Notice 2015-16

Johnson & Johnson

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

Ladies and Gentlemen:

On Behalf of Johnson & Johnson's Operating Companies, we are pleased to provide the Department of the Treasury (Treasury) and the Internal Revenue Service (IRS) with comments in response to Notice 2015-16 and the excise tax on employer-sponsored health coverage under Section 4980I of the Internal Revenue Code.

Johnson & Johnson (J&J) is the world's most comprehensive and broadly-based manufacturer of health care products for the consumer, pharmaceutical and medical devices and diagnostics markets. For more than 125 years, J&J Companies have supplied the health system with a broad range of products and have led the way in innovation, beginning with the first antiseptic bandages and sutures.

J&J is a member of the Pharmaceutical Research and Manufacturers' Association, the ERISA Industry Committee, the Business Roundtable, The United States Chamber of Commerce, and the American Benefits Council. We support and endorse their comments in response to Notice 2015-16.

J&J separately submits this comment letter because of our concern that the excise tax under Section 4980I will negatively impact J&J employees' health care benefits.

I. Summary of Comments

A. Calculation of the Cost of Coverage

(i) *Cost of the benefit package*. J&J recommends that employers be permitted to use the common actuarial practice for calculating budget and COBRA rates when multiple benefit packages are offered to a defined group of employees by (i) first aggregating all plan costs for all self-insured benefit packages for all employees in all locations; and (ii) next, assigning a cost to each benefit package based on factors including the relative actuarial value of each benefit package.

(ii) *Cost of self-only and other-than-self-only*. J&J supports the approach taken in the notice to permit a determination of cost for self-only coverage and a cost of "other-than-self-only" tier, rather than separately calculating the cost of each tier within the broader category of other-than-self-only coverage (e.g., employee plus spouse, employee plus child/ren, employee plus family).

(iii) *Cost of pre- and post-Medicare eligible retiree coverage.* J&J recommends that Treasury and IRS provide in future guidance that the cost of the coverage provided to pre-65 and post-65 retirees may be determined by aggregating these groups for purposes of both cost determination and threshold development.

(iv) *Cost of health reimbursement arrangements (HRAs).* J&J recommends that Treasury and IRS provide in future guidance that there is no need to separately calculate the cost of an HRA that is integrated with an employer-sponsored group health care plan and satisfies certain additional criteria (including that the cost of the HRA is already included in the employer's aggregate health care costs).

(v) *Cost of certain on-site medical clinics.* J&J recommends that Treasury and IRS provide in future guidance that the cost of an on-site clinic that provides substantial health care services is not required to be separately calculated, provided that the cost of the clinic is included in the employer's aggregate health care costs in the same manner as other health care costs.

B. Applicable Employer-Sponsored Coverage

(i) *On-site medical clinics.* J&J recommends that Treasury and IRS provide in future guidance that an on-site clinic is excluded from the definition of applicable employer-sponsored coverage if it meets specified criteria that track a combination of the criteria to exclude an on-site medical clinic from the definition of a group health plan under the COBRA regulation (Treas. Reg. § 54.4980B-2 Q&A-1(d)) and the preventive services criteria for HSAs in Notice 2008-59.

(ii) *Health savings accounts (HSAs).* J&J urges Treasury and IRS to use their regulatory authority under the statute to exclude employee pre-tax salary reduction contributions to HSAs from the definition of applicable employer sponsored coverage.

(iii) *Limited scope dental coverage.* J&J supports the approach suggested in the notice to exclude limited scope dental coverage regardless of how the coverage is funded.

(iv) *Employee assistance programs (EAPs).* J&J supports the proposal to exclude an EAP that meets the criteria of an excepted benefit from the definition of applicable employer-sponsored coverage.

(v) *Executive diagnostic physicals.* J&J urges Treasury and IRS to exclude from the definition of applicable employer-sponsored coverage any program providing for executive medical diagnostic procedures that meets the exception under the Section 105(h) regulations.

C. *Applicable dollar threshold.* J&J supports an approach that compares the average age and gender composition of the employer's covered employees to the average age and gender composition of the national workforce, as reported by the Bureau of Labor Statistics (BLS) or another credible source. J&J recommends that the age and gender adjustment to the applicable dollar threshold be based on the projected additional cost under the applicable benefit package arising from less favorable age and gender characteristics.

D. *Transition Relief and Permanent Safe harbor.* J&J urges Treasury and IRS to establish transition relief for any applicable employer-sponsored coverage with the terms of coverage that are substantially similar to the terms of a gold-level plan offered on the SHOP Exchange marketplace in the geographic area where the majority of the employer's employees are located.

J&J also urges Treasury and IRS to establish a permanent safe harbor for plans that meet the Section 4980H % minimum value standard.

E. *Liability to pay the excise tax.* J&J urges Treasury and IRS to use their regulatory authority to interpret these provisions of Section 4980I in a manner that imposes the liability for excise tax on the entity that serves as the "plan administrator" for purposes of ERISA Section 3(16).

II. Background

J&J employs approximately 40,000 employees in in the United States in multiple locations. Nearly half of J&J's US employees reside in New Jersey, where its corporate headquarters are located, and Pennsylvania. A significant number of employees reside in California and the remaining employees reside in numerous other states.

J&J offers comprehensive medical benefit to all of its US employees, regardless of their employment status or work schedule. The J&J medical plans cover approximately 115, 000 lives in the US including employees, 11,000 retirees, and 64,000 dependents. J&J also employs 1,000 union employees who participate in separately negotiated health care plans. It also provides insured health care coverage for approximately 500 globally mobile employees through its expatriate program.

J&J's culture and practice places the highest priority on providing its employees with comprehensive health care benefits that focus on quality, competitiveness and overall promotion of good health.

J&J offers comprehensive medical benefit to employees including:

- *High Deductible Health Plan (HDHP) option coupled with a health savings account (The HD HSA Plan).* For employees who enroll in this option, J&J makes an annual contribution to the HSA and enrolled employees may make pre-tax contributions up to applicable IRS limits.

- *Health care option with an integrated health reimbursement arrangement (the HRA Plan).* For employees who enroll in this option, J&J provides credits to a notional HRA that permits employees to roll over unused HRA credits from year-to-year. Employees forfeit their unused HRA credits if they terminate employment prior to reaching retirement eligibility. Retirement eligible employees retain their HRA rollover balance in a special Retiree HRA.

- *HMO options.*

- *Pre-65 and post-65 retiree medical coverage.* J&J offers coverage for all eligible retired employees. When a retired employee or dependent attains age 65, Medicare becomes the primary coverage and the J&J coverage is secondary.

In addition to offering J&J employees comprehensive medical benefits, J&J makes additional investments in its employees' health by offering the following:

- *Stand-alone dental coverage.* J&J self-insures its dental coverage.

- *Flexible spending arrangement (FSA).* Employees who are not enrolled in the HD HSA Plan may make pre-tax salary reduction contributions (from $50 to $2500) to the FSA.

- *On-site medical clinics.* J&J maintains two distinct types of on-site medical clinics:

    - Three on-site medical clinics managed and operated by a third party health care provider. These clinics provide employees with a range of health care services during working hours. The care and services at these on-site clinics include annual physicals, urgent care and walk-in services, lab and biometric services, immunization shots and injections for allergies, and education and counseling for a wide range of health-related issues, among other services. These on-site medical clinics also provide some of the services offered through the J&J wellness program. J&J includes the cost of care provided by the third party provider in its aggregate medical costs and treats these clinics as part of its health care benefit program.

    - Twenty-seven on-site medical clinics are available to employees during working hours that provide services limited to treatment of a health condition, illness or injury that occurs during working hours and well as preventive care such as immunizations and injections for allergies. These on-site medical clinics also handle some of the services offered through the J&J wellness program. These clinics are not considered part of the J&J health care benefit program and, as such, their costs are not currently considered as part of the health care benefit program.

- *Employee Assistance Program (EAP).* The J&J EAP program provides confidential assistance to employees, their families, and management for a wide range of work-related and personal issues. EAP professionals are trained to facilitate private, culturally sensitive solutions for a variety of challenges that may negatively impact individual or organizational health if left unresolved. Some locations have on-site counselors and all employees can contact our third party vendor, for assistance, if they prefer to not use on-site resources where available. In general, employees are provided with up to five sessions under EAP and then they are referred out to other resources if additional services are required.

- *Executive physicals examinations.* J&J has a physician on staff who performs medical diagnostic physical examinations at no cost to the executive. These services and their associated costs are not considered part of the J&J health care benefit plan.

J&J has undertaken extensive modeling on the potential impact of the Section 4980I excise tax. This analysis considered the point at which the coverage provided to active salaried employees, active union employees, and pre- and post-Medicare eligible retirees could become subject to the excise tax. Like many other employers, J&J anticipates taking steps to reduce the cost of its health care benefit offerings to avoid becoming subject to the nondeductible excise tax starting in 2018. Due in large part to the high cost of health care in the regions where J&J operates, even significant changes to the J&J health care benefits may not prevent J&J from becoming subject to the excise tax within a few years after the excise tax becomes effective.

Of course, the timing and amount of the excise tax will depend on how Treasury and IRS implement Section 4980I through regulations. We appreciate the careful and collaborative process that Treasury and IRS are taking to promulgate regulations under Section 4980I. We recognize that the statute imposes certain limitations, but we urge IRS and Treasury to exercise the agencies' administrative regulatory authority to the fullest extent possible to mitigate the potential employee impact under Section 4980I. Our comments and recommendations are set forth below.

J&J welcomes the opportunity to meet with Treasury and IRS to discuss its forecasts and impact of the Section 4980I excise tax on its health care plans, as well as the comments discussed below.

III. Comments and Recommendations

Notice 2015-16 requests comments on the substantive provisions of Section 4980I. (Treasury and IRS plan to issue a second notice that will provide guidance and seek comment on the administrative and procedural provisions of Section 4980I.) Notice 2015-16 requests comments on: (i) the definition of applicable employer-sponsored coverage; (ii) the determination of the cost of applicable employer sponsored coverage; and (iii) the dollar limit threshold above which the excise tax is imposed. Each of these categories of substantive questions is critically important to the implementation of Section 4980I. This letter responds to each of these categories, but begins with comments related to calculating the cost of coverage.

A. Calculating the cost of coverage

The determination of the cost of applicable employer-sponsored coverage is critical to assess whether the aggregate cost of the applicable coverage provided to an employee exceeds the applicable dollar threshold.

Section 4980I provides that the cost of applicable employer-sponsored coverage will be determined under rules similar to the COBRA rules. Section 4980B(f)(4) provides that the COBRA applicable premium is based on the average cost of providing coverage for individuals who are similarly situated, instead of the cost of providing coverage based on the characteristics of each individual.

J&J has the following comments and recommendations regarding the calculation of the cost of applicable employer-sponsored coverage and the tiers of coverage.

(i) Cost of the benefit package

The notice provides that Treasury and IRS are considering an approach to determining the cost of coverage by starting that calculation with the employees enrolled in a "particular benefit package," and then subdividing that group based on mandatory disaggregation and permissive disaggregation rules. The notice emphasizes that under this method "employees enrolled in each different benefit package would be grouped separately". Benefit packages would be defined by differences in health plan coverage (e.g., high value coverage and low value coverage) and there may be more than one benefit package provided under a group health plan.

The approach described in the notice for calculating the cost of a benefit package that first requires aggregation by enrollees in that particular benefit package is not consistent with common practice for development of costs when different benefit packages are offered as options to the same class of eligible employees. Although in limited cases COBRA rates for a particular benefit package may be calculated in this manner, the common practice for calculating the cost of self-insured coverage when multiple benefit package options are offered is to first aggregate the medical claims and costs in a single risk pool, as described below.

J&J recommends that employers be permitted to use the common practice for calculating COBRA rates when multiple benefit packages are offered. Under the common practice, the cost of a benefit package is determined generally by:

- First, aggregating the medical claims and related costs (such as administration fees and stop loss insurance) of all self-insured benefit packages for all eligible employees within a defined group (e.g., salaried active employees) in all locations;

- Next, assigning a cost to each benefit package based on the relative actuarial value of each benefit package and after taking into consideration other factors, but generally without regard to the risk selection of each separate option within the benefit package.

This approach neutralizes the impact of adverse selection when multiple options are offered by spreading health care risks across the entire covered population.

To ensure that the appropriate cost is allocated to each benefit package, we recommend that Treasury and IRS provide in future guidance that employers sponsoring self-insured plans must obtain an actuarial certification regarding the method used to develop rates, including the setting of relative actuarial value of each benefit option, from a member of the American Academy of Actuaries. Prior Treasury and HHS guidance has required an actuarial certification in similar situations in which an actuarial determination of the value or cost of a health care benefit was required.[1]

J&J believes that determining the cost of applicable employer-sponsored coverage in this manner – by treating all employees within a defined eligible group (e.g., all salaried active employees) as "similarly situated" and first aggregating all medical claims in a single risk pool – would be the most appropriate and least disruptive approach to the calculation of the cost of applicable employer-sponsored coverage. J&J also believes that this approach is consistent with common practice and with existing legal precedence.

This common practice is designed to accurately reflect the incremental cost of each benefit package. An example illustrates the consequence of calculating the cost of coverage by first segregating the enrollees by benefit package. Assume that an employer offers multiple benefit package options to its employees; the healthier employees typically elect the lower cost option and the less healthy employees elect the higher cost option. By calculating the cost based on the actual enrollees in each benefit package, the cost of the lower value plan would be even lower than it would be based on its relative actuarial value and cost of the higher value plan would be even higher than it would be based on its relative actuarial value. By first aggregating all medical claims in a single risk pool and then allocating the cost to the different benefit packages based on a relative actuarial value, the cost of each benefit package more accurately reflects the risk of the entire covered population, with rates for each option appropriately reflecting the incremental cost across the entire group of enrolled employees.

The practice of first aggregating all medical claims in a single risk pool is also consistent with existing precedent. The Affordable Care Act Section 1312 and the underlying HHS regulations require the cost of individual market and small group market plans to be determined by first considering the claims experience of all enrollees in all health plans and then applying a plan level adjustments based on the (i) actuarial value and cost-sharing design of the plan, (ii) the plan's provider network, delivery system

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[1] See, Treas. Prop. Reg. § 36B-6. See, also, 42 CFR § 423.265 regarding the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, which created a voluntary prescription drug benefit (Part D) that became effective on Jan. 1, 2006. To be eligible for the Part D subsidy, plan sponsors must apply for the subsidy each year, including an attestation by a qualified actuary that the plan is actuarially equivalent to the Part D benefit. MMA requires that the qualified actuary be a member of the American Academy of Actuaries.

characteristics, and utilization management; (iii) the benefits provided, and administrative costs.[2] In addition, the single reported case (that we have found) to consider the methodology of calculating COBRA applicable premiums essentially concludes that COBRA premiums should be calculated on an employer-wide basis so as not to inflate the COBRA premium for employees in certain businesses with higher claims costs.[3]

(ii) Cost of self-only and other-than-self-only coverage

First, J&J supports the approach taken in the notice to permit a determination for a cost of self-only tier of coverage and a cost of "other-than-self-only" tier of coverage, rather than separately calculating the cost of each separate tier within the broader category of "other-than-self-only" coverage (e.g., employee plus spouse, employee plus child/ren, employee plus family). J&J urges Treasury and IRS to apply this approach in future guidance and to clarify that this approach to determining the cost of the tiers applies, regardless of whether the employer's policy requires employees to contribute amounts that vary by each level of coverage within the broader category of "other-than-self-only" coverage (e.g., employee plus spouse, etc.).

With respect to the calculation of the cost of self-only and other-than-self-only coverage, J&J recommends permitting employers to use a common practice for determining rates by coverage tier, as described below.

- First, the total cost for a particular benefit package is projected, as part of the single risk pool approach described earlier if multiple options are offered, for the entire group of employees enrolled in either self-only or other-than-self-only coverage.

- Then, rates for self-only and other-than-self-only coverage are developed according to the expected cost relationships of each coverage tier based on appropriate actuarial or underwriting norms on cost relationships by coverage tier.

This is a simple, well-established and practical approach for determining appropriate costs for each tier of coverage.

(iii) Cost of Pre- and Post-Medicare eligible retiree coverage

Section 4980I(d)(2) provides that "[i]n the case of applicable employer-sponsored coverage which provides coverage to retired employees, the plan may elect to treat a retired employee who has not attained age 65 and a retired employee who has attained age 65 as similarly situated beneficiaries".

Given this statutory direction, J&J recommends that Treasury and IRS clarify in future guidance, that the cost of the coverage provided to pre- and post-Medicare eligible retirees may be determined by

[2] 45 CFR § 156.80.
[3] Draper v. Baker Hughes Inc. (E.D. CA 1995).

aggregating these groups without regard to their actual benefit package, provided the employer offers health care coverage to all eligible retirees. J&J offers both pre- and post-Medicare eligible retirees health care coverage. However, once a J&J retiree attains age 65, Medicare becomes primary and the J&J coverage is secondary.

Permitting employers to aggregate pre-and post-Medicare eligible retirees, after taking Medicare into account, would have the effect of lowering the cost of a retiree health care plan. Without the ability to aggregate retirees, many employers will likely move to terminate their pre-65 retiree coverage because the cost of this coverage for most employers will exceed the thresholds even with the adjustment for a qualified retiree. (We note that the ratio of cost of health care coverage for pre-65 retirees compared to active employees is vastly higher than the ratio of Section 4980I thresholds for pre-65 retirees compared to the thresholds for active employees).

(iv) Permissive disaggregation

The notice provides that Treasury and IRS are considering whether it would be appropriate for employers to permissively disaggregate employees based on their collectively bargained status, as well as on other bases, for purposes of calculating the cost of coverage.

J&J supports providing a rule in future guidance that would permit employers to disaggregate certain defined groups of employees and separately calculate the cost of their health care benefits. For example, employers should be able to disaggregate collectively bargained employees and separately calculate the cost of their health care coverage when the bargaining representative has negotiated for health care benefits that are distinct from the benefits offered to other employees.

(v) Health Reimbursement Arrangements

Treasury and IRS anticipate that the proposed regulations will provide that an HRA is applicable employer-sponsored coverage that will be included in the cost of the coverage. Treasury and IRS expressed the concern in the notice that making available multiple methods for determining the cost of an HRA could materially increase administrative complexity.

J&J agrees that minimizing administrative burden is a sound objective for calculating the cost of an HRA. J&J recommends that Treasury and IRS guidance provide that there is no need to separately calculate the cost of an HRA that is integrated with an employer-sponsored health plan and satisfies certain additional criteria including that the cost of claims paid under the HRA is included in the cost of the overall health care benefit program.

In J&J's situation, an active employee who enrolls in a particular coverage benefit package option (the HRA Plan) is eligible for credits made to an HRA notional account. The HRA is integrated with the benefit package and the balance can be used to pay for the employee's out-of-pocket costs such as deductibles and co-pays. J&J, like most employers that provide a plan with an integrated HRA, includes the cost of the HRA in its aggregate medical program cost by treating the claims paid from the HRA like any other

claims. Under this approach the cost of the HRA is already embedded in the aggregate program cost and allocated to the particular benefit package. To separately calculate the cost of the HRA would add needless administrative burden.

J&J's eligible retirees who have unused HRA credits at retirement retain the credits in a Retiree HRA. J&J recommends that future guidance provide that retiree HRAs can be aggregated with other forms of retiree medical coverage for purposes of calculated the cost of the aggregate coverage.

(vi) Cost of certain on-site clinics

J&J recommends that Treasury and IRS provide in future guidance that the cost of an on-site clinic that provides substantial medical and health care services is not required to be separately calculated, provided that the cost of the clinic is included in the employer's aggregate health care costs in the same manner as other health care program costs. Requiring the employer to separately calculate the medical claims and fees attributable to this type of on-site clinic would cause a needless and inefficient administrative burden.

B. Applicable Employer-Sponsored Coverage

Section 4980I(d)(1)(A) provides that applicable employer-sponsored coverage is "coverage under any *group health plan* made available to the employee by an employer which is excludable from the employee's gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106)." (emphasis added). The statute specifically excludes certain benefits such as certain excepted benefits, coverage for long-term care, coverage for specified disease or a fixed indemnity policy if paid for on an after-tax basis, and coverage for treatment of the mouth and eye if provided by a separate policy, certificate or contract.

J&J has the following comments and recommendations regarding the definition of applicable employer-sponsored coverage.

(i) On-Site Medical Clinics

The notice states that Treasury and IRS anticipate that the forthcoming proposed regulations will exclude on-site clinics that offer only de minimis medical care to employees. The notice requests comments regarding the application of Section 4980I to on-site clinics.

J&J recommends that Treasury and IRS provide in future guidance that an on-site clinic is excluded from the definition of applicable employer-sponsored coverage if it meets specified criteria that track a combination of the criteria to exclude an on-site medical clinic from the definition of a group health plan under the COBRA regulation (Treas. Reg. § 54.4980B-2 Q&A-1(d)) and the preventive services criteria for HSAs in Notice 2008-59. In other words, an on-site clinic that meets the following criteria should be excluded from the definition of applicable employer-sponsored coverage with highlighted changes to the COBRA regulation:

(a) The health care consists primarily of ~~first-aid~~ [urgent care] provided during the employer's working hours for treatment of a health condition, illness, or injury that occurs during those working hours [or for preventive services including immunizations and injections for antigens];

(b) The health care is available only to current employees; and

(c) Employees are not charged for the use of the facility.

J&J further recommends that Treasury and IRS clarify that the availability of an on-site clinic that meets these criteria to an employee will not cause an employee to be ineligible to contribute to an HSA under Section 223(c)(1).

(ii) Health Savings Accounts (HSAs)

The notice states that future proposed regulations are anticipated to provide that employer contributions to HSAs and employee pre-tax salary reduction contributions to HSAs are included in the definition of applicable employer-sponsored coverage. Employee after-tax contributions to HSAs would be excluded from applicable coverage.

HDHPs and their corresponding HSA contributions are one of the principal methods employers use to reduce the cost of employer-sponsored health care. A Congressional objective in enacting Section 4980I was to use the excise tax to motivate employers to design their health care benefits in a manner consistent with slowing growth in health care costs. As a result, it is no surprise that many employers are moving to HDHPs, since this type of coverage both causes many employees to avoid unnecessary utilization of health care services and slows growth in total spending on medical care which will help the employers to avoid or limit exposure to the excise tax.

Like many employers over the past several years, J&J has offered HDHPs and has provided incentives for its employees to elect the HDHP option.[4] Employees who enroll in the J&J HD HSA option automatically receive a J&J contribution to the HSA and may make additional pre-tax salary reduction contributions up to the applicable IRS limits. Having an HSA encourages employees to save to defray the cost of the HDHP deductibles and co-payments and to pay for other qualified medical expenses with pre-tax dollars.

If employer and employee-pre-tax contributions to an HSA are counted as applicable employer-sponsored coverage, employers likely will discontinue contributing to the HSA and will discontinue the option for employees to contribute to an HSA on a pre-tax basis. The consequence of eliminating pre-tax HSA contributions will disproportionately affect lower-wage employees. We urge Treasury and IRS to consider a different regulatory approach.

[4] In 2015, 81 percent of employer offered HDHPs as one of the health plan options, an increase from 53 percent of employers in 2010. In 2015, close to 32 percent of employers offered only an HDHP, an increase from 22 percent in 2014 and 10 percent in 2010. National Business Group on Health 2014 Survey.

From a policy perspective, the elimination of pre-tax HSAs contributions will dampen the opportunity for many workers to save for their future health care needs. Furthermore, the elimination of pre-tax HSA contributions disproportionately affects lower wage employees. The disproportionate effect arises because HSA contributions may be made either by the employer on a pre-tax basis or by the employee and deducted on the employee's individual tax return. The difference is that employee-after tax contributions that are deducted on the individual return are not exempt from employment taxes (e.g., FICA and HI). Economists would predict that the response to the elimination of pre-tax HSA contributions as applicable employer-sponsored coverage would be for the employer to simply pay additional wages to employees and allow the employees to make their own tax-deductible HSA contributions. Higher wage workers whose earnings are above the FICA wage limit will be relatively indifferent; however, lower wage workers who will have to pay employment taxes on all their wages likely will not be able to make an HSA contribution at the same level.

From a statutory perspective, we believe that Treasury and IRS have the authority to exclude pre-tax contributions to an HSA from the definition of applicable employer-sponsored coverage because such contributions are not otherwise considered a group health plan and Section 4980I(d)(1)(A) provides that only "group health plan" coverage is included in the definition of applicable employer-sponsored coverage. Under current law, contributions to an HSA are not considered part of a group health plan subject to COBRA[5] and are not considered a group health plan subject to ERISA except in certain limited circumstances that would not apply to J&J or many other large employer plans.[6] Although Section 4980I(d)(2)(C) seems to include in applicable employer-sponsored coverage employer contributions to an HSA that are excluded under Section 106(b) and (d), which would include employee pre-tax contributions, this provision could be interpreted to apply only to contributions to those HSAs that are considered group health plans subject to ERISA.

If Treasury and IRS conclude in future guidance that all HSA pre-tax contributions are included as applicable employer-sponsored coverage, J&J requests future guidance to clarify that employers may design their HDHP health care offerings to permit employees to elect to have after-tax salary reduction

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[5] Treas. Reg. § 54.4980B-2 Q&A-1(f) provides: "Under section 106(b)(5), amounts contributed by an employer to a medical savings account (as defined in section 220(d)) are not considered part of a group health plan subject to COBRA. See, Section 106(d)(2) ("Rules similar to rules of paragraphs (2), (3), (4), and (5) of subsection (b) shall apply for purposes of this subsection") and Section 106(b)(5) providing that a medical savings account is not treated as employer-provided coverage for purposes of section 4980B.

[6] DOL Field Assistance Bulletin 2004-1 (April 7, 2004) provides: "Accordingly, we would not find that employer contributions to HSAs give rise to an ERISA-covered plan where the establishment of the HSAs is completely voluntary on the part of the employees and the employer does not: (i) limit the ability of eligible individuals to move their funds to another HSA beyond restrictions imposed by the Code; (ii) impose conditions on utilization of HSA funds beyond those permitted under the Code; (iii) make or influence the investment decisions with respect to funds contributed to an HSA; (iv) represent that the HSAs are an employee welfare benefit plan established or maintained by the employer; or (v) receive any payment or compensation in connection with an HSA." Also see Field Assistance Bulletin No. 2006-02 (October 27, 2006).

contributions made to an HSA. This design would be consistent with guidance under the Section 4980G comparability rules that permit employees to request that the employer make his or her salary reduction contributions on an after-tax basis. See, Treas. Reg. § 54.4980G-2 Q&A-2.

(iii) Limited Scope Dental and Vision Benefits

The notice provides that Treasury and IRS are considering extending the exclusion from applicable employer-sponsored coverage to self-funded limited scope dental and vision benefits that are excepted benefits under recently issued regulations. See, Treas. Reg. § 54.9831-1(c)(3).

J&J supports this approach. Our self-insured dental benefits are a core component of the health care benefits offered to J&J employees.

All dental and vision coverage that qualify as an excepted benefit under Section 9832(c)(2)(A) should be excluded as applicable employer-sponsored coverage. The exclusion should not be based on how the benefit is funded.

(iv) Employee Assistance Programs (EAPs)

The notice provides that Treasury and IRS are considering whether to exercise authority under Section 4980I(g) to exclude EAPs that qualify as an excepted benefit under the recently issued regulations. See, Treas. Reg. § 54.9831-1(c)(3) (vi).

J&J supports the proposal to exclude an EAP that meets the criteria of an excepted benefit to be excluded from the definition of applicable employer-sponsored coverage.

(v) Executive Diagnostic Physicals

The notice states that future guidance is expected to provide that executive physical programs are treated as applicable employer sponsored coverage. J&J urges Treasury and the IRS to reconsider this position.

In J&J's case, the diagnostic physicals offered to J&J executives are provided for the company's benefit to ensure that the executives function at a high level to satisfy their work requirements. These exams are not considered part of the J&J health care benefit program.

Executive physical programs, similar to J&J's program, that are limited to providing medical diagnostic procedures are not treated as a self-insured employer-provided medical reimbursement arrangement under long-standing Section 105(h) regulations.[7] J&J urges Treasury and IRS to exclude from the definition of applicable employer-sponsored coverage any program providing for medical diagnostic procedures that meets the exception under the Section 105(h) regulations.

[7] Treas. Reg. § 105-11(g).

C. Applicable dollar threshold

The statute provides that the applicable dollar thresholds may be increased by an age and gender adjustment if the age and gender characteristics of an employer's workforce are less favorable than those of the National workforce.

J&J supports an approach that compares the average age and gender mix of the employer's covered employees to the average age and gender mix of the national workforce, as reported by the Bureau of Labor Statistics (BLS) or another credible source. This comparison would generate an age and gender adjustment factor that would apply to increase the applicable dollar threshold if the average age and gender of the employer's covered employees is less favorable than the national average from the standpoint of projected health care benefit costs. Future guidance should clarify that the age and gender adjustment factor may never be applied to decrease the applicable dollar threshold.

J&J recommends that the age and gender adjustment to the applicable dollar threshold be based on the projected additional cost under the applicable benefit package arising from less favorable age and gender characteristics. In other words, the dollar value of the adjustment to the threshold should be based on the added cost the employer anticipates bearing on its health care benefit program arising from less favorable age and gender characteristics.

D. Safe Harbor and Transition relief

J&J urges Treasury and IRS to exercise the full extent of their regulatory and administrative authority to provide for an administratively viable implementation of Section 4980I. J&J supports the comments of the Pharmaceutical Research and Manufacturers' Association, the ERISA Industry Committee, the Business Roundtable, The United States Chamber of Commerce, and the American Benefits Council requesting a reasonable delay in the implementation of Section 4980I to provide employers with sufficient time following the issuance of regulatory guidance to make the necessary health care plan adjustments.

J&J further recommends that Treasury and IRS establish in future guidance the safe harbor and transition relief, discussed below, that is consistent with the standards of minimally acceptable health care coverage provided elsewhere in the Affordable Care Act. The Affordable Care Act provides various indications of what is considered a minimum level of acceptable health care coverage and in certain cases mandates a specified level of coverage. For individuals purchasing coverage on the marketplace Exchange, the Affordable Care Act uses the second lowest cost silver plan as the index on which to base the amount of the premium tax credit.[8] Large employers are required to offer their full-time employees coverage that meets a "minimum value" standard, which is roughly a 60% actuarial value, or potentially face an excise tax liability.[9] Finally, health insurance issuers that are certified to issue qualified health

[8] Section 36B of the Internal Revenue Code.
[9] Section 4980H of the Internal Revenue Code.

plans (QHPs) on the individual Marketplace generally must offer silver and gold level coverage on the small business SHOP Exchange.[10] It seems unlikely that Congress intended a silver level plan that sets the index for the premium tax credit, or the 60% minimum actuarial value plan that employers must offer to employees to avoid an excise tax, or the silver and gold level plans that insurers in certain circumstances are required to offer on the SHOP Exchange, are the types of "high cost" plans that may become subject to the Section 4980I excise tax.

Because health care costs are projected to rise more quickly than the Section 4980I applicable dollar thresholds, the gap between these minimum value plans and the excise tax threshold narrows and will ultimately disappear. These plans generally would not be considered "high cost" plans. For example, silver plans in the marketplace Exchanges are below-average in benefit value among health plans nationally. They typically have at least $2,000/$4,000 (single/family) in deductibles, which is well above U.S. average employer-provided deductibles of $1,213/$2,357 in 2013.[11] Coinsurance and copayment are also typically above national averages for employer-based coverage.

Nevertheless, we understand that is certain high-cost local areas, the second-lowest cost silver plan is likely be above the Section 4980I applicable dollar threshold beginning in 2018. Not surprisingly, the premiums for gold plans offered on the SHOP Exchanges and in the individual market in multiple high cost areas also would likely be above the excise tax threshold in 2018 when Section 4980I goes into effect in 2018.

J&J urges Treasury and IRS to establish transition relief for any applicable employer-sponsored coverage with the terms of coverage that are substantially similar to the terms of a gold-level plan offered on the SHOP Exchange in the geographic area where the majority of the employers employees are located. This transition relief would be designed to ensure that health insurance issuers offering small group coverage on the SHOP Exchange, as well as larger employers offering their employees insured or self-insured plans have the time to redesign their plans to reduce the cost.

J&J also urges Treasury and IRS to establish a permanent safe harbor for plans that meet the Section 4980H minimum value standard. Under this proposed safe harbor applicable employer-sponsored coverage that has an actuarial value of between 60 percent and 70 percent would not cause the employer to become subject to the excise tax, even if the cost of the coverage is above the applicable dollar threshold. Employers who design their health care offerings to satisfy the minimum value requirement to avoid the Section 4980H excise tax should not be subjected to the Section 4980I excise tax if the cost of the coverage exceeds the applicable dollar threshold.

[10] 45 CFR § 156.200.

[11] Source: Medical Expenditures Panel Survey, Insurance Component (MEPS-IC), AHRQ.

E. Liability to pay the excise tax with respect to self-insured employer-sponsored coverage

Although Notice 2015-16 does not request comments on the administrative or procedural aspects of Section 4980I, J&J is taking this opportunity to address the liability for payment of the excise tax by employer that sponsors self-insured employer-sponsored coverage.

Section 4980I(c)(1) imposes the excise tax on the "*coverage provider*." In the case of insured health benefits, the coverage provider is the insurer. In the case of self-insured health benefits, the coverage provider is "*the person that administers the plan benefits.*"[12] The person that administers the plan benefits "*shall include the plan sponsor if the plan sponsor administers benefits under the plan.*"[13]

J&J urges Treasury and IRS to use their regulatory authority to interpret these provisions of Section 4980I in a manner that imposes the liability for excise tax on the entity that serves as the "plan administrator" for purposes of ERISA Section 3(16). In the case of self-insured health benefits, a third party administrator (TPA) and the ERISA plan administrator, which is typically the employer, share administrative duties.

If the TPA were responsible for paying the excise tax, the TPA would bill the plan sponsor for: (i) an amount equal to the excise tax payable by the TPA; plus (ii) the income tax the TPA expects to pay on the receipt of that amount from the plan sponsor. In effect, the plan sponsor would pay the TPA an amount equal to the tax-on-the-tax. This arrangement would be inconsistent with Section 4980I(d)(2)(A), which provides that in determining the cost of applicable employer-sponsored coverage, "any portion of the cost of such coverage which is attributable to the tax imposed under this section shall not be taken into account."

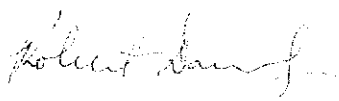
[12] Section 4980I(c)(2).

[13] Section 4980I(f)(6).

IV. Conclusion

In conclusion, we appreciate that Treasury and IRS recognize the potentially significant impact that this excise tax may have on employers who are offering the coverage and benefits required by the Affordable Care Act and on their employees. We respectfully submit these comments and proposed approaches to the future guidance and we look forward to providing additional details as the regulatory process proceeds. Should officials at Treasury or IRS need any further information from J&J on these important issues, please do not hesitate to contact us.

Sincerely,



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