Notice 2015-16

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Room 5203
Internal Revenue Service
P.O. Box 7604
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Washington, D.C. 20044

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

Ladies and Gentlemen:

Introduction

We are writing on behalf of our firm, Towers Watson, to submit comments in response to your request in Notice 2015-16 to help frame upcoming guidance and identify potential approaches and issues relevant to the "excise tax on high cost employer-sponsored health coverage" under Section 4980I of the Internal Revenue Code, as added by the Patient Protection and Affordable Care Act (PPACA). Our comments are set forth below.

Towers Watson is a leading global professional services company that helps organizations improve performance through effective people, risk and financial management. With 15,000 associates around the world, we offer consulting, technology and solutions in the areas of benefits, talent management, rewards, and risk and capital management. Towers Watson's Health and Group Benefits business sector assists employers in optimizing both global and local benefit program performance and gaining maximum value from the annual expenditure for medical, dental and risk (life, accident and disability) programs. We work with many of the country's largest employers on their health care benefits.

Our comments are intended to promote the following objectives and principles:

- Solicit guidance on a comprehensive range of issues and scenarios in effect for large employers so that they can prepare properly for assessing the impact of this tax, and take mitigating steps as necessary, well in advance of the 2018 effective date
- Support plan sponsor flexibility and reasonable ease of administration, given the wide array of complex plan arrangements in effect for large self-insured employers
- Develop appropriate definitions of applicable coverage, within the constraints of regulatory authority, and ensure alignment of cost determination approaches with reasonable, well-established and effective plan pricing arrangements in effect for large employers across the US

We are seeking to provide comments of a more technical nature given our role working with large employers on all aspects of health care benefit financial management. Notwithstanding the last

statement, however, we are offering comments in a few areas where we believe the impact of this statutory provision may not align with our understanding of the legislative intent.

Comments on Section III: Definition of Applicable Coverage

III-A. General

Section 4980I(d)(3) defines an employee to include any former employee, surviving spouse, or other primary insured individual. The term "other primary insured individual" is not clearly defined and we request that future guidance expand on this by providing a comprehensive list of individuals who should be included or excluded for purposes of Section 4980I. For example, while it is clear that the excise tax applies to applicable coverage provided to active employees and retirees, we request that future guidance clarify the applicability of the excise tax to other categories of covered individuals, such as inactive employees (e.g., employees on short-term or long-term disability, a leave of absence, severance, COBRA, etc.), as well as non-employees who are enrolled in coverage such as partners, and non-employee Board members. With respect to divorced spouses who continue coverage under COBRA, and children who lose eligibility under the terms of the plan (e.g., they have attained age 26) and continue coverage under COBRA, we recommend that future guidance exclude both categories of individuals from the definition of employee for purposes of the excise tax since neither category of individuals has a direct employment relationship with an employer, nor are they generally considered primary insureds, but rather have their eligibility for coverage derived from their family member's employment (i.e., the employee is the primary insured). Finally, we also request that future guidance clarify whether "statutory employees" under Section 7701(a)(20) (such as certain life insurance agents) would be included in the definition of employee for purposes of Section 4980I.

III-B. Types of Coverage Included in Applicable Coverage

Health FSAs

With respect to the inclusion of employee salary reduction contributions to an FSA in the determination of cost under Section 4980I, we see a reasonable policy argument for excluding such contributions since they are not viewed as part of the employer-provided benefit plan and in fact are seen as a way to fill gaps in employer health plan coverage on a tax effective basis. Employees elect to put part of their salary into an FSA in order to cover eligible out of pocket expenses on a tax favored basis. In many cases, FSA contributions are made in reaction to employer plan design changes. We believe that if these contributions are included in the excise tax calculation, employers will limit and then eliminate employee salary reduction contributions to an FSA over time. Since the excise tax will have the effect of compelling employers to reduce the value of their health plans, also including FSA contributions in the excise tax calculations will ultimately eliminate these accounts as an employee option enabling tax favored treatment for eligible out-of-pocket expenses.

We request that future guidance confirm that a limited purpose health FSA which by its terms reimburses *only* qualified dental and vision benefits not be included in the definition of applicable coverage. We believe this approach would be consistent with the approach outlined in Notice 2015-16 to exclude from the excise tax calculation limited scope dental and vision benefits, regardless of whether such benefits are insured or self-insured.

Multiemployer Plans

We request that future guidance confirm that employers who contribute to a multiemployer plan are not required to calculate the excise tax liability in the common situation where the contributing employer is not the named plan sponsor. In addition, we request confirmation that an employer that merely contributes to a multiemployer plan is not considered to be "the person that administers the plan benefits" and therefore is not liable for payment of the excise tax. We believe this result is consistent with the statutory language in Section 4980I since these employers simply make contributions (as required under their collective bargaining agreement) on behalf of their employees and do not play a role in the ongoing administration of the multiemployer plan's benefits.

In addition, we seek clarification on how the excise tax will be calculated in situations where certain benefits which are considered applicable coverage are provided directly by the employer while the primary health care benefits are provided by the multiemployer plan. For example, assume that an employer provides access to an on-site health clinic to employees who receive their primary health care benefits from the multiemployer plan. We request that future guidance address how the parties would need to coordinate in determining the overall tax obligation under Section 4980I.

Lastly, we request that future guidance confirm that age and gender adjustments, as addressed later in this comment letter, will be determined separately for each multiemployer plan within the employer's controlled group.

Executive Physicals

Notice 2015-16 states that "future guidance is expected to provide that executive physical programs...are applicable coverage." First, we note that executive physicals are not typically considered part of the employer's health care benefit program and instead are viewed as an employment based program to ensure that a company's executives have demonstrated a fitness for duty. Accordingly, we believe that these programs should be excluded from the definition of applicable coverage. In the absence of a full exclusion, we request that future guidance clarify how employers could determine the cost for such programs and recommend that employers be given flexibility in utilizing various reasonable methodologies for making this determination. This would be consistent with the varying approaches large employers currently use to determine the cost of executive physical programs for other purposes, such as internal financial projections, budgeting, COBRA compliance, etc. In our view, one reasonable approach would be for the employer to determine the total projected cost for all executive physicals and then divide that by the number of eligible executives, with that dollar amount serving as the cost of coverage with respect to each eligible executive.

III-D. HSAs/Archer MSAs

Notice 2015-16 states that future proposed regulations will provide that employer contributions to HSAs (and Archer MSAs), including employee salary reduction contributions to HSAs, will be included in the definition of applicable coverage under Section 4980I, whereas employee after-tax contributions will be excluded. We believe that there are several reasons why Treasury and the IRS should consider excluding employee pre-tax salary reduction contributions to HSAs from the definition of applicable coverage.

First, Section 4980I(d)(2)(C) provides that, with respect to HSAs and Archer MSAs, the cost of coverage is equal to the amount of the employer contributions under the arrangement and makes no reference to employee contributions, whether made on a pre-tax or after-tax basis. We believe this statement reasonably could be interpreted narrowly to only factor in direct employer contributions to an HSA when

determining any potential excise tax liability, and exclude all employee contributions, including pre-tax salary reduction contributions. The Joint Committee on Taxation (JCT) technical explanation of the PPACA revenue provisions, issued March 21, 2010, states that "the amount subject to the excise tax on high cost employer-sponsored health insurance coverage for each employee is the sum of the aggregate premiums for health insurance coverage, the amount of any salary reduction contributions to a Health FSA for the taxable year, and the dollar amount of employer contributions to an HSA or an Archer MSA, minus the dollar amount of the threshold." While the JCT specifically references the inclusion of salary reduction contributions to an FSA, they do not similarly reference HSA salary reduction contributions, which indicates Congressional intent to limit the inclusion for excise tax purposes to only direct employer contributions to an HSA.

In addition, as alluded to in our earlier comments, many employers are adopting HSA-qualified high deductible health plans as a means to help control medical inflation and, starting in 2018, to mitigate the impact of the new PPACA excise tax. Including employee pre-tax HSA contributions in the excise tax calculation would result in employers less likely to facilitate employee HSA contributions which likely will result in fewer employees saving for current and future out-of-pocket medical expenses. It has been argued that the current income tax exclusion for the value of employer-provided health care benefits may promote richer benefits and higher utilization. We do not believe, however, that the favorable tax treatment of employee HSA contributions presents a similar type of incentive for over-utilization since employees using their own money for out-of-pocket expenses (whether tax-free or not) have every incentive to consume medical resources carefully.

III-E. On-site Medical Clinics

Notice 2015-16 states that proposed regulations are expected to provide that on-site medical clinics that offer only de minimis medical care to employees will not be included in the definition of applicable coverage. We believe that the de minimis standard should be based solely on the scope of services provided by the on-site health clinic, and not based on cost of the services provided. In our view a scope of services standard is easier to apply across a wide array of different approaches under which employer on-site health clinics are structured.

We believe that limiting the definition of de minimis medical care to the definition under the COBRA regulations (as described in Notice 2015-16) would be too restrictive for employers who provide this benefit to their employees. Instead, we believe that when determining whether an on-site clinic provides more than de minimis medical care and therefore should be included in the definition of applicable coverage, a standard should be adopted which permits an on-site clinic to offer a broader range of medical services without causing it to be included in the excise tax calculation.

Generally, employer-sponsored on-site medical clinics provide benefits which go beyond simply providing first-aid. In many cases, on-site medical clinics may provide preventive care, disease management, health coaching, biometric screenings, health risk assessments, and physical therapy. We seek clarification that these services may be offered without jeopardizing the on-site clinic's status as de minimis. Furthermore, in some cases, services are available only to employees while in other cases eligible family members may also access care on-site. We request that future guidance clarify that an employer may provide access to its on-site clinic to family members while still being considered de minimis. In any event, we request that future guidance expand and clarify this definition to enable employers to more definitively determine (a) whether their on-site clinics are subject to the excise tax, and (b) if subject to the tax, how to calculate the applicable cost.

With respect to calculating the applicable cost of an on-site clinic, we request that future guidance specify how expenses such as real estate, overhead and salaries impact the cost calculation and whether employers will be subject to a "fair market value" standard. We request that future guidance confirm that only those individuals who have reasonable access to the on-site clinic be considered covered by the clinic. For example, employees who regularly work from home or who do not regularly work at the location where the on-site clinic operates should not be considered covered. In addition, we recommend that employees who have reasonable access to the on-site clinic be considered covered even if they don't actually utilize the services during any determination period. This rule would similarly apply for determining the per employee cost of the on-site clinic.

III-F. Limited Scope Dental and Vision Benefits

We agree with the rationale set forth in Notice 2015-16 to exclude limited scope dental and vision benefits from the definition of applicable coverage, regardless of whether such coverage is insured or self-insured.

III-G. Employee Assistance Programs (EAPs)

We agree with the approach outlined in Notice 2015-16 to exclude EAPs from the definition of applicable coverage in Section 4980I if the EAP qualifies as an excepted benefit pursuant to the recently issued regulations under Section 9831.

Comments on Section IV: Determination of Cost of Applicable Coverage

IV-A. General

We understand that the rules for determining cost for the excise tax will be similar to the rules for determining cost for COBRA purposes. We believe that the cost determination method for Section 4980I should be allowed to differ from the method for use in COBRA rate development to reflect the varying purposes of each calculation. Given the lack of definitive guidance on how to determine COBRA cost under self-insured plans, it will be important to receive guidance on COBRA rate determination. Note that virtually all of our clients offer one or more self-insured plans, and that generally consulting firms like Towers Watson are retained to develop self-insured plan costs for budgeting and COBRA purposes. Accordingly, our thoughts which follow on broader cost projection and rate development principles reflect our breadth of experience.

IV-A.1. Determination of Applicable Premium under COBRA

We note that our clients have generally been following a good faith standard for several decades in interpreting the limited guidance under Section 4980B(f)(4) for use in determining cost for COBRA coverage. We appreciate that further guidance will be forthcoming in this area to help define allowable approaches for determination of costs for excise tax purposes as well as for COBRA premiums.

IV-A.2. Specific Rules under Section 4980I

Retirees

We would like to note at the outset that, as is generally well known in the benefit community, few employers still offer retiree medical benefits and many who do have taken steps to reduce or eliminate their obligation for these benefits. This erosion trend will only accelerate once employers face the added cost of the excise tax as an increase to either employer or retiree cost. This could be especially burdensome for retirees in plans with capped employer subsidies when employers may elect to pass the

full cost of any assessment under Section 4980I onto retirees as added contributions. Such capped subsidy plans are very common among the relatively small share of large employers still sponsoring retiree medical plans. While we appreciate that the regulators may not be able to interpret the statute differently, we believe that inclusion of retiree medical costs in the calculation of Section 4980I cost will only hasten the demise of employer-sponsored retiree medical benefits while adding substantially to the cost of coverage imposed on retirees, especially in plans with capped employer subsidies.

We note also that higher thresholds are provided in the statute for retirees who have not qualified for Medicare (pre-65 retirees). The increase in these thresholds, however, is in no way comparable to the higher cost for pre-65 retiree coverage compared to active employee coverage. The 2018 thresholds are increased by 16% for self-only coverage and by 13% for other-than-self-only coverage. Actual plan costs for pre-65 retirees will typically range from 50% to more than 100% higher than costs for the same plans offered to active employees. This places an immense and disproportionate burden on employers offering pre-65 retiree coverage as well as on enrolled retirees who may be required to bear the higher cost of this new tax as an addition to their regular retiree contributions.

With respect to item (3), Retirees, the statute indicates that a plan may elect to treat a retired employee who has not attained age 65 and a retired employee who has attained age 65 (post-65 retirees) as similarly situated beneficiaries. Some observers have interpreted this as providing an option for employers to blend costs for pre-65 and post-65 retirees in determining whether plan costs exceed the applicable thresholds. Please confirm if some form of cost blending is anticipated in future guidance. If so, we request that you provide detailed guidance on precisely how a blending provision would work for employers offering coverage to both pre-65 and post-65 retirees, including how blended costs would be compared to thresholds that differ for pre-65 and post-65 retirees.

ABC Employer Example

An example as to how that might be done follows below, based on the following assumptions:

- 2,600 total members covered for retiree medical
  - 900 pre-65 retirees or spouses and 1,700 post-65 retirees or spouses
  - Total members covered include 200 "split couples" with one pre-65 member and one post-65 member
- Annual plan cost for each covered member of $11,000 for pre-65 and $4,500 for post-65
- Threshold for split couples set at $29,225 (one half of $27,500 plus $30,950)

Combining Pre-65 and Post-65 Retirees		All Retiree Participants	
		Self-Only	*Other-Than-Self-Only*
	Number of Pre-65 Retirees	300	200
	Number of Post-65 Retirees	500	500
	Split Couples	-	200
		800	900
		Plan Cost	
Determining the Cost	Pre-65 Retirees	$9,900,000	
	Post-65 Retirees	$7,650,000	
	Total	$17,550,000	
		Self-Only	*Other-Than-Self-Only*
	Combined Cost per Covered Member	$6,750	$13,500

Determining the Threshold

Observation: Age/gender analysis is not relevant as a comparison to employed population is inappropriate for a retired population.

		Blending Based on Dependent Status	
2018 Threshold	Unadjusted	*Self-Only*	*Other-Than-Self-Only*
Pre-65 Retiree		$11,850	$30,950
Post-65 Retiree		$10,200	$27,500
Split Couples			$29,225
		Self-Only	*Other-Than-Self-Only*
Blended Threshold		$10,819	$28,650

We note that for most employers offering coverage to both pre-65 and post-65 retirees, the plans they offer to pre-65 retirees vary substantially from plans provided to post-65 retirees. Please describe how these differences will be factored into the treatment of pre-65 and post-65 retirees as similarly situated beneficiaries.

As background, employer plans offered to pre-65 retirees often mirror the plans offered to active employees, while plans offered to post-65 retirees can take a number of different forms arising from the unique characteristics of Medicare and its related private insurance market programs, including:

- Traditional employer sponsored group post-65 medical plans which provide secondary benefits that coordinate with Medicare as the primary payer. Benefits normally differ from benefits offered to pre-65 retirees due to the unique role of Medicare as the primary payer. Such plans may be combined with pharmacy coverage provided under either a Retiree Drug Subsidy (RDS) program or a Part D Employer Group Waiver Plan.
- Group Medicare Advantage medical plans, again often combined with either RDS or Part D pharmacy benefit plans.
- Standalone retiree-only HRAs which provide reimbursement for premiums or out-of-pocket expenses for individual post-65 coverage, including Medicare Supplement, Medicare Advantage

and Part D plans. Such HRA-based arrangements are often structured as part of a private Medicare exchange made available by their former employer under which retirees can purchase individual health insurance plans.

In our experience, it is uncommon for employers to offer precisely the same coverage to pre-65 and post-65 retirees. We recommend that future guidance not adopt a strict standard for treating pre-65 and post-65 retirees as similarly situated beneficiaries, such as requiring that coverage be identical other than for the applicable coordination with Medicare. Such a strict standard would penalize both employers who continue to offer retiree coverage and their retirees who may be forced to absorb higher contributions as employers pass added costs under Section 4980I onto retirees. Instead, we advise adoption of a standard that allows employers to treat pre-65 and post-65 retirees as similarly situated beneficiaries under the full array of pre-65 and post-65 programs employers now provide to help ensure the financial security of their retirees.

Please address the handling for purposes of cost and threshold determination of "split couples" with one individual on Medicare and another individual not on Medicare.

We would also like to address the common situation under which employers offer the same plan options to pre-65 retirees that are available to active employees. While most employers determine plan costs separately for active employees and pre-65 retirees, a few employers elect to develop rates that blend experience for active employees and pre-65 retirees into a single risk pool. Please confirm whether or not such a cost determination approach (i.e., blending of active and pre-65 retiree cost) would be allowable and, if so, how thresholds of varying levels would be blended for this purpose.

Lastly, we would like to confirm that for employers offering group post-65 pharmacy benefit plans through a Part D Employer Group Waiver Plan, applicable cost for post-65 coverage will reflect (i.e., be reduced for) projected third party payments from CMS and from the pharmaceutical industry for the Coverage Gap Discount Program.

Monthly Costs

With respect to item (6), Monthly Costs, we note that some employers provide an HSA seed at the start of a plan year to help employees pay for eligible out-of-pocket costs before they have been able to set aside funds into the HSA. Please confirm that an employer seed provided in a lump sum at the start of the plan year could be allocated evenly across the 12 months of the plan year for purposes of Section 4980I cost determination.

In addition, some employers provide an HRA credit to employees who earn specified wellness and health promotion incentives (e.g., by completing a health risk assessment or participating in a smoking cessation program). Such credits may be provided upon certification that the appropriate wellness activity has been completed. Please confirm that an employer HRA credit provided upon completion of a specified wellness activity could be allocated evenly across the 12 months of the plan year for purposes of Section 4980I cost determination.

IV-C. Potential Approaches for Determining Cost of Applicable Coverage

The Notice indicates that determination of cost under Section 4980I will use rules similar to the rules of Section 4980B(f)(4) for determining cost under COBRA continuation of coverage. As referenced earlier in the Notice, employers have been operating under a good faith standard given the absence of regulatory guidance on COBRA cost determination under Section 4980B(f)(4). As noted earlier in our commentary, we will provide input later in this submission on how we determine COBRA rates for our large employer clients with self-insured plans (our clients range in size from about 1,000 employees up to more than 100,000 employees).

We believe that there are significant reasons to adopt an approach for determination of cost under Section 4980I that will differ in certain substantive ways from the determination of cost for COBRA continuation under Section 4980B(f)(4). We will elaborate further on this later in our submission.

IV-C.1. Similarly Situated Individuals

The concept of similarly situated beneficiaries for COBRA purposes is generally well understood within the large employer community. With the dramatic proliferation of different medical plan types and benefit delivery arrangements in recent years, however, the determination of what constitutes a similarly situated beneficiary has become more complicated. We believe that future guidance on similarly situated individuals, for both COBRA and excise tax purposes, should allow employers some latitude, within the constraints of actuarial soundness, in considering these widely varying circumstances in determining how to apply this standard. We also believe that it may be appropriate to apply the standard somewhat differently for COBRA continuation and for calculation of Section 4980I cost determination, as these provisions of law have different policy objectives as well as some differences in includible costs (for example, HSAs are not subject to COBRA but employer and employee pre-tax contributions to an HSA are includible for purposes of Section 4980I cost determination).

Notice 2015-16 outlines a possible approach under which "*each group of similarly situated employees would be determined by starting with all employees covered by a particular benefit package provided by the employer, then subdividing that group based on mandatory disaggregation rules, and allowing further subdivision of the group based on permissive disaggregation rules.*" Our comments on this possible approach are set forth below.

Aggregation by Benefit Package

We recommend that the experience of all participants eligible for the same suite of benefit options be included in rate development with separate rates by benefit package based on actuarial value of the individual plan options. We further request that future guidance set forth how differences in health plan coverage would and would not constitute separate benefit packages. For example, assume an employer provides generally the same type and level of coverage administered by two different self-insured plan vendors, with benefits that are substantially identical but with provider networks and certain claim administration policies that are different. Please confirm if this would constitute a single benefit package or two separate benefit packages; we advise that employers be provided the flexibility to treat such plans with minor differences as a single benefit package.

In another example, assume that an employer offers the same plan to employees in two different locations, but employees in only one location have convenient access to the employer's on-site health clinic for certain non-occupational (and non-de minimis) services covered under the plan. Confirm whether this would constitute a single benefit package or two separate benefit packages. Explicit

guidance and supporting examples would be helpful for employers making this determination. We do not support a standard that requires benefits to be "identical" since in many cases employers offer plans to employees in the same employment categories (such as salaried or hourly) that are substantially the same, but not identical. Accordingly, a standard such as "substantially similar" could be applied in a more consistent and reasonable manner than a standard requiring benefits to be literally identical which as a practical matter is virtually impossible.

Later in our commentary, we outline how costs are typically determined for large employers offering multiple self-insured plan options to the same group of beneficiaries. Using a "single risk pool" approach, claim experience is combined for all plan options offered to a group, with rates for each option then set according to the relative actuarial plan value of each option. This approach neutralizes risk selection in a multiple option environment while ensuring that rate differences align with benefit value differences across the combined risk pool. We believe that it is both appropriate and consistent with longstanding practice that employers use a single risk pool rating approach for plan options that constitute separate benefit packages for purposes of Section 4980I.

Mandatory Disaggregation (Self-Only Coverage and Other-Than-Self-Only Coverage)

We agree with the rationale for mandatory disaggregation by self-only (SO) and other-than-self-only (OTSO) coverage as this reflects the typical practice among employer of developing separate costs for each tier of coverage. We note, however, that in typical practice employers determine rates for each applicable level of coverage by use of actuarial relationships which reasonably reflect projected costs levels for each tier of coverage. Rates for each coverage level are generally not based on a separate evaluation of claim experience for that coverage level (such as applying experience rating separately for single and family coverage). Accordingly, we anticipate that future guidance will specify that employers can continue to develop rates separately by SO and OTSO coverage levels under a single risk pool rating approach and then using actuarial cost relationships, rather than requiring separate experience analyses for each unique level of coverage, to determine costs by each coverage level.

Mandatory Disaggregation (Active and Retiree Coverage)

Based on the statute, the cost of qualified early retirees may be allowed to be combined with the cost of Medicare eligible retirees. Higher thresholds are provided for qualified early retirees. Similarly, adjustments to the thresholds for age and gender characteristics are allowed based on a comparison of covered employees to the national employed workforce. Given these facts, we believe it is reasonable to not allow for cost aggregation of active employees and retirees, either pre-65 or post-65.

Permissive Aggregation within Other-Than-Self-Only Coverage

In our experience, the overwhelming majority of employers split the OTSO coverage level into two or three separate tiers such as Employee + Spouse, Employee + Child/ren and Employee + Family. This is generally done both for purposes of developing plan costs and for determining employee contributions. Notice 2015-16 appears to allow employers with more than one tier of OTSO coverage to aggregate those tiers into one level of OTSO coverage. Accordingly, the employer could retain several different levels of OTSO coverage for purposes of employee enrollment and payroll contributions, but aggregate those different levels of OTSO coverage for purposes of determining costs for comparison to the Section 4980I OTSO cost threshold ($27,500 for 2018). Please confirm if this understanding is correct.

For purposes of COBRA cost development, employers generally set separate rates for each unique level of OTSO coverage (Employee + Spouse, etc.). This helps ensure that COBRA costs are most appropriate for the level of COBRA coverage elected by the COBRA qualified beneficiary. Please confirm that employers with more than one level of OTSO coverage can continue to develop COBRA rates on this basis even if for purposes of Section 4980I the multiple levels of OTSO coverage are aggregated into a single cost for purposes of Section 4980I OTSO cost determination.

Permissive Disaggregation

Notice 2015-16 indicates the future guidance may permit, but not require, further disaggregation based on distinctions traditionally made in the group insurance market. This permissive disaggregation may apply for both Sections 4980I and 4980B(f)(4). We support continuing to allow these traditional distinctions to be used in developing costs for both of these purposes. We recommend adopting a broad approach under which you consider providing a non-exhaustive list of examples to guide employers in making this determination. Employers could then consider their relevant business circumstances in determining how to apply these permissive disaggregation rules.

Some of the disaggregation distinctions we often see with our clients include the following:

- Salaried vs. hourly employees
- Nonunion vs. union employees
- Within a union population, by each separate bargaining agreement
- Full time vs. part time
- Current vs. former employees (with former employees often broken down into additional subgroups such as disableds, pre-65 retirees, post-65 retirees, etc.)
- Active vs. retired employees
- Within a retiree population, pre-65 vs. post-65 retirees
- Business unit or division
- Geography
- Subsidiaries or joint ventures that are wholly or partially owned

As noted earlier, we believe that it is advisable for future guidance to allow for some differences in how costs will be determined for purposes of Section 4980I and for Section 4980B(f)(4). We believe that allowing a reasonable degree of employer latitude will be beneficial in recognizing the different purposes served by each applicable Code Section.

IV-C.2. Self-Insured Methods (for cost determination)

Notice 2015-16 outlines the two methods set forth under Section 4980B(f)(4)(B) for use by employers in developing costs for self-insured plans. These methods include the Actuarial Basis Method (ABM) and the Past Cost Method (PCM). The Notice indicates that the ABM must be used unless the plan is eligible for and elects to employ the PCM.

As specified in the Notice, the ABM involves development of a reasonable estimate of future plan cost for similarly situated beneficiaries; the method is determined on an actuarial basis and takes into account such factors as may be prescribed in regulations. We understand that such factors have not been articulated in COBRA regulations.

The PCM entails development of cost based on actual plan cost during a defined determination period adjusted by a change in the implicit price deflator of the GNP, as calculated by the Chamber of

Commerce Survey of Current Business. The PCM is not available "in any case in which there is any significant difference between the determination period and the preceding determination period, in coverage under, or in employees covered by, the plan...".

In our experience, some form of the ABM is used universally by large employers to develop rates for budget and COBRA cost development purposes. The PCM has never been viewed as an appropriate means to reasonably project future costs under a self-insured benefit program. Accordingly, we recommend that future guidance specify use of the ABM approach by employers sponsoring self-insured plans for purposes of Section 4980I cost development. This fosters simplicity by aligning with a well-established and highly credible means for projecting future health care benefit costs. In addition, we recommend that future guidance require that employers sponsoring self-insured programs obtain certification from a qualified actuary that the ABM approach used in cost development is reasonable within the broad parameters to be set forth in future regulations. This could be similar to the current approach under the Medicare Modernization Act's Retiree Drug Subsidy (RDS) program under which a qualified actuary must attest to a plan's qualification for claiming RDS payments.

IV-C.2.a. Changing Between Methods

As noted earlier, we recommend that future guidance specify that employers use an ABM approach in determining cost under Section 4980I, in which case, changing between methods would not occur.

IV-C.2. b. Actuarial Basis Method

In this section, we offer commentary on the methods we typically employ with our clients in developing self-insured plan costs for purposes of setting budget rates and COBRA costs. Broadly speaking, these methods all fall within what we would consider to be an ABM cost determination approach.

Self-Insured Cost Projection Factors

The factors typically used in projecting costs for a future plan year include:

- Prior claim experience for a period typically ranging from one to three years is reviewed and used to help project costs for the next plan year. Experience in prior years may be weighted according to actuarial or underwriting judgment to reflect its probability of influencing future cost.
- Prior claims experience is adjusted for any plan design changes, vendor changes, health care provider payment changes, or any other changes effective during the experience period that would influence future costs.
- Prior claims experience may also be adjusted to remove certain high cost claimants for whom stop loss reimbursements may be available or on whom future high cost claims are not anticipated to continue (e.g., if a high cost claimant is no longer enrolled in the plan).
- Projected claim costs are then adjusted for any changes to apply effective in the next plan year relating to the factors described in the preceding bullet (such as vendor, plan design, coverage rule or provider network changes).
- Adjustments are also made for any known or anticipated changes in the number, composition, geography, demography or other characteristics of the covered population (employees and family members) that could influence future plan costs.
- A further adjustment may be made to convert claim experience reported on a paid basis into claims projected into the future plan year on an incurred basis
- A medical trend factor is applied to each period of actual claim experience into the future plan year. Sources for trend factors typically include surveys on plan costs for large employers.

- Once future claim costs are projected, a number of additional administration and related costs are typically added into the development of rates. These costs include, but are not limited to, the following:
    - Vendor administration fees for a range of services relating to plan operation (such as a self-insured claims administrator, a provider of health risk assessments and disease management services, etc.)
    - Stop loss insurance premiums, if such coverage is in effect
    - Any state or federal fees or taxes applicable to self-insured plans (e.g., the PPACA Transitional Reinsurance Fee)
- Some rate projections include a margin for potential adverse claim experience; margin levels vary with group size, but may range from about 2% to 3% of total cost for a larger group.
- Rates for each level of coverage (e.g., single, employee plus spouse, employee plus family) are then set based on the expected actuarial relationship of costs for each applicable coverage tier. While employers may from time to time assess actual claim costs separately by each tier of coverage, as a practical matter this is not done annually as the use of actuarial relationships by coverage tier produces more appropriate and stable rates for each level of coverage).
- The resulting rates are used for budget purposes and, after applying a load of 2%, for purposes of determining cost for COBRA continuation coverage.

Self-Insured Cost Projection Methods for Multiple Plan Options Offered to the Same Group

Most large employers offer multiple plan options to the same employee group. For example, an employer might offer two or three different self-insured benefit options to their salaried active employee population. These options will typically vary in terms of plan design provisions (e.g., deductibles, coinsurance, out-of-pocket limits and copays) as well as in payroll contributions. In addition, some employers will provide options that may vary by vendor and/or region in addition to the benefit differences outlined above.

Our general approach going back at least to the 1980s with the advent of flexible benefit plans offering multiple plan options is to employ one or more variations on a "single risk pool" rating approach when employers offer more than one option to the same population.

Under a single risk pool approach, claim experience for all enrolled members who are eligible to participate in the same menu of plan options is combined for purposes of projecting total program costs. Projections are then developed based on the factors outlined above. Once final total program costs are projected, then rates are developed for each unique plan option based on the relationship of each plan's relative benefit value (similar to Actuarial Value as specified under the PPACA). The essence of this approach is in viewing an employer's set of plan options as one program overall with a number of different options within that program, as opposed to a disparate and unconnected set of individual options, each of which needs to be self-sustaining financially.

The outcome is that rates vary by plan based only on the differences in plan value and not on the differences in the underlying risk characteristics of only that plan's enrolled population. (Note that for some employers we develop rates and contributions by plan option that reflect the impact of risk selection on the *incremental* difference in plan value from one option to another.) The single risk pool approach ensures that rates and employee contributions by plan are set appropriately to account for (and neutralize the impact of) adverse selection that naturally occurs when plan options of varying value are offered to the same population. This is the standard approach used by our firm on a longstanding basis and, to our understanding, by many other parties involved in setting self-insured plan costs.

We note that under the PPACA carriers offering qualified health plans to individuals and small groups, both on-exchange and off-exchange, are required to use single risk pool rating in setting rates for the various metallic plan options they offer. This approach is appropriate both for issuers of qualified health plans and for employers sponsoring self-insured programs with multiple benefit options.

We anticipate that future guidance will explicitly allow the continuation of single risk pool rating when multiple self-insured options are offered to the same employee population. This ensures continuity of a long-standing practice within the group insurance market, one that is embedded in federal rules on qualified health plans under the ACA, and one that successfully helps employers develop overall budget rates and employee contributions that are fair and equitable on plan-by-plan basis.

Self-Insured Cost Projection Methods for Plans Offered to Different Employee Groups

Many employers offer different self-insured programs to different subsets of employees, for example salaried and hourly employees. Programs may differ in terms of vendor, plan design, total cost, contribution levels and underlying population risk. These varying program terms are generally based on bona fide business needs. If multiple options are offered to different employee groups, the employer may use a single risk pool rating approach for each separate population cohort. For example, a multiple option program offered to salaried employees would constitute one risk pool while a separate multiple option program offered to hourly employees may (or may not) constitute a separate risk pool.

We recommend that future guidance enable employers to continue making these bona fide business distinctions in determining how to rate unique plan options offered to different population groups. We also support guidance that allows some latitude for employers to determine the rating approaches which work best for their particular circumstances and health care benefit program configuration. Broad-based rules with a requirement for an actuarial attestation could be a feasible approach to balance the objectives of the statute and the regulations against the existing practices in place within the group insurance market.

IV-C.2.c. Past Cost Method

In case the Past Cost Method (PCM) approach is determined to be an allowable option, which we do not recommend, we offer the following comments. Please provide further guidance on the operation of the PCM in areas including conditions under which an employer could choose to use this method instead of the ABM, what options exist for selecting a determination period, the adjustments that can apply to reflect medical cost inflation, and the conditions under which an employer could no longer use the PCM approach (based on changes to the covered group or to the coverage under the plan). In addition, we request that future guidance specify which additional costs are includible in computing costs under the PCM, such as premiums for stop-loss insurance, third party administrative expenses and reasonable overhead expenses incurred by the employer in the operation of the plan. We advise allowing employers to select whether to count claims during the determination period on either an incurred basis or a paid basis, depending on the availability and timeliness of data under the different bases.

We note that most large employers with whom we work elect to make some changes to their health care benefit program each year, and for many employers there are shifts in their covered populations annually as well, often due to merger, acquisition and divestiture activities. We are concerned that the PCM approach, which may be advantageous to the employer from the standpoint of Section 4980I excise tax obligation compared to costs determined under the ABM approach, would not in fact be available to the majority of employers who in fact make changes to their plans each year. Few employers have the ability to "stand pat" on their health care benefits each year, thus the restrictions on use of the PCM approach could render the choice illusory for most employers.

IV-C.3. HRAs

Notice 2015-16 indicates that future guidance will define an HRA as applicable coverage under Section 4980I. We note that there are a variety of approaches for the design and operation of an HRA. Under one common approach, the HRA is integrated with an underlying medical benefit plan that is typically a high deductible plan. Under this type of plan, often known as a consumer driven health plan, certain claims incurred under the plan are withdrawn automatically from the HRA without intercession by the employee. For an HRA of this type, we believe that the cost method outlined in the Notice based on a projection of actual claim payments plus administration fees is the most appropriate method. HRAs are generally unfunded and therefore no actual employer payment is made until a claim is processed. With this in mind, we believe that an ABM rating approach is most appropriate for this type of HRA. A cost approach based on employer credits to this type of an HRA (as opposed to claims paid) would misstate cost since HRA credits are typically subject to forfeiture in certain circumstances and are not necessarily used in the year of crediting since unused balances are then carried forward to the subsequent year.

Many large employers use HRAs in different forms than the consumer driven plan approach outlined above. For example, an HRA is often part of a retiree medical program (most commonly for retirees on Medicare) under which the employer has ceased sponsorship of a traditional group benefit plan and instead provides a subsidy through the HRA for use in reimbursing eligible premiums and out-of-pocket expenses for individual insurance coverage purchased by the Medicare retiree. In this type of program, the HRA is structured as part of a benefit plan with fewer than two active participants and, as such, is not subject to certain market reform requirements under the PPACA that would otherwise prevent the offering of this type of arrangement (we know that offering a stand-alone HRA for use by active employees to purchase other coverage would not be in compliance with the PPACA's market reforms).

With the opening of the ACA exchanges in 2014, some employers have similarly structured a standalone HRA to reimburse premiums for PPACA qualified plans for their pre-65 retirees.

We request additional guidance on the treatment under Section 4980I of standalone HRAs used to fund certain retiree health care expenses where the HRA is structured legally as a plan with fewer than two active participants (and thus not subject to the ACA market reforms). Under this type of plan, we assume that the projected average level of HRA funds used (i.e., amounts withdrawn from the HRA) would represent includible cost for purposes of Section 4980I. Please confirm that the cost of the individual (non-group) coverage purchased with HRA funds would not be reflected in the cost of the employer provided HRA.

We also request guidance relating to standalone retiree-only HRAs and Section 4980I(d)(2)(A) which provides that a plan may elect to treat a retiree under age 65 and a retiree age 65 or older as similarly situated beneficiaries. In particular, if cost blending is allowed under the provision, please provide guidance on whether that option will extend to employers who, for example, may still sponsor a traditional group retiree medical plan for pre-65 retirees but offer a standalone retiree-only HRA for Medicare retirees. Please also provide guidance on whether blending of costs, if allowed, would be available to employers who provide a standalone retiree-only HRA to both pre-65 and Medicare retirees (and do not sponsor a traditional employer group plan for eligible retirees).

IV-D. Determination Period

Notice 2015-16 indicates that cost for purposes of Section 4980I may be determined on a prospective basis, as is required for cost under COBRA. Comments are requested on whether an approach based on actual self-insured plan costs, determined after the end of the applicable plan year, could be used in lieu

of prospective cost development under Section 4980I. We discourage consideration of this approach as it introduces a level of variability, unpredictability and administrative burden as compared to a prospective cost determination method. Accordingly, we request that future guidance focus only on prospective cost determination methods.

V: Applicable Dollar Limit

V-B. Potential Approach for Application of Dollar Limit to Employees with both Self-Only and Other-Than-Self-Only Applicable Coverage

The Notice outlines a situation under which an employee may simultaneously have both Self-Only (SO) and Other-Than-Self-Only (OTSO) coverage. This could occur if an employee elects SO medical coverage and also has access to an HRA that covers other family members. It seems that this could also apply to an employee in SO medical who elects a health care flexible spending account or a Health Savings Account that would reimburse eligible expenses for other family members. In addition, although this is rare, some employers allow separate elections of medical and pharmacy coverage, in which case an employee might elect SO medical and OTSO pharmacy coverage, or vice versa.

The Notice suggests potential use of either a "majority cost" rule or a pro ration approach. We believe that a majority cost approach would produce a more equitable and easier to administer result for employers. In the most common situation where an employee elects SO medical and also has access to an HRA, FSA or HSA which can cover expenses for family members, the value of the HRA, FSA or HSA is generally the smaller part of the total value. In addition, since these accounts can cover expenses for any family member, allocating the value of the account by an otherwise-unnecessary calculation of account value by its SO and OTSO components would be administratively burdensome.

V-C.1. Adjustments for Qualified Retirees

Comments are requested on how employers determine ineligibility for Medicare. In our experience, it is more common for employers to determine when eligibility for Medicare begins, whether before age 65 due to disability or at age 65, or later, in case of Medicare eligibility due to age. We request that future proposed regulations provide more guidance on how employers will determine status as a qualified retiree and how costs will be determined under the "similarly situated beneficiary" standard outlined under Notice section IV-A.2.

V.C.2. Adjustments for High-Risk Professions

Comments are invited on how an employer would determine whether a majority of its employees covered by a plan are engaged in a high-risk occupation. We suggest that a simple majority (over 50% of the entire workforce) be used as the basis for determining whether that plan qualifies for the higher thresholds. We request that future guidance provide explicit rules on whether this majority measure would apply at the level of the employer controlled group or at the level of the PPACA Applicable Large Employer Member within the controlled group. Numerical examples would be very helpful in illustrating how these rules would operate.

V.C.3. Age and Gender Adjustments

We request confirmation that age and gender adjustments would only work to raise, and not lower, the applicable cost thresholds. We also wish to confirm whether employers will be able to make age and gender adjustments at the level of each unique benefit package. We advise allowing this determination at the benefit package level to recognize the differing demographic characteristics by plan. Data from the Bureau of Labor Statistics, coupled with an industry accepted age/gender morbidity factor table, could be combined to provide threshold adjustment factors. An example of such an approach is provided below:

ABC Employer
All Active Participants

	Age/Gender Actuarial Factor		**BLS Counts (in 000s)**		*All Employer Active Participants*			
					Self-Only		*Other-Than-Self-Only*	
	Male	Female	Male	Female	Male	Female	Male	Female
16 to 19 years	0.33	0.74	2,222	2,326	-	-	-	-
20 to 24 years	0.33	0.74	7,187	6,707	22	13	4	
25 to 29 years	0.33	0.74	8,487	7,382	211	124	83	7
30 to 34 years	0.46	0.95	8,807	7,300	236	171	248	81
35 to 39 years	0.58	0.95	8,230	6,914	180	92	371	126
40 to 44 years	0.70	1.02	8,504	7,318	131	68	492	104
45 to 49 years	0.95	1.14	8,407	7,483	131	69	529	131
50 to 54 years	1.18	1.39	8,711	7,955	164	116	540	133
55 to 59 years	1.60	1.55	7,535	6,980	200	137	534	131
60 to 64 years	2.04	1.84	5,226	4,654	163	71	345	55
65 to 69 years	2.25	1.96	2,445	2,101	27	10	73	6
70 to 74 years	2.45	2.09	1,102	872	5	3	5	2
75 years and over	2.45	2.09	830	621	-	-	2	-
Total			77,693	68,613	1,470	874	3,226	776
Average Factor			1.032		1.046		1.134	
Threshold Adjustment Factor					1.013		1.099	
2018 Threshold			Unadjusted					
Single			$10,200		$10,334			
Family			$27,500		$30,221			

Closing

Thank you for inviting comments on Notice 2015-16. We look forward to the release of future regulatory and sub-regulatory guidance on this issue of immense importance to our clients as they continue to evaluate their health care benefit offerings in light of this substantial new tax.

Very truly yours,

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