

Notice 2015-16

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May 15, 2015

CC: PA: LPD: PR
Notice 2015-16
Internal Revenue Service
U.S. Department of the Treasury
Room 5203
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Comments on Excise Tax on High Cost Employer-Sponsored Health Coverage – Exclusion of Self-Insured Dental Benefits

To Whom It May Concern:

I am writing in response to the invitation for comments included in Notice 2015-16, guidance on “Section 4980I - Excise Tax on High Cost Employer-Sponsored Health Coverage”. *IRB 2015-10* at 732. In particular, I am writing about a new wraparound excepted benefits coverage that is offered as a “group health plan” arrangement and that it would be considered an “excess benefit” under the excise tax on high cost employer-provided health coverage.

The excise tax is imposed on “excess benefits” provided by any applicable employer-sponsored group health plan coverage. The benefits subject to the excise tax are all of the group health plan benefits that are excludable from the employee’s gross income. In calculating the “excess benefits” subject to the tax exception is expressly provided only for: accident and disability insurance; long term care insurance; dental insurance; and insurance for specified disease or illness, and hospital indemnity or other fixed indemnity insurance that is purchased by individuals with after-tax dollars. See, *Internal Revenue Code*, section 4980I(d)(1)(B).

There is no exclusion for this new wraparound excepted benefit coverage. As a result it would be part of the calculation in determining whether an employer-sponsored group health plan had “excess benefits” that are subject to the excise tax. The Congress expressly excepted the two principle “limited benefit” excepted benefits for long-term care and dental or vision coverage. This excise tax on high-cost employer sponsored health coverage includes group health plans offered by an employer or an employee organization, and so would include collectively bargained group health plans that would offer wraparound excepted benefits.

* * * * *

In conclusion, new wraparound excepted benefits coverage that is offered as a "group health plan" arrangement and that it would be considered an "excess benefit" under the excise tax on high cost employer-provided health coverage . I very much appreciate the agency's consideration of these comments and request the agency to expressly address wraparound excepted benefits in any rulemaking.

Sincerely,

A handwritten signature in black ink, appearing to read "W. G. Schiffbauer", with a long horizontal flourish extending to the right.

William G. Schiffbauer, Esq.

**SCHIFFBAUER LAW OFFICE COMMENTS ON
GUIDANCE CONCERNING FUTURE PROPOSED REGULATIONS REGARDING THE EXCISE
TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE
UNDER SECTION 4980I AND THE TREATMENT OF NEW WRAPAROUND EXCEPTED BENEFIT
TYPE OF LIMITED EXCEPTED BENEFIT COVERAGE**

On March 18, 2015, the three federal departments with joint jurisdiction over the ACA issued final regulations to establish a new excepted benefit type entitled “wraparound” excepted benefits in the group market. It is intended to permit employers to provide employees with overall coverage that is comparable to the employer’s group health plan in combined with individual health insurance purchased by the employee. This new excepted benefit was proposed under authority to specify in regulation “such other similar, limited benefits” that are comparable to “limited scope dental or vision benefits” and “benefits for long-term care”.

The “limited benefits” category of excepted benefits generally consists of coverage for a single kind of “condition” that is “stand-alone” and limited in scope, and is separate and distinct (i.e., “not an integral part” of) from an employer’s group health plan. The new wraparound excepted benefits coverage: (1) differs significantly from the coverage excepted under this category of excepted benefit because it is not limited in scope; and (2) is an integral part of an employer’s group health plan because it is specifically designed to “wraparound” employer-sponsored major medical health insurance coverage.

Wraparound is Not a Limited Benefit

The authority to specify in regulation such “other” limited benefits in this category of excepted benefits is not unrestricted. The statutory language limits these “other” regulatory created excepted benefits to those that are “similar” to those already established by statute in this category by the Congress. The benefits established in the statute consists of coverage for a single kind of “condition” that is “stand-alone” and limited in scope: limited scope dental or vision benefits; long-term care; nursing home care; home health care; and community-based care. See Public Health Service Act section 2791(c)(2)(C)(the “(c)(2)” category).

To be “similar” as the express statutory language directs, we must determine the characteristic that is in common and in conformity to the meaning of “limited benefit”. The common trait of limited scope dental and vision is that they provide benefits for “only” items and services required to treat conditions of the mouth or eyes; and long-term care, nursing home, home health, and community based care all share the common trait of providing benefits for “only” non-medical items and services required to treat a chronic or disabling condition. See, *Washington State Department of Social and Health Services v. Guardianship Estate of Keffeler*, 537 U.S. 371, 384 (2003) (general words are construed to embrace only objects similar in nature to those objects enumerated by the preceding specific words).

The new wraparound excepted benefit is not for a single kind of “condition” as these other types of coverage in this category of excepted benefits. Rather than a single “condition” the wraparound coverage may include a significant variety of supplemental medical benefits such as expanded in-network medical clinics or health care providers, or benefits that are not included in the essential health benefits and that are not covered under the individual health insurance of the enrolled employee. None of these kinds of benefits are for a single “condition” such as a dental condition, a vision condition, or a chronic long-term care condition.

In addition, the premium value of this new wraparound excepted benefit is “limited” in amount to no more than \$2,500 on an annual basis. However, simply limiting the annual cost per employee of this proposed coverage does not make it a “limited benefit”. This is significantly more in premium than the annual cost of a limited scope dental or vision plan, by comparison. A stand-alone dental benefit plan can range in annual premiums from \$300 to \$600. See, *MetLife Federal Dental Plan* (2015).

It is the “benefit” that must be limited in order to be “similar” to the limited single “condition” coverage types like limited scope dental and vision, or long-term care, as examples. An annual premium of \$2,500 per year allowed for this new wraparound coverage can purchase a major medical high-deductible health insurance plan, or a bronze “metal level” health insurance plan offered in the individual market. The bronze level health insurance plan is estimated to have an “average” annual premium of \$3,180, so there may be lower cost plans available near the “limited amount” condition proposed for the wraparound coverage. See ASPE Research Brief, *Health Plan Choice and Premiums in the 2015 Health Insurance Marketplace* (January 8, 2015 update).

Calling the annual premium a “limited amount” does not satisfy the statutory requirement for a “similar” benefit to be classified as a “limited benefit” for purposes of this category of excepted benefits.

Wraparound is Integral to a Group Health Plan

The statutory condition that such excepted benefits are “otherwise not an integral part” of the group health plan defeats the inclusion of this “wraparound” coverage under the “(c)(2)” limited benefits category of excepted benefits. The “(c)(2)” excepted benefits are “stand-alone” benefits and do not expressly “supplement” the necessary benefits of the primary health insurance coverage but are additional and elective. Yet, the very purpose of the proposed “wraparound” coverage is “integral” to the “unaffordable” primary employer group plan and is designed to maintain the level of the employer’s primary health benefits offered to employees. See, *Internal Revenue Code*, section 9831(c)(1)(B); *ERISA*, section 1191a(c)(1)(B); and *Public Health Service Act*, section 300gg-21(c)(1)(B).

While the phrase “not integral” is undefined in the statute for this new wraparound coverage, the plain meaning of “integral” is “a part or component necessary to complete the whole”. To be “not integral” as the statute requires would mean that the proposed “wraparound” excepted benefit be separate from the group health plan and that neither the benefits nor administration of the group health plan and the wraparound excepted benefits coverage would be considered together as “component parts” necessary to complete the plan sponsor’s “whole” group health plan coverage.

This new wraparound coverage was described in the proposed rule as a benefit design “intended to allow a plan sponsor to pursue ‘equity in coverage’ by maintaining a comparable level of benefits for enrollees. See, Preamble Background, 79 *Fed. Reg.* 76931, 76934. It was further described as coverage that plan sponsors could offer “through a group health plan” that wraps around individual insurance of the plan sponsor’s employees. See, Preamble Economic Impact, 79 *Fed. Reg.* 76931, 76937. As described by the Departments in the proposed rule, the wraparound coverage is “integral” in its purpose and so fails to meet the “not integral” test.

In the proposed rule, the Departments noted that the employer’s annual contributions for both its primary and wraparound coverage must be “substantial” to satisfy the employer responsibility requirements. See, Preamble Economic Impact, 79 *Fed. Reg.* 76931, 76938. The Departments considered the combination of the primary coverage and the wraparound excepted benefits coverage together as the total “group health plan”.

Accordingly, by the Departments' own analysis and description, the wraparound coverage is an "integral" component of the group health plan arrangement and so fails to meet the "not integral" test to be a "limited" excepted benefit.

The Departments also noted that one effect of giving some plan sponsors the "choice" of wraparound excepted benefit coverage is that they may choose to increase the affordability of their primary coverage rather than to offer limited wraparound coverage. The Departments also noted that some plan sponsors may not be in a financial position to make their primary health plans affordable or to contribute to wraparound coverage. The Departments expressly sought comment on the extent that premiums for comprehensive health coverage would or would not change in the presence or absence of the proposed wraparound excepted benefits coverage. See, Preamble, Economic Impact, 79 *Fed. Reg.* 76931, 76938.

These statements and requests for comment by the Departments demonstrate clearly that the new wraparound excepted benefits coverage is a component of the whole group health plan, and so is integral to the group health plan offered by the plan sponsor. The statute, however, requires that limited benefit excepted benefits are "not integral" to a group health plan.

Excise Tax on High Cost Employer-Sponsored Coverage

The Departments had also requested comment in the proposed rule on whether this wraparound excepted benefit would "increase employers' propensity to provide health insurance" and "to what extent, if any, this proposed regulation could affect plan sponsors' decision making." As highlighted by this Notice 2015-16, importantly, for taxable years beginning after December 31, 2017, there is imposed an excise tax on "high cost" employer sponsored health coverage. See, *Internal Revenue Code*, section 4980I. The new wraparound excepted benefits coverage is offered as a "group health plan" and so would be considered an "excess benefit" under the new excise tax.

The tax is imposed on "excess benefits" provided by any applicable employer-sponsored group health plan coverage. The benefits subject to the excise tax are all of the group health plan benefits that are excludable from the employee's gross income. In calculating the "excess benefits" subject to the tax exception is expressly provided only for: accident and disability insurance; long term care insurance; dental insurance; and insurance for specified disease or illness, and hospital indemnity or other fixed indemnity insurance that is purchased by individuals with after-tax dollars. See, *Internal Revenue Code*, section 4980I(d)(1)(B).

There is no explicit exclusion listed for this new wraparound excepted benefit coverage. As a result it would be part of the calculation in determining whether an employer-sponsored group health plan had "excess benefits" that are subject to the excise tax. The Congress excepted only the two principle "limited benefit" excepted benefits for long-term care and dental or vision coverage. This excise tax on high-cost employer sponsored health coverage includes group health plans offered by an employer or an employee organization, and so would include collectively bargained group health plans and the new wraparound excepted benefits offered in connection with these health plans.

Conclusion

The new "wraparound" excepted benefit is in conflict with the statutory authority for this type of "limited" excepted benefit. This is because the new wraparound excepted benefits coverage: (1) differs significantly from the coverage excepted under this category of excepted benefit because it is not limited in scope; and (2) is an

integral part of an employer's group health plan because it is specifically designed to "wraparound" employer-sponsored major medical health insurance coverage. In addition, the new wraparound excepted benefit coverage would contribute towards "excess benefits" subject to the excise tax on so-called high-cost employer health coverage.
