of consumer-directed benefit (so-called "exchange") health arrangements for active employees and/or retirees. With regard to such arrangements an array of benefits may be offered where some are potentially subject to the Excise Tax while other coverage (*e.g.*, vision or dental) may be exempt. We believe that with regard to such an arrangement the Excise Tax should apply with respect to the value of coverage actually elected—rather than any HRA or credit based accrual.

D. FSA and HRA administrators should have the option of reporting the value of coverage provided or, alternatively, the value of major medical (*i.e.*, non-excepted benefits) actually reimbursed.

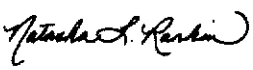
In many cases FSAs and HRAs may be general purpose arrangements (*i.e.*, not limited scope coverage which should be exempt as noted above) but employees will utilize them primarily for excepted benefits (*e.g.*, vision or dental) benefits. FSA and HRA third party administrators (TPAs) that have the ability to differentiate claims based on whether they are primary medical coverage or excepted vision/dental benefits should be able to calculate any Excise Tax based solely on the level of non-excepted benefits reimbursed.

Conclusion

ECFC believes that consumer-directed benefit arrangements are an important component of the current employer provided health system and, as such, the Agencies should provide appropriate regulatory guidance for the implementation of the Excise Tax so that employers can continue to offer these plans without triggering the Excise Tax.

We very much appreciate the opportunity to comment on these critical issues. If further information on any of these issues would be helpful, please contact our Committee Chair John Hickman at 404-881-7885 or jhickman@alston.com.

Sincerely,



Natasha L. Rankin, CAE
Executive Director