Notice 2015-16

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CC:PA:LPD:PR (Notice 2015-16)
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By email: Notice.comments@irscounsel.treas.gov

May 15, 2015

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

Ladies and Gentlemen:

Mercer welcomes the invitation to provide input to the Treasury Department and the Internal Revenue Service in response to Notice 2015-16 on the excise tax on high cost employer-sponsored health coverage (Code Section 4980I).

Mercer is a global consulting leader in talent, health, retirement, and investments. In the United States, Mercer provides consulting and actuarial services to more than 4,800 health and benefit clients, serving employers of all sizes, with varying employee demographics, in all parts of the country. Mercer also offers a private exchange providing access to health and other benefits to more than 500,000 employees and retirees.

Mercer and its clients are committed to continuing employers' provision of health coverage to employees. In a recent Mercer survey in which 572 employers participated, just 3% reported that they are likely to terminate health plans for their active employees within the next five years. But 63% report that paying the excise tax is a significant or very significant concern. Absent significant changes to respondents' current plans, about one-third of large employers (those with 500 or more employees) expect to pay the tax in 2018, and 58% expect to do so in 2022. While the excise tax may have been intended to discourage overly rich employer-provided coverage, employers expecting to pay the tax in 2018 report their current plans already have significant deductibles, averaging $1,121 for small employers and $640 for large employers. While Mercer continues to study this issue, we believe that the higher cost of certain plans is driven more by factors — such as geographic location and age — that are either not or inadequately addressed in the Affordable Care Act than by "Cadillac" designs.

Given that the indexing formula for the excise tax is tied to the consumer price index (CPI) rather than medical inflation, we project the number of employers paying the tax will rise steadily over time, eventually affecting even employers that drastically change their coverage, such as by reducing actuarial value to 60%.

In sum, we are concerned that the employer goal to continue to provide employee health coverage that satisfies Affordable Care Act mandates, avoids employer shared responsibility assessments and meets employee needs is on a collision course with the excise tax. While we would prefer more dramatic changes to the tax, we realize that Treasury's and IRS's regulatory authority is limited by the terms of Section 4980I, and certain changes may only be achieved legislatively. Nonetheless, we urge that the excise tax regulations: (A) exclude, to the extent permitted by the statute, non-core medical benefits from the calculation of coverage costs; (B) provide employers flexibility to calculate coverage costs consistent with reasonable actuarial principles and (C) delay implementation or provide a good faith compliance period.

As discussed in more detail below, we recommend that regulations:

A. Exclude non-core medical benefits:

1. Define de minimis on-site clinics that are broadly excluded from applicable coverage to permit the cost-effective and efficient provision of basic health services to employees. Include a clarification that these de minimis benefits are also not subject to COBRA and do not prevent eligibility for contributions to health savings accounts (HSAs).

2. Exclude self-funded dental and vision plans and employee assistance programs that are excepted benefits from applicable coverage, as suggested by Notice 2015-16.

3. Exclude pre-tax employee HSA contributions from applicable coverage included in the excise tax calculations.

B. Provide flexibility in calculating the cost of coverage:

4. Permit the cost of applicable coverage to be determined consistent with reasonable actuarial principles rather than requiring determination by prescriptive rules.

5. Offer flexibility in aggregating benefit options, rather than requiring a rigid "benefit package" for cost determination, and permit pooling actual claims costs across options so

employers can maintain options that best meet the needs of employees with adverse health factors.

6. Permit plans with multiple other-than-self-only tiers to combine them when applying the higher other-than-self-only threshold, as suggested in the notice.

7. Permit optional permissive disaggregation of similarly situated individuals based on a wide range of standards, including bona fide employment-related criteria as well as more specific criteria, including geographic distinctions.

8. Provide alternative methods to determine the excise tax, including safe harbors.

9. Clarify the requirement that at least one non-employee beneficiary must have access to all minimum essential coverage benefits available to employees for employers to use the higher other-than-self-only coverage threshold.

10. Permit the demographic age and gender adjustment to be based on enrolled employees and confirm its application to retirees and those in high-risk professions.

C. Delay implementation of the excise tax or provide a good faith compliance period.

Discussion

A. The regulations should exclude non-core medical benefits from tax calculations, to the extent permitted by the statute.

Section 4980I is projected to have a significant impact on employer-sponsored health benefits — reaching far beyond the high cost coverage that the statute was intended to limit. At the same time, employers are exploring innovative types of benefits to supplement the primary health plans offered employees. These supplemental plans can improve healthy behaviors and lead to overall cost reductions in an employer's primary health plan — the goal of the excise tax. Yet if the excise tax applies to these additional benefits, an employer will likely drop them to keep coverage costs below the excise tax thresholds or minimize any excise tax owed. The regulations should exclude these innovative benefits so employers will continue to explore new ways to enhance employees' health and reduce costs in primary plans.

1. De minimis on-site medical clinics

Many employers offer or are considering offering access to on-site medical clinics. Mercer's 2014 National Survey of Employer-Sponsored Health Plans ("Mercer's 2014 survey") finds that 41% of large employers (500 or more employees) offer either primary care or occupational on-site clinics. Although originally designed to provide first aid and urgent care, the majority of today's worksite clinics offer general primary care, and the number is growing. Among employers with 5,000 or more employees — the group most likely to have a clinic — 29% offer an on-site or near-site primary care clinic, up from 24% last year.

The structure and scope of on-site clinics vary widely, but employers increasingly view these clinics as a key way to provide more cost-effective, convenient, and effective care. Workplace clinics often serve multiple purposes — treating workplace injuries and providing job-required physicals; managing routine illnesses and injuries (even if not work-related), including writing and filling prescriptions; and providing wellness screenings and preventive immunizations that reduce employee absences. Some on-site clinics are expanding their primary services to help employees manage chronic illnesses like diabetes. Others are at the forefront of delivering health care through telemedicine and other technologies. On-site clinic benefits may be offered to all employees (not just those enrolled in the health plan), and some cover non-employee family members.

In defining on-site clinics providing "de minimis medical care" that will be excluded from applicable coverage, Treasury and IRS should provide a flexible definition that will accommodate the evolving nature of these benefits. Permitted services should be broadly defined to include (1) telemedicine; (2) immunizations; (3) injections of antigens, regardless of whether the employee provides the antigen; (4) treatment of injuries and illnesses — whether work-related or not — that need only clinical care and provision of prescription drugs for those conditions; (5) physicals — whether job related or not — and work-related medical services, such as drug testing; (6) biomedical screenings included in wellness programs meeting nondiscrimination standards under the Affordable Care Act; (7) provision of non-prescription pain relievers; and (8) disease management for chronic conditions. On-site clinics should also be defined broadly enough to capture common variants, such as near-site clinics where several employers share a clinic close to all of them, and to permit coverage of family members as well as employees. This proposed broad definition would be more consistent with the benefits currently offered by many on-site clinics and allow employers to experiment with offering expanded ones.

Notice 2015-16 also solicits comments on whether regulations should denominate a specific dollar limit on the cost of a clinic providing de minimis care. Many variables affect the cost of on-site clinics, including such factors as the services offered, location, staffing model, plan design, and ratio of eligible members to actual users. As a result, Mercer believes it would be difficult to set a single cost that would reasonably apply on a national basis. If the regulations provide a dollar cost threshold, Mercer suggests that it function as an alternative to defining de minimis benefits by reference to services provided.

Finally, if services are offered beyond the specified benefits for de minimis status (or exceed an annual dollar amount — if one is adopted), only the cost of non-de-minimis benefits or the excess cost of the services over the specified dollar limit should be treated as included in calculations for the excise tax. This will allow employers to offer expanded on-site services without being adversely impacted relative to employers whose services are de minimis.

Mercer further suggests that on-site clinics providing de minimis medical care under 4980I should be (1) excluded from group health plans subject to COBRA and (2) disregarded coverage that has no impact on HSA eligibility under Section 223. This treatment will make it easier for employers to comply with these multiple federal requirements. As Notice 2015-16 recognizes, employees don't typically view on-site clinics as part of their group health plans and often don't want access to these clinics as COBRA qualified beneficiaries. In addition, employers may find it problematic for security and other reasons to provide on-site clinic access to former employees. As these employee benefits are often provided to improve access to and usage of health care, they are typically offered at no cost or a modest copayment (and thus not subject to an HSA-compliant deductible). In Notice 2008-59, Q&A-10 currently provides that individuals with access to on-site clinic services that are free or cost less than fair market value can be eligible to contribute to HSAs if those services are not "significant benefits in the nature of medical care." Any on-site clinics that are de minimis under 4980I should likewise be compatible with HSA eligibility so employers can continue to offer both of these valuable benefits.

2. Self-funded dental and vision coverage and employee assistance programs

IRS is considering exercising its regulatory authority to exclude self-insured dental and vision coverage that qualifies as an excepted benefit under Treas. Reg. Section 54.9831-1(c)(3) from applicable coverage. Mercer supports this exclusion. Treasury and IRS, the Department of Labor, and the Department of Health and Human Services recently amended the regulations for these benefits under Code Section 9831 to provide greater consistency between insured and self-insured coverage. There is no reason not to extend this equal treatment for excise tax purposes. Otherwise, employers with self-funded programs will likely either need to insure any dental and vision offerings or consider terminating these valued benefits, even though good dental and vision health are known to contribute to better overall health.

We also suggest clarification of one issue relating to the exclusion of self-insured dental and vision coverage. Because Notice 2015-16 mentions that stakeholders raised questions about stand-alone self-insured dental and vision benefits, the regulations should confirm that the cost of self-funded dental and vision benefits that are integrated with other medical coverage are excluded if they qualify as excepted benefits — in other words, such self-funded benefits do not have to be stand-alone.

Mercer likewise supports the proposed applicable-coverage exclusion for employee assistance programs (EAPs) that are excepted benefits under Treas. Reg. Section 54.9831-1(c)(3)(vi). EAPs that are excepted benefits are typically provided to all employees (not just those enrolled in other health coverage) and often have non-medical benefits, such as financial counseling or assistance in locating child- or elder-care services. Medical benefits in these programs are necessarily limited and cannot be coordinated with other health care coverage, so employers could not shift major medical expenses to these programs to avoid the excise tax. EAPs have proven to be valuable benefits for employees that can help employers control the cost of overall health coverage. For example, many EAPs provide nurse help-lines that can steer an employee to the right level of care (e.g., an office visit rather than a trip to the emergency room) and keep costs down in the primary group health plan.

3. Employee contributions to HSAs

Treasury and IRS should exercise their regulatory authority to provide that pre-tax employee salary reduction contributions to HSAs, as well as after-tax contributions, are excluded from applicable coverage.

Many employers have changed or will be changing their plan design to include high deductible health plans in anticipation of the excise tax. Mercer's 2014 survey reports that 41% of large employers offered HSA-compatible health plans in 2014 — a 9% increase from 2013. Two-thirds of large employers expect to offer a consumer-directed heath plan — defined as an option with either an HSA or a health reimbursement arrangement (HRA) — by 2017. The great majority of CDHPs are already HSA-compatible plans, and this percentage is projected to further increase.

Employers offering HSA-compatible options want employees to be able to take full advantage of these accounts. HSAs have grown popular with employees as a way to either save for health care expenses in retirement or to pay for current health care expenses under a high deductible health plan before the deductible is met. In fact, there were 13.8 million HSAs in the United States as of Dec. 31, 2014, according to Devenir's annual market survey.

If pre-tax salary reduction HSA contributions are included in the excise tax while after-tax ones are not, employers will have little practical choice but to amend their cafeteria plans to exclude pre-tax HSA contributions. This will make it less convenient for employees to contribute to HSAs and more difficult for employers to provide their own HSA contributions, given the challenges of complying with Section 223's comparability rules. According to Mercer's 2014 survey, 71% of employers offering HSAs in 2014 made true employer contributions (as opposed to employee pre-tax salary reductions), averaging $500 for self-only and $1,000 for family coverage.

If pre-tax HSA contributions count for excise tax purposes, the result will be less use of and funding for HSAs tied to employer-sponsored plans. This may disproportionately hurt lower-paid employees, since they face greater financial challenges meeting higher deductibles. Because contributions to health flexible spending arrangements (FSAs) and HRAs are expected to be included in applicable coverage, the excise tax greatly reduces employers' options to offer account-based benefits to assist employees with co-payments, co-insurance, and other non-covered expenses. Employees and their families will be further disadvantaged if pre-tax salary contributions to HSAs are similarly included in the cost of coverage subject to the excise tax.

Section 4980I(d)(2)(c) states that if "the employer makes contributions" described in Section 106(b) or (d), the cost is equal to the amount of the employer contribution. We recognize that employee pre-tax contributions are excluded from employee income under Section 106(d) as employer contributions. However, there seems no logical reason to treat employee pre-tax and after-tax contributions differently, when the after-tax ones are subject to an above-the-line deduction. Further, 4980I's reference to health FSAs specifies "employer contributions under any salary reduction election," while the discussion of HSAs does not. IRS should interpret the statute to permit excluding employee pre-tax HSA contributions from coverage subject to the excise tax.

B. The regulations should provide employers flexibility to calculate the cost of applicable coverage consistent with reasonable actuarial principles.

Section 4980I as drafted has low dollar thresholds, as well as an indexing factor that will not keep pace with medical inflation. This will impact many employer plans that are merely providing coverage to employees that meet federal and state insurance market reforms and satisfy the employer shared responsibility rules. These plans don't provide coverage that employees or health care experts would consider to be high cost or excessive. While Mercer hopes for legislative changes to the excise tax, regulators can ease its impact by providing employers the flexibility to apply reasonable actuarial standards in calculating the cost of coverage subject to the tax. This is particularly necessary because we cannot predict every scenario (e.g., demographic or geographic differences in the cost of coverage) that employers will encounter after the excise tax is implemented. Because these calculations, especially for self-funded plans, are necessarily complex, it is important that they be undertaken, as suggested in the notice, by individuals with some accreditation for making actuarial estimates, as well as certification by such individuals that estimates meet appropriate industry standards.

4. Determining the cost of applicable coverage

Section 4980I(d)(2) says that the cost of applicable coverage will be "determined under rules similar to" those used for determining applicable premiums for COBRA. As Notice 2015-16 says, rules to determine COBRA costs are not well-developed in some areas, particularly with respect to identifying who is similarly situated to COBRA qualified beneficiaries and how employers with self-funded plans should determine their COBRA rates. Yet employers, working with actuaries, underwriters and other advisers, have almost 30 years' experience setting COBRA rates.

The notice proposes that 4980I costs for self-funded plans may be based on the past cost and actuarial basis methods specified in COBRA. Mercer agrees that these methods can form an appropriate basis for determining cost. The notice further asks whether guidance should provide specific factors for use of the actuarial basis method or adopt a broad standard derived from "reasonable actuarial standards and practices". Mercer suggests the guidance adopt the broad standard that can better accommodate the wide variety of employer plans and other potentially relevant factors. As noted above, regulations can require accreditation of individuals making these determinations. The notice also solicits comments on an actual cost method. While Mercer thinks this might be an appropriate alternative cost determination method for certain employers — such as large employers that can more reliably predict claims experience -- we think that the variability of actual claims would make it too unpredictable for many employers, particularly small ones. We recommend that if this option is provided, it be an alternative to the past cost and actuarial basis methods.

In developing 4980I guidance, IRS is also considering providing more prescriptive rules as well as developing more specific COBRA rules. The two sets of rules would be likely to be "harmonized." We are concerned that if Treasury and IRS try to develop detailed rules for both COBRA and excise tax purposes, particularly in the time frame available for employers to have reasonable knowledge of the determination of the excise tax before it applies to their coverage, the guidance won't take the wide variety of employer-sponsored benefits and employer-specific situations that may arise into account, or some key differences between the excise tax and COBRA.

We therefore recommend that employers be permitted to apply their current processes for setting COBRA rates to the excise tax, recognizing that in some areas the different purposes of the two provisions may mean that the calculations — while similar — are not identical. For example, plan aggregation — or disaggregation — might reasonably differ between COBRA and the excise tax, as well as aggregation of other-than-self-only coverage tiers for the excise tax (see comments 5 and 6). Mercer also welcomes an opportunity to react to more detailed guidance if it is issued, including the degree to which application of specific rules for the excise tax and COBRA might differ.

5. Aggregation by benefit package

Notice 2015-16 proposes that to calculate the excise tax employees (defined to include employees, retirees, and surviving spouses) be aggregated by benefit package, "based on differences in health plan coverage." The benefit package approach, however, is not necessary for the excise tax, will unduly complicate cost calculations, and will limit employers' ability to offer plans tailored to employees with adverse health factors.

Employers should have the flexibility to tailor their overall health care offerings to the excise tax, rather than having to measure each package separately against it. This will encourage employers to manage overall health care costs without having to drop options favored by employees with adverse health conditions. Disaggregation by benefit packages should be permitted (for example if employers have a higher deductible option tied to a health FSA and a low deductible HMO without any account-based feature), but this approach should not be required.

If Treasury and IRS propose to require aggregation by benefit package, Mercer suggests that the cost of each package be determined by applying the pooling principles that actuaries commonly use in setting COBRA rates. With this approach, actual claims costs are first aggregated across various health plan options and then allocated according to the actuarial values of the various options. This levels the effect of adverse selection in the options with lower employee cost-sharing, keeping their COBRA costs more reasonable. This approach will let employers continue to offer better coverage choices to the portion of their workforce with adverse health conditions, rather than having these options trigger excise taxes when — evaluated on a more aggregated basis — the applicable cost is below the excise tax threshold.

6. Permissive aggregation of other-than-self-only coverage

As Notice 2015-16 recognizes, many employers have more than one other-than-self-only coverage tier. The IRS and Treasury propose that all these other tiers be grouped separately from self-only coverage. The notice further states that the cost of applicable coverage does not have to reflect the number of individuals who are receiving coverage in addition to the employee.

Mercer supports the proposal that employers determining the cost of applicable coverage should not have to factor in the number of individuals covered in addition to the employee (even if actual cost varies on this basis). This is an area where the purpose of COBRA deviates from the excise tax. Employers offer multiple other-than-self-only tiers so employees pay more to cover more individuals (or in some cases, if an employee covers not only children but a spouse, since spousal coverage typically costs more than a child's). This cost allocation is required to carry through to COBRA cost calculations. In contrast, the excise tax provides only two thresholds, so it is logical to permit employers to aggregate their other-than-self-only coverage tiers. This approach will permit employers to continue offering multiple other-than-self-only tiers without facing additional cost calculations for the excise tax.

Mercer also supports permissive disaggregation of other-than-self-only coverage tiers, again to provide flexibility to employers in calculating the cost of coverage subject to the tax.

7. Permissive disaggregation of similarly situated individuals.

Mercer supports allowing permissive disaggregation of similarly situated individuals for purposes of applying the threshold limits for the excise tax based on a wide range of standards, including bona fide employment-related criteria like nature of compensation, specified job categories, and collective bargaining status, as well as more specific criteria, such as geographic distinctions, current versus former employee status, or the number of additional individuals covered. These should not be exclusive lists of standards — Mercer requests that the regulations be broad enough to permit additional reasonable categories of similarly situated individuals that may be disaggregated based on the facts and circumstances of a particular employer.

Neither Mercer nor the IRS can predict every employer's situation when it comes to providing employee health care, and the regulations should provide flexibility in allowing employers to disaggregate certain groups. For example, an employer may have an expensive group exceeding the excise tax thresholds in a particular state simply because the cost of health care is more expensive in that state, while employees in every other state are provided coverage that costs less than the excise tax thresholds. While the threshold dollar limit for the excise tax currently is not varied for geographic differences in cost of this type, the regulations could allow employers flexibility through permissive disaggregation rules so that an employer could choose to pay the excise tax only on coverage for employees in that state rather than being forced to blend the cost of that coverage with all participants in the plan.

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8. Alternative methods to determine cost of applicable coverage

The Notice asks for comments on whether any alternative approaches to determining the cost of applicable coverage would be consistent with 4980I and, if so, what would be useful.

Mercer urges Treasury and IRS to explore this issue further with the employer community, including beyond the close of the formal comment period. The excise tax is intended to apply to excess or high cost coverage. Employer coverage that is comparable to coverage offered by the federal government to its workforce should not trigger this tax, particularly as the employer's cost may be driven by ACA mandates (such as bans on annual or lifetime limits for essential health benefits), or an employer's location or other demographic factors. Regardless of the method used to determine the cost of applicable coverage, we recommend that IRS and Treasury consider the use of safe harbor thresholds against which to compare that cost of coverage.

A possible approach that could fall within Treasury and IRS's regulatory authority follows:

- Identify the cost of a nationally available plan (such as the Blue Cross/Blue Shield Standard Benefit Option in the Federal Employees Health Benefits Plan) based on national workforce data.

- Create a safe harbor for employer plans that on a reasonable actuarial basis — based on national workforce data — do not exceed this cost by a specified percentage.

- If the employer plan does not satisfy the safe harbor, the employer pays the excise tax only to the extent its costs are determined to exceed the specified percentage.

The regulations should deem the benchmark plan — regardless of its actual cost — to be at or below the excise tax threshold as a reasonable interpretation of the intended application of the tax solely to "high cost" plans. This approach would address one of the chief concerns with the current threshold approach: that if the thresholds are indexed to CPI while employer plan costs continue to trend at approximately twice CPI, even well-managed, well-intentioned and very average plans will inevitably exceed the thresholds. Using a dynamic benchmark based on the design and cost of an identified plan deemed to have a satisfactory level of "richness" would allow employers an opportunity to manage their costs below the thresholds, comply with applicable law, avoid employer shared responsibility assessments and continue to provide health coverage that meets employees' needs.

9. Applicable dollar limits — use of other-than-self-only threshold

The regulations should clarify that limited minimum essential coverage benefits available to employees, but not other "beneficiaries," do not prohibit use of the other-than-self-only coverage threshold.

Section 4980I(f)(1) states that employees are treated as having self-only coverage unless minimum essential coverage is available to the employee and at least one other "beneficiary" and "the benefits provided under such minimum essential coverage do not vary based on whether any individual covered under such coverage is the employee or another beneficiary." We request that regulations clarify the meaning of this provision.

In some cases employers offering MEC to spouses and dependents may include minor benefits that are or might be characterized as minimum essential coverage to their employees, but not other family members. Examples may include on-site wellness program activities, employee physicals, dispensing medications or inoculations to employees traveling internationally, or some on-site clinics (depending on how de minimis is defined). Often these offerings serve multiple purposes — for example they be work related or are offered for employee convenience and to reduce absenteeism in addition to providing medical care. Regulations should clarify that these minor benefits included in MEC do not prevent an employer from using the other-than-self-only coverage threshold to determine whether their benefits are subject to the excise tax; otherwise employers will have no choice but to terminate these offerings.

We also ask that regulations clarify the relationship between 4980I(f)(1) and employer shared responsibility assessments. Employers avoid shared responsibility assessments if they offer employees minimum value, affordable coverage and their children minimum essential coverage. Under shared responsibility rules, minimum essential coverage offered children may therefore differ from that offered employees without triggering an assessment. We request that regulations address how such differences in minimum essential coverage would be treated under 4980I(f)(1). We suggest regulations clarify that employers can use the other-than-self-only threshold for any coverage as long as non-employee beneficiaries are offered minimum essential coverage.

10. Demographic adjustment to dollar limits relating to age and gender

The regulations should permit employers to apply the demographic adjustment to the dollar limits for age and gender by comparing employees enrolled in employers' health plans subject to the excise tax to the US workforce. This determination will let employers adjust their excise tax thresholds according to the demographics of employees they are actually covering. Additionally, if employers are required or permitted to disaggregate employees by benefit package (or other factors), they should be able to apply the demographic adjustment separately for each separate cost unit used to determine the excise tax.

The regulations should further clarify that employers can apply the demographic adjustment for age and gender to covered retirees, including retirees age 55 and over who are not Medicare eligible and entitled. The dollar limit adjustment provided in 4980I(b)(3)(iv) for pre-Medicare retirees may be an adequate adjustment for morbidity differences between active employees and retirees of the same age, but an additional adjustment is required for the higher average ages that a particular employer's population -- including retirees -- may have relative to the national workforce.

Similarly, we ask that guidance clarify that the age and gender demographic adjustments also apply to dollar limits for plans covering employees in high-risk professions or electrical and phone line installers or repairers (collectively referred to as high-risk employees). The dollar limit adjustments for plans covering high-risk employees, similar to the retiree adjustments, account for the higher morbidity differences between high-risk employees and the general employee population, but not for costs associated with the relative differences in age and gender for a particular plan's enrollees.

If IRS and Treasury want to explore specific demographic adjustment factor studies and source data relevant to these issues, we suggest they meet with US actuarial organizations during the rule-making process.

C. The regulations should delay implementation of Section 4980I or provide an initial period of good faith compliance

The excise tax imposes significant new compliance obligations on employer-sponsored health plans of all sizes. Given the many unresolved issues about how the tax will be calculated and paid, the time needed to develop regulations to resolve those issues, and the time employers will need both to implement plan changes and prepare to calculate (and perhaps allocate) the tax, we urge that regulations delay the effective date of the excise tax. At a minimum we request that regulations provide an initial period when an employer's good faith efforts to determine and allocate the cost of applicable coverage will avoid the penalties potentially assessed under Section 4980I(e)

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If you have any questions or need further information, please contact Leslie Anderson at 612 642- 8711 or leslie.anderson@mercer.com, Cheryl Risley Hughes at 202 263-3918 or cheryl.hughes@mercer.com or, for actuarial questions, Molly Loftus at 860 550-8257 or molly.loftus@mercer.com. We thank Treasury and IRS for the opportunity to respond to the request for comments in Notice 2015-16.

Sincerely,

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