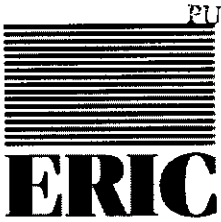

The ERISA Industry Committee

May 15, 2015

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

RE: Notice 2015-16 (Excise Tax on High Cost Employer-Sponsored Health Coverage)

Ladies and Gentlemen:

The ERISA Industry Committee ("ERIC") is pleased to respond to the request of the Internal Revenue Service ("IRS") for comments on Notice 2015-16, in which the IRS describes items that may be incorporated in the development of proposed regulations under new Internal Revenue Code ("Code") section 4980I (excise tax on high cost employer-sponsored health coverage). Added to the law by the Affordable Care Act ("ACA"), Code section 4980I first applies to taxable years beginning after December 31, 2017.

ERIC'S INTEREST IN CODE SECTION 4980I

The ERISA Industry Committee (ERIC) is the only national trade association advocating solely for the employee benefit and compensation interests of the country's largest employers. ERIC supports the ability of its large employer members to tailor health, retirement and compensation benefits for millions of employees, retirees and their families.

ERIC's members, which sponsor some of the largest private group health plans in the country, are committed to, and known for, providing high-quality, affordable health care. Our members expend considerable resources to maintain plans that cover many disparate populations across a wide range of geographic areas and that operate in all states and territories. These plans provide health care to millions of workers and their families with a high standard of cost containment and effectiveness.

While we appreciate the government's solicitation of comments in advance of the development of proposed regulations under Code section 4980I, Notice 2015-16 in reality heralds a transformational approach to the regulation of employer-provided health care, one that cannot and should not be imposed without careful consideration of possible effects and without sufficient time for employers, as necessary, to understand, adapt to, and implement these fundamental changes.

Code section 4980I represents a profound change in the tax treatment of employer-provided health coverage. For over 60 years, Code section 106 has excluded the value of employer-provided health coverage from employee income. Beginning in 2018, Code section 4980I will effectively cap the income tax exclusion by clawing back the cost of "excess" health coverage in the form of a 40% excise tax – a rate that exceeds both the top individual and corporate income tax rates.

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But Code section 4980I is not a model of clarity - neither the scope nor the mechanics of Code section 4980I are clearly explained in the statute or in the relevant legislative history. For instance, the statutory language provides that the cost of employer-sponsored coverage is to be determined "under rules similar to the rules of [Code] section 4980B," without recognition of the fact that such rules have never been promulgated by the IRS. While ERIC members have always determined COBRA premium rates reasonably and in good faith, there are no specifically mandated methodologies for determining COBRA cost, and no one methodology produces a single "correct" COBRA cost.

And Notice 2015-16 creates additional uncertainty. The discussion of applicable coverage assumes that Code section 4980I should apply broadly to certain benefits that have never been perceived as employer-provided coverage. The discussion about determining the cost of coverage implies that the IRS will adopt highly specific, and very rigid, rules that have not been articulated, have never been tested, and may not be consistent with current employer or actuarial practices.

With a tax change of this magnitude, we feel strongly that this rule-making process must proceed in a cautious, deliberate and practical manner. The IRS must recognize that the employer community has never before been tasked with an undertaking of this magnitude. The statute seems to contemplate that, beginning in 2018, employers will be able to instantaneously compute accurate monthly "costs" for over 90 million covered employees and retirees[1]. This is simply not feasible. Developing rules for COBRA premium cost determinations would, by itself, be an arduous years-long process. To think that the 4980I rule-making process will take less time is inappropriately optimistic.

Flexibility and administrability are key concerns – the liberal use of delayed effective dates, transition rules, good-faith compliance standards and safe harbors should be a cornerstone of this rule-making effort. Safe harbors are particularly important. There is no one method for determining "cost," and current actuarial practices use various approaches for making reasonable cost determinations. Employers must have sufficient time to test and implement any IRS-mandated cost determination process, and the cost determination rules must not penalize employers for cost determinations that are actuarially reasonable.

Finally, the impact on employees and retirees cannot be understated. Generations of workers have relied on employer-provided health coverage and have never before been exposed to the magnitude of change that will occur when employers reduce benefits or increase employee contributions to avoid a 40% excise tax. Recent analysis confirms that even plan designs that some may not consider generous – such as the Blue Cross and Blue Shield standard benefit option under the FEHBP – are likely to be subject to the Code section 4980I excise tax, and that plan design alone is not the only factor that will trigger excise tax exposure.[2] Employees and retirees will be understandably surprised when they learn that their benefits have been reduced, or that they will need to pay far more, for the long-standing benefits coverage to which they have become accustomed. These concerns are particularly acute with respect to coverage negotiated through the collective bargaining process, where ERIC members are already noting the influence of anxiety over the excise tax on current bargaining negotiations. The decisions the IRS makes in implementing Code section 4980I have the potential to alleviate concerns for employees and retirees, but we cannot ignore the reality of the magnitude of the disruption exacted by these excise tax changes on the American workforce.

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[1] Based on data compiled for the 2013 Current Population Survey, the Census Bureau estimated that 87,097,000 people had employer-sponsored coverage through their own employment (not as dependents). See http://www.census.gov/hhes/www/cpstables/032014/health/hi01_1.xls.

[2] See Milliman Client Report *"What does the ACA excise tax on high-cost plans actually tax?"* (December 9, 2014), in which the authors demonstrate that the 2018 cost of the BCBS standard benefit option under the FEHBP may exceed the Code section 4980I thresholds in multiple geographic regions around the country, and discuss how other factors unrelated to plan benefits will drive cost determinations. As of May 15, 2015, a copy of the Milliman report is available here: https://www.nea.org/assets/docs/Milliman--What_Does_the_Excise_Tax_Actually_Tax.pdf

Our recommendations and suggestions below emanate from these core principles and concerns.

SUMMARY OF MAJOR COMMENTS

As discussed in detail below, ERIC recommends that:

- Given the limited amount of planning and development time before 2018, we urge the IRS and Treasury Department to immediately postpone the implementation date of Code section 4980I. We suggest a two-year transition period to provide ample time to develop appropriate cost-determination rules, to develop a workable system for collecting and paying any excise tax due, and to provide employers time to plan and implement benefit design changes, to develop and test systems and to communicate changes to covered employees and retirees.

- The definition of applicable coverage for purposes of Code section 4980I should be narrowed to exclude health savings accounts ("HSAs"), most on-site medical clinics, all ACA/HIPAA excepted benefits (including limited scope dental and vision plans and employee assistance programs), wellness programs, and employee physical programs. These benefits are all incidental, and do not in any way represent "high-value" employer-provided coverage; many, in fact, have been instituted to keep employees and their dependents healthier and to help reduce the cost of health care coverage. In addition, we suggest that the IRS create a blanket exception for retiree health plans. At a minimum, neither employers nor retirees should be punished for adhering to bona-fide health coverage expectations created prior to the effective date of Code section 4980I.

- The cost-determination methods used for purposes of Code section 4980I should not be "locked-in" to COBRA cost determination rules, which serve an entirely different purpose. Instead, the cost-determination methods should be flexible enough to permit employers to use any actuarially reasonable cost determination.

- As an alternative to individual cost determinations, the IRS should create an "excise tax safety zone" for coverage that does not exceed specified actuarial value standards. In other words, plans that do not exceed the specified actuarial standard – such as a 90% actuarial value, equivalent to a marketplace platinum plan – would not be subject to the excise tax for a given year. This approach would ensure that the focus of the excise tax is on richness of plan design, and not necessarily on other premium-driving factors (such as geographic location).

COMMENTS

I. TRANSITION RELIEF

For most employers, the 2018 budget and planning cycle will begin in March or April of 2017 – less than two years from now. Although Notice 2015-16 is a start, it does not address many of the complex issues associated with the definition of applicable coverage, the determination of excise tax "cost" or the computation of the excise tax itself. Nor is there even preliminary guidance discussing the mechanics of who, how and when: Who will pay the tax and under what procedures? How will the excise tax be determined? When must "cost" be determined for 2018 and will the applicable thresholds be known before 2018? We understand that the IRS intends to issue additional guidance discussing the procedural aspects of Code section 4980I, but our members are concerned that the clock is ticking very rapidly.

We urge the IRS and the Treasury Department to immediately postpone the implementation date of Code section 4980I. We suggest, at a minimum, a two-year delay, so that the implementation would not be required earlier than for taxable years beginning after December 31, 2019. The IRS needs time to develop appropriate rules, to develop reasonable and workable procedures for determining and collecting the tax, to issue proposed regulations with opportunity for comment, and to issue final regulations. After such regulations are finalized, employers need time to plan and implement benefit design changes, to develop and test systems in conjunction with their actuarial resources and to communicate changes to covered employees and retirees.

II. SCOPE OF APPLICABLE COVERAGE

By its terms, Code section 4980I establishes a broad list of "applicable employer-sponsored coverage" potentially subject to the excise tax. Among other things, this list includes health savings accounts (HSAs), on-site medical clinics, and coverage for retirees. The statute lists a narrow set of exceptions, including the types of liability and ancillary coverages excluded under Code section 9832(c)(1) (other than on-site medical clinics), coverage for long-term care, and insured limited scope dental and vision coverage.

Notice 2015-16 recognizes that the statutory list of covered and excepted benefits is inconsistent, and suggests that the IRS will create an alternative list of applicable coverage. Thus, Notice 2015-16 suggests that the IRS intends to exclude self-insured limited scope dental and vision coverage and will create exceptions for other types of coverage, including on-site medical clinics providing de minimis care and employee assistance programs (EAPs).

At the outset we note that many of the plans and programs targeted by the statute provide coverage that is either ancillary, or even unrelated to, comprehensive major medical coverage. For example, some types of coverage targeted by the statute, particularly HSAs and Health Reimbursement Accounts (HRAs), share the same policy goals of Code section 4980I – they reduce health care costs by empowering consumers to purchase health care based on value and quality. Other types of coverage targeted by the statute, such as on-site medical clinics and EAPs, provide valuable services to employees from a worksite safety and productivity perspective, services that are not necessarily related to major medical coverage. In order to maintain major medical coverage, however, companies may be forced to eliminate these ancillary or unrelated benefits, to the great detriment of affected employees and their families.

In the interest of fairness, administrability and employee/retiree expectations, we urge the IRS to approach the definition of applicable coverage with a high degree of flexibility. To the extent the IRS can develop permanent relief by excluding certain types of coverage from the definition, it should do so. To the extent the IRS cannot develop permanent relief, it should consider providing temporary transition relief and/or safe harbors for these types of coverage. The following discussion elaborates on the types of coverage for which relief should be provided.

A. HSAs. Many ERIC members have adopted HSA-compatible high-deductible health plans. This is a national trend. Recent survey data indicates that nearly half of large employers offer a high-deductible health plan, and nearly a quarter of covered employees have enrolled in these plans.[3] ERIC members offer modest levels of employer HSA contributions (frequently as an incentive for employee participation in a wellness program) and permit employees to make pre-tax HSA contributions through convenient payroll deductions. If the point of Code section 4980I is to rein in the cost of health coverage, it is hard to comprehend why employers and their employees should be discouraged from using HSAs. We believe strongly that HSAs should be excepted from the definition of applicable coverage for several reasons.

[3] See http://www.mercer.com/content/mercer/global/all/en/newsroom/modest-health-benefit-cost-growth-continues-as-consumerism-kicks-into-high-gear.html.

First, and most importantly, HSAs are not group health plans. By its terms, Code section 4980I(d)(1)(A) applies only to coverage under a "*group health plan* made available to the employee by the employer." Code section 4980I(f)(4) defines the term "group health plan" by cross-reference to Code section 5000(b)(1). The IRS, however, has never taken the position that HSAs are group health plans subject to Code section 5000(b)(1), and doing so would put the IRS in conflict with its sister agencies. More than ten years ago, the DOL confirmed that HSAs generally are not employee welfare benefit plans subject to ERISA[4] and, based on that position, the agencies collectively confirmed that HSAs are not "group health plans" subject to the requirements of the Public Health Service Act and the parallel provisions of ERISA and the Code.[5] CMS has similarly concluded that HSAs are not "group health plans" for purposes of the Medicare retiree drug subsidy[6], and that HSAs are not "group health plans" subject to the Medicare Secondary Payer mandatory reporting requirements.[7] If HSAs are not group health plans for purposes of ERISA, the Public Health Service Act (and its parallel provisions), and the Medicare Secondary Payer rules, then the same arrangements should also not be treated as group health plans for purposes of Code section 4980I.

Second, unlike nearly any other type of health coverage excluded from income under Code section 106, *contributions* to HSAs are already subject to specific contribution limits under Code section 223. These contribution limits apply to both employer and employee contributions to HSAs, and operate independently of whether employees make their HSA contributions on a pre-tax basis. Given these specific, statutory contribution limitations, ERIC members believe there is no reason to subject these contributions to a second limitation in the form of the Code section 4980I excise tax.

Third, the statute by its terms does not require employee pre-tax contributions to HSAs to be treated as applicable coverage. This is abundantly clear by comparing the plain language of Code section 4980I(d)(2) and (d)(3). Under the first provision, Congress specifically requires employee salary reduction contributions to health FSAs to be taken into account in determining cost. But under the second provision, Congress does not mention employee salary reduction contributions to HSAs. To the contrary, the second provision specifies that only employer contributions to HSAs are to be taken into account in determining cost. If Congress had intended that employee salary reduction contributions to HSAs should also be taken into account in determining cost, it would have said so.

Fourth, counting the full amount of HSA contributions against the Code section 4980I dollar thresholds greatly distorts the impact and significance of HSAs. By treating pre-tax HSA contributions as applicable coverage, the effect is to substantially reduce the amount of the Code section 4980I dollar threshold available for comprehensive major medical coverage. For example, the 2015 HSA contribution limits would consume nearly one-third of the 2018 dollar threshold for self-only coverage, and nearly one-fourth of the 2018 dollar threshold for family coverage. And by 2018, this effect will be even more disproportionate. Moreover, if employers are required to count employer HSA contributions, many may be forced to limit the amount and shift additional out-of-pocket costs to employees. These are not desirable results.

Finally, the IRS proposal to except only after-tax employee contributions to HSAs is unworkable, both legally and practically. From a legal perspective, switching from pre-tax to after-tax employee HSA contributions will make any employer HSA contributions subject to the comparability rules of Code section 4980G. Currently, ERIC members rely on the cafeteria plan exception to the comparability rules. This exception exempts variable employer HSA contributions from comparability testing if the employer allows employees to

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[4] See Field Assistance Bulletin 2004-01 (April 7, 2004) available at http://www.dol.gov/ebsa/regs/fab2004-1.html.

[5] See PHSA §2791(a)(1), defining the term group health plan "as an employee welfare benefit plan (as defined in section 3(1) of ERISA)." See also 69 Fed. Reg. 78734 (December 30, 2004) – "Because HSAs are generally not employee welfare benefit plans, the HIPAA portability requirements under ERISA or the PHS Act generally will not apply."

[6] See 42 C.F.R. §423.882

[7] See page 7-45 of the "GHP User Guide" available at http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Downloads/New-Downloads/MMSEA-Section-111-GHP-User-Guide-Version-46-Jan-5-2015.pdf

make pre-tax employee HSA contributions through a cafeteria plan, whether or not employees actually make such contributions.[8] Thus, the cafeteria plan exception permits employers to make variable employer HSA contributions, including matching employer HSA contributions and employer HSA contributions linked to wellness programs.[9] If employees are not permitted to make pre-tax employee HSA contributions, then the cafeteria plan exception does not apply, and employers will need to standardize employer HSA contributions to avoid the Code section 4980G excise tax. Faced with the prospect of an excise tax Hobson's choice (4980G vs. 4980I), employers are likely to significantly reduce or eliminate their employer HSA contributions.

From a practical perspective, changing pre-tax HSA contributions to after-tax HSA contributions will discourage employee participation and require significant modification to payroll systems. Employees would face immediate increases in federal and state income tax and federal employment tax, and would need to file the more complicated Form 1040 (rather than 1040A or 1040-EZ) to claim the Code section 223 deduction. Employers would need to revise payroll systems to accommodate both pre-tax and after-tax HSA contributions, and to ensure that after-tax HSA contributions are taken into account for federal income and employment tax purposes. If employees cannot make pre-tax contributions to HSAs, then the incentive to enroll in high-deductible health plans is greatly reduced.

For all of these reasons, we urge the IRS to exclude HSAs from the scope of applicable coverage subject to Code section 4980I or, at a minimum, to limit applicable coverage to employer contributions to HSAs.

B. On-site medical clinics. Historically, employers have offered on-site medical clinics to promote workplace safety and manage occupational services. Their focus has generally been limited to services such as treatment for on-the-job injuries, disability determinations, return-to-work activities, pre-employment screenings, and health monitoring activities required by the Occupational Safety and Health Administration or other government agencies.[10]

More recently, a growing number of employers have expanded the role of their on-site clinics to provide preventive care, primary care and chronic care. These clinics assist in the operation of employer wellness programs by administering health risk assessments, conducting biometric tests and coordinating routine preventive screenings. Some clinics offer primary care for employees and dependents, and coordinate disease management programs and services for individuals with chronic conditions.

The growth of on-site medical clinics is widely believed to reduce absenteeism (by cutting the amount of time necessary for employees to receive primary care), to help manage employer health spending (by allowing the employer to negotiate the cost of primary care services) and to increase employee satisfaction (by offering a convenient, accessible, trusted care facility to employees). On-site clinics also keep employees healthier, which has the beneficial effect of decreasing costs: on-site immunizations, for instance, increase the rate of immunization among employees and their families, protecting them against disease and thus reducing medical expenses. Recent survey information indicates that among employers with 5,000 or more employees, 29% offer a clinic providing primary care services.[11]

Much of the applicable agency guidance for on-site medical clinics is inconsistent. The ERISA regulations provide an exception for on-site clinics that treat minor injuries or illness or render first aid in the case of

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[8] See Treas. Reg. §54.4980G-5, Q&A-1.

[9] See Treas. Reg. §54.4980G-5, Q&A-2 and Q&A-3.

[10] A number of ERIC members are not able to offer "on-site" medical clinics because of federal or state regulations limiting access to the workplace by spouses and dependents (e.g., FAA rules at airports, DOD rules at military facilities and DOE rules at energy facilities). We urge the IRS (and its sister agencies) to expand the definition of "on-site" medical clinics to include "near-site" clinics for employers that are prohibited from maintaining "on-site" clinics.

[11] See http://www.mercer.com/content/mercer/global/all/en/newsroom/modest-health-benefit-cost-growth-continues-as-consumerism-kicks-into-high-gear.html.

accidents.[12] The COBRA regulations provide an exception for on-site clinics that consist primarily of first aid for the treatment of a health condition, illness or injury that occurs during working hours, but only if the care is available for current employees and employees are not charged.[13] The HIPAA/ACA excepted benefit regulations provide a general exception for on-site medical clinics, but never define the term.[14]

On the other hand, IRS guidance on HSA-compatible high deductible health plans provides that an individual will not fail to be an eligible individual if he/she has access to free or below market value care from an on-site clinic if the clinic "does not provide significant benefits in the nature of medical care" (ignoring preventive care). An example concludes that an on-site clinic providing certain types of free health care satisfies this requirement.[15] The types of permitted health care described in that example include: (1) physicals and immunizations; (2) injecting antigens provided by employees (e.g., performing allergy injections); (3) a variety of aspirin and other nonprescription pain relievers; and (4) treatment for injuries caused by accidents at the plant. Notice 2015-16 asks for comments on whether the same four types of care should be excepted from the definition of applicable coverage.

The IRS should not create another definition of "on-site medical clinic" to be used solely for purposes of Code section 4980I. Instead, the IRS should consider the following standards for on-site clinics:

- If a clinic offers care that is limited in scope and does not provide significant benefits in the form of medical care, then the clinic should be excepted from the definition of applicable coverage. The term "limited in scope" should be interpreted to include not only the four types of care noted above, but any type of preventive service/treatment for which the ACA requires coverage.[16] In addition, "limited in scope" should be interpreted to permit services/treatment to support employer wellness programs (such as the administration of health risk assessments and conducting biometric screening), to permit services/treatment related to business travel (such as destination-specific immunizations, prescriptions for anti-jet-lag drugs and malarial treatment), to permit treatment of any and all workplace injuries, and to permit the types of activities commonly associated with occupational services.

- If a clinic offers care that exceeds the limited-scope standard, then the clinic should still be excepted from the definition of applicable coverage if the employer integrates the clinic as part of its comprehensive health plan. In other words, if the clinic is treated as a covered network facility for purposes of the employer's health plan, then the employer is already treating the cost of the clinic as part of the cost of that plan. Making a separate cost determination for this type of clinic would amount to "double counting" and should not be required.

Although ERIC members generally favor an exception for on-site medical clinics based on a standard that examines the scope of benefits rather than a standard based on a specific dollar value, we would also support a safe harbor approach whereby on-site (or near-site) clinics providing services that amount to less than $700 per individual per year on average (adjusted annually for inflation) would not be considered applicable coverage for purposes of the excise tax. [17] If such a safe-harbor approach were to be adopted, we would strongly urge that it be one option among several and not the sole arbiter of whether the cost of an on-site medical clinic would be subject to the excise tax.

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12 See DOL Reg. § §2510.3-1(c)(2).

13 See Treas. Reg. §54.4980B-2, Q&A-1(d).

14 See Treas. Reg. §54.9831-1(c)(2)(viii).

15 See IRS Notice 2008-59, Q&A-10.

16 See §2713 of the Public Health Service Act.

17 Another possible approach is to exclude any on-site medical clinic if the value of that clinic would be excluded from income, applying rules similar to the de minimis fringe benefit rules applicable to on-site/near-site employer-sponsored eating facilities. See Code section 132(e)(2).

C. ACA Excepted Benefits. Notice 2015-16 suggests that the IRS is considering an exception to applicable coverage for two types of excepted benefits coverage; namely, self-insured limited scope dental and vision plans and employee assistance programs, both as described in the recently finalized excepted benefit rules.[18] We strongly endorse both of these suggestions.

Further, the IRS should confirm that the prohibition on "double counting" described above with respect to on-site medical clinics applies with equal force to EAPs. In other words, if an EAP does not satisfy the excepted benefit rules, it will still be excepted from applicable coverage if the EAP is integrated with the employer's comprehensive health plan, and the cost of the EAP coverage is included in the cost of the health plan. In such a case, the EAP should not be treated as applicable coverage for which a separate cost determination is required.

D. Retiree Health Plans. Notice 2015-16 appears to contemplate that retiree health plans are included in the definition of applicable coverage. We urge the IRS to consider whether this is necessary or appropriate. In recent years, retiree health plans have undergone great changes. Most notably, the prevalence of these plans has decreased significantly. With the advent of the FAS 106 rules and private exchanges, many employers have chosen to convert their traditional defined benefit retiree health plans to defined contribution retiree health plans. Instead of a promise to pay a percentage of incurred claims, the employer promises to make a fixed sum of money available, which the retiree can use to purchase coverage. These defined contribution arrangements are particularly common for retirees age 65 and older.

Many ERIC members continue to provide retiree health coverage to various categories of former employees but are now faced with significant concerns about how Code section 4980I will impact their retiree health benefits for both bargained and non-bargained retirees. These concerns are particularly acute given the "retiree-friendly" positions taken by the IRS and the other departments in interpreting other ACA requirements. For example, nearly five years ago the IRS and the other departments concluded that most ACA requirements do not apply to retiree-only plans.[19] More recently, the IRS and the other departments concluded that stand-alone (non-integrated) health reimbursement arrangements are permitted if structured as retiree-only plans.[20] ERIC members and their retirees have relied on these conclusions in establishing and modifying retiree health benefits.

Code section 4980I diverges significantly, and detrimentally, from these prior positions. In the absence of administrative relief, Code section 4980I will eventually expose their former employees to the excise tax. This is true despite the additional threshold allowance for qualified retirees, and despite the fact that these retiree health plans were established, and retirees performed services, prior to 2018.

Code section 4980I will punish retirees uniformly, without regard to the amount of contributions paid by their former employer. For excise tax purposes, a retiree will be treated the same whether the former employer pays 75% of the cost of coverage or 25% of the cost of coverage. Moreover, retirees typically pay their share of contributions with after-tax dollars because they do not have access to the pre-tax payment mechanism of Code section 125.

Retirees often will face difficulty in making additional contributions to continue benefits that they have been expecting to receive, nor will they be able to find comparable sources of coverage to replace the employer-provided coverage lost to the excise tax. Thus, the IRS should exercise its administrative authority to except retiree-only plans from the definition of applicable coverage.

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[18] See 79 FR 59130 (October 1, 2014)

[19] See 75 FR 34538 (June 17, 2010).

[20] See IRS Notices 2013-54 and 2015-17.

E. Wellness Programs. The ACA includes statutory clarifications regarding the legal status of employer-sponsored wellness programs. With these clarifications, wellness programs have become widespread and well-established - recent survey information shows that, nationally, 56% of large employers offer wellness programs with financial incentives.[21]

Wellness programs (and their financial incentives) should not be treated as a separate "coverage" for which an excise tax cost determination is required. Wellness programs do not provide medical care per se, but instead establish incentives and provide tools to encourage the promotion of health. Informed and educated employees, armed with empirical data about their health status, are in a much better position to access healthcare services that are specific and appropriate.

A fundamental tenet of the ACA is the promotion of preventive care. The ACA requires group health plans and individual insurance policies to provide coverage for specific preventive care services, without cost-sharing, including early detection and screening for a variety of conditions. Wellness programs expand upon and complement this goal by encouraging employees to seek out these services, and to take greater ownership of their health status.

In many cases, wellness programs and their related incentives are integrated with other employer-sponsored coverage. In such cases, the value of wellness program incentives is already accounted for when an employer determines the "cost" of the other coverage, such as a high deductible health plan. But even where wellness programs are offered independently of other employer-sponsored coverage, there is no compelling reason to treat these programs as "coverage" for purposes of Code section 4980I. Doing so will only discourage the further development of wellness programs.

F. Employee Physical Programs. Many ERIC members offer programs that pay or reimburse the cost of periodic physical examinations. In some cases, these programs are available only to executives at or above certain compensation levels. In other cases, these programs are available to employees who are required to complete physical examinations in accordance with requirements of various government agencies (e.g. the Department of Transportation, the Department of Justice and the Department of Homeland Security). In still other cases, these programs are available to employees broadly through on-site medical clinics. These programs are common and long-standing, and serve the simple purpose of promoting employee health. We do not believe that employee physical programs should be treated as employer-provided "coverage" for purposes of Code section 4980I.

Over 35 years ago, the IRS took the position that a plan providing medical diagnostic procedures is not treated as a self-insured medical reimbursement plan subject to Code section 105(h).[22] The medical diagnostic procedure exception applies to plans that pay or reimburse the cost of "routine medical examinations, blood tests and X-rays." The rationale is that such programs are beneficial, regardless of the group of employees to whom the programs are offered. If these programs are not treated as coverage for purposes of Code section 105(h), they should not be treated as coverage for purposes of Code section 4980I.

In addition, employee physical programs required by federal or state agencies should never be treated as coverage for purposes of Code section 4980I. These programs are typically required by law or as a condition of doing business, are necessary to ensure that certain employees can perform the terms and conditions of their employment and, in many cases, serve to protect public safety. These government-mandated employee physical programs are in no way similar to the types of health coverage provided by employers that are the focus of Code section 4980I.

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[21] See http://www.mercer.com/content/mercer/global/all/en/newsroom/modest-health-benefit-cost-growth-continues-as-consumerism-kicks-into-high-gear.html.

[22] See Treas. Reg. §1.105-11(g).

Where employee physical programs are offered through on-site medical clinics, the cost of such programs is integrated into the cost of the clinic. As noted above in our discussion of on-site medical clinics, if the employee physical program is part of the services offered by an on-site clinic (and integrated with an employer health plan), then the employer is already treating the cost of the program as part of the cost of that plan. The IRS should clarify that where employee physical programs are offered through on-site medical clinics, employers are not required to make a separate cost determination for such programs. Making a separate cost determination in this context would amount to "double counting" and should not be required.

III. COST DETERMINATION APPROACHES

A critical problem in developing regulatory guidance under Code section 4980I is the significance the law places on "cost" determinations. The statute seems to presume that there is one excise tax "cost" which can easily and precisely be computed by reference to "rules similar to" the COBRA cost determination rules. ERIC members generally rely on internal or outsourced actuarial resources for determinations of COBRA cost. In determining COBRA cost, the actuarial profession follows generally accepted actuarial principles and methodologies, which do not necessarily yield identical results.

Before responding to some of the specific topics discussed in Notice 2015-16, it will be useful to describe how large employers with self-insured coverage typically develop their cost estimates for an upcoming plan year. The most important number for business purposes is "budget cost" – the amount the employer projects it will need to pay for claims and administrative expenses in the following year. The determination of "COBRA cost" typically flows from, and occurs at the end of, the process for determining budget cost.

- *Step 1 – Develop projected budget cost on a "no change" basis.* Actuarial resources first develop projected budget cost assuming no changes to plan design. This process involves reviewing average claims costs over a specified period of experience, projecting these costs forward based on trend information (employers may use separate trends for medical services, prescription drugs and/or other categories of benefits), building in appropriate reserves for incurred but unpaid claims, adding projected administrative fees for service providers, then calculating a premium equivalent for each benefit option (based on projected enrollment and utilization) and each tier of coverage.

- *Step 2 – Evaluate plan design changes.* After the initial budget projections are completed, the employer has an opportunity to consider plan design changes and review the impact those changes may have on the premium equivalents. Benefit options may be added or deleted, deductibles and out-of-pocket limits may be modified, eligibility standards may change, and employee contributions may be altered. The impact of any plan design changes is evaluated, and the claim projections may be updated, based on emerging claim and enrollment data. This process allows the employer to determine what, if any, plan design changes will be made for the following plan year.

- *Step 3 – Negotiate/confirm fixed costs with vendors and carriers.* The third step in the process is to "lock down" administrative costs for the upcoming plan year with third party administrators, pharmacy benefit managers, and other service providers, as well as premium costs with insurance carriers for any fully-insured coverage. In some cases, multi-year contracts fix administrative costs over a multi-year period, but many administrative costs may require year-by-year review and negotiation. This is particularly the case with insurance premium renewals, assuming the employer offers HMO or other fully-insured coverage in addition to its self-insured coverage.

- *Step 4 – Finalize the budget cost estimates.* Once the plan design changes have been determined and the administrative costs are fixed, final premium equivalents can be developed, and the employer can decide how much employees will be required to contribute for each benefit option and for each tier of coverage. COBRA premiums for the following plan year are generally linked to the final premium equivalents.

Despite this extensive analysis, budget "cost" is still only an estimate – actual costs may vary significantly. Participants may not enroll in benefit options as expected, trend assumptions may be too high or too low, claims cost may move up or down, micro or macroeconomic forces may affect both enrollment and spending for health care services, drug patent durations and drug pipeline predictions may be wrong, and expected network changes may not be realized. (In-network providers and negotiated rates may vary from predictions.)

In the past, budget cost and COBRA cost determinations did not trigger tax consequences. If budget cost was off, an employer would pay either more or less for plan benefits. If COBRA cost was off, IRS excise tax obligations and/or participant lawsuits could theoretically follow, although neither has ensued over the last 30 years. And, as noted above, both budget cost and COBRA cost are only estimates; they will always be higher or lower than actual costs.

With the advent of Code section 4980I, this dynamic changes abruptly. If a Code section 4980I cost determination is "wrong", the repercussions can be brutally significant. The employer (and/or its service providers) may face a whopping 40% excise tax assessment, combined with the inconvenience and resource-draining challenge of responding to an IRS audit and possible notice and demand for payment.

Thus, we urge you to clarify that the process and methodology for determining COBRA costs may, at the employer's option, be entirely separable from those that will be used for determining the cost of applicable coverage under Code section 4980I and that the determination of the cost of applicable coverage be based first and foremost on principles of flexibility and simplicity.[23]

A. ***Similarly Situated Individuals.*** Notice 2015-16 devotes significant space to a discussion of how the excise tax cost determination rules should follow, or vary from, the COBRA cost determination rules. The Notice focuses extensively on the concept of "similarly situated" employees and invites comments about how this term should be interpreted. We have several comments in this regard.

The attention given to identifying "similarly situated" employees is misplaced – Code section 4980I does not mention this phrase. The phrase that actually appears in Code section 4980B is "similarly situated beneficiary with respect to whom a qualifying event has not occurred." This term appears multiple times in Code section 4980B, where its purpose is to ensure that COBRA qualified beneficiaries are treated in the same manner as covered participants who are not COBRA qualified beneficiaries. *Thus, the phrase has no particular meaning – or relevance – with respect to Code section 4980I.*

The purpose of the cost determination rule in Code section 4980I is to compute, with reasonable accuracy, whether the cost of an individual's coverage is above or below an applicable threshold. The COBRA cost determination approach, per our illustration above, typically produces a separate COBRA cost for each benefit option and each tier of coverage. Developing highly complex rules concerning who must be grouped with whom for purposes of the excise tax cost determination does not facilitate simplicity, efficiency, accuracy, or fairness.

Employers need the flexibility to develop excise tax "cost" determinations per their traditional processes, without the added complexity and distraction of overly complicated, inappropriate rules regarding similarly situated employees that have no currency in the context of the excise tax.

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[23] A threshold question is whether the cost of applicable coverage is based on the coverage in which an employee is actually enrolled, or the cost of applicable coverage which is made available to that employee. The statute defines applicable employer-sponsored coverage by reference to group health plan coverage "made available" to an employee, but Notice 2015-16 assumes that cost must be determined by reference to the coverage in which an employee is enrolled. Some ERIC members have suggested that the IRS permit excise tax cost determinations to be made by reference to the lowest-cost employer-sponsored group health plan that is available to an employee. We urge the IRS to clarify this issue.

B. Mandatory and Permissive Aggregation/Disaggregation. Notice 2015-16 suggests that the IRS will adopt specific "mandatory" aggregation and disaggregation rules for benefit packages. The Notice does not invite comments on this approach, but only invites comments on whether, and to what extent, permissive aggregation is appropriate. We nonetheless express our strong disagreement with the mandatory aggregation and disaggregation approach, and we urge the IRS to consider more flexible alternatives to permit the determination of excise tax "cost."

Because of the nature of their workforces, large employers frequently offer a significant number of plans. These plans may vary across diverse members of a controlled group and may vary from one location to another. In some cases, active employees and retirees are covered under the same plan. In other cases, they may be covered by separate plans. Employers need the flexibility to define both the populations and the plans that must be measured for excise tax purposes so that employers are able to determine the approach that best addresses their diverse populations, thereby protecting their limited benefit resources.

As noted above, the process ERIC members follow for determining budget cost and COBRA cost is a process that is already consistent with the mandatory aggregation approach advocated by Notice 2015-16. That process eventually creates estimated premium equivalents for each benefit option and tier of coverage, and relies on actuarial analysis and expertise rather than specific "mandatory" concepts of aggregation and disaggregation. By suggesting that excise tax cost determinations must be made following specific "mandatory" aggregation and disaggregation rules, Notice 2015-16 risks imposing a "one-solution" approach instead of recognizing that accepted actuarial methodologies may provide "multi-solution" approaches to this issue.

We urge the IRS to think about the cost-determination process differently. Instead of forcing plan sponsors to slice and dice their plans in accordance with complicated aggregation and disaggregation rules, we suggest that the IRS allow the cost determination process to proceed in accordance with longstanding employer processes for determining costs, which have served them well over many decades of providing benefits to employees and their families. ERIC members want and need this flexibility to make good-faith determinations of the excise tax "cost".

C. Actuarial Cost Method vs. Past Cost Method. Notice 2015-16 invites comments on a variety of issues associated with the two COBRA cost determination methodologies available for self-insured plans – the actuarial cost method and the past cost method.[24] The actuarial cost method determines COBRA cost based on an actuarial estimate of future claims, adjusted for inflation by medical trend. The past cost method determines COBRA cost based on claims incurred during a prior determination period, adjusted for inflation by "the implicit price deflator of the Gross National Product" (the "GNP deflator").[25] The Notice then discusses how these methods might be used to determine excise tax cost.

Before commenting on this specific question, we need to reaffirm a broader point – nothing in the law or the legislative history requires excise tax "cost" to be determined exactly as COBRA cost is determined. The law directs that the excise tax cost determination be determined under rules "similar to" the COBRA cost determination rules but goes no further. Because specific guidance on the COBRA cost determination rules has never been the subject of regulatory or even sub-regulatory guidance, there is no compelling reason to "lock in" to rules that don't formally exist. At this stage in the process, we believe it is imperative for the IRS to think more broadly about facilitating reasonable approaches for determining excise tax cost, rather than becoming mired in a rulemaking process to prescribe rules for making COBRA cost determinations.

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[24] Compare Code section 4980B(f)(4)(B)(i) and (ii).

[25] The GNP deflator is an index that demonstrates how inflation affects the Gross National Product. Unlike the Consumer Price Index, which measures inflation based on a limited group of goods and services, the GNP deflator is based on all goods produced by the economy. The GNP deflator is updated monthly by the Bureau of Economic Analysis of the Department of Commerce. Refer to line 27 at:
http://www.bea.gov/iTable/iTable.cfm?reqid=9&step=3&isuri=1&903=13#reqid=9&step=3&isuri=1&903=13

With respect to the specific question about the two COBRA cost determination methodologies, we note that ERIC members do not use the past cost method to determine COBRA cost. There are several reasons why this is true. First, and most important, the actuarial cost method relies on actual medical trend, while the past cost method relies on the GNP deflator. Because the GNP deflator measures inflation over a broad range of economic goods, it is typically much lower than medical trend. Thus, compared to the actuarial cost method, the past cost method generally understates COBRA cost. Second, as explained above, the normal process for estimating budget cost relies on actuarial estimates, so it is logical and convenient to use the same actuarial approach in determining COBRA cost. Finally, under Code section 4980B, the use of the past cost method is prohibited when there is "any significant difference" in the coverage under, or employees covered by, the plan. In the absence of guidance explaining when such differences are "significant," self-insured employers have not been willing to use this method.

Some employers may, however, wish to consider the possibility of using the past cost method for excise tax cost determination purposes if several hurdles can be overcome. Use of the past cost method would generally produce a lower excise tax cost than the actuarial cost method, and a lower excise tax cost may delay the moment in time when the plan's cost exceeds the permissible thresholds. The hurdles may be summarized as follows:

- Employers would need the discretion to use the actuarial cost method for COBRA purposes and the past cost method for excise tax purposes. As noted previously, there is nothing in the statute that requires employers to use the same cost determination methods for purposes of both Code section 4980B and Code section 4980I.

- Employers would need the discretion to change their excise tax cost methodology for any bona-fide business reason. This is especially true in the case of corporate reorganizations where a buyer and seller may be using different cost determination approaches.

- Employers would need certainty that they can use the past cost method even with coverage or enrollment changes, which are common for ERIC members. Code section 4980I says that the excise tax cost determination rules should be made under rules "similar to", not "exactly identical to", the COBRA cost determination rules. Thus, the IRS could choose to ignore the "significant differences" provision in Code section 4980B(f)(4)(B)(iii), or provide a more flexible rule for purposes of Code section 4980I.

With respect to the actuarial cost method, Notice 2015-16 asks whether broad or narrow standards should be adopted for determining excise tax cost under that methodology. We suggest that the best answer may be "both." ERIC members need maximum flexibility and certainty, and want to be able to rely on time-tested and actuarial reasonable approaches for determining excise tax cost. As suggested above, we urge the IRS to look beyond the narrow confines of the COBRA cost determination rules to develop flexible and administrable rules for determining excise tax cost.

With respect to the past cost method, Notice 2015-16 asks a series of questions about the mechanics for applying that methodology. We do not have specific comments on those questions.

D. Health Reimbursement Arrangements (HRAs). Notice 2015-16 invites comments on several issues associated with the determination of excise tax cost for HRAs. The Notice presumes that a separate cost determination is required for HRAs, and asks whether pre-2018 carryover amounts should be excluded.

We do not agree that a separate cost determination is required for all HRA coverage. Most remaining HRAs are integrated with another coverage option, such as a consumer driven health plan, which means that the value of the HRA is already accounted for when the employer determines its premium equivalents. Thus, for these integrated HRAs, we would make the same observation that we have previously made for on-site medical clinics. Where the employer is already treating the cost of the HRA as part of the cost of a plan, then

making a separate cost determination for the HRA would amount to "double counting" and should not be required.

If the IRS continues to believe that a separate methodology is necessary to determine the cost of HRA coverage, we urge you to be as flexible as possible and to permit, at a minimum, both of the approaches identified in Notice 2015-16 as well as other approaches that are actuarially reasonable. Employers have been sponsoring HRAs for many years without specific cost determination rules, and mandating a single cost-determination methodology for HRA coverage is an inappropriately rigid approach.

For standalone HRAs that are retiree-only plans, we again urge the IRS to consider a broader exception carving such HRAs out of the definition of applicable coverage.

For both integrated HRAs and standalone HRAs, carryover amounts from pre-2018 years should not be taken into account in determining excise tax cost as these amounts were contributed prior to the date of applicability of the excise tax.

E. Alternative Method for Determining Excise Tax Cost. Notice 2015-16 invites comments on whether there are other alternative methods for determining the cost of applicable coverage "consistent with the statutory requirements."

In addition to the alternative methodology we discuss above, we strongly urge the creation of an "excise tax safety zone" based on a plan's actuarial value. Under this approach, plans that do not exceed a specified actuarial value – such as the 90% actuarial value that applies to marketplace platinum plans – would automatically be deemed not to exceed the applicable thresholds for all covered employees or retirees. Employers would thus be able to establish plan actuarial values below these safety zones for a particular year and receive advance assurance that no excise tax would be applicable for that year with respect to any employee covered by the "safety zone" plan.

This alternative approach would offer some degree of greater simplicity, with the added advantage of providing advance assurance and excise tax certainty to employers (and their employees and retirees). It would also be a more equitable approach as employers with high-claims employees and dependents and those living in geographic areas with higher provider costs would not be inappropriately penalized.

ERIC appreciates the opportunity to provide comments on Notice 2015-16. If you have questions concerning our comments, or if we can be of further assistance, please contact us at (202) 789-1400.

Sincerely,

Annette Guarisco Fildes

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