

Notice 2015-16

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Submitted Electronically via Email: Notice.comments@irs.counsel.treas.gov

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

***RE: Section 4980I – Excise Tax on High Cost Employer-Sponsored Health Coverage
(Notice 2015-16)***

To Whom It May Concern:

The U.S. Chamber of Commerce (the “Chamber”) submits these comments in response to Notice 2015-16 which describes potential approaches with regard to a number of issues under §4980I of the Internal Revenue Code, as added by §9001 of the Patient Protection and Affordable Care Act and amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the “Affordable Care Act” or “ACA”).¹ The Notice invites comments on these potential approaches which, according to the Notice, could be incorporated in future proposed regulations. This Notice was released by the Department of the Treasury (“Treasury”) and the Internal Revenue Service (“IRS”).

The Chamber is the world’s largest business federation, representing the interests of more than three million businesses and organizations of every size, sector and region, with substantial membership in all 50 states. More than 96 percent of the Chamber’s members are small businesses with 100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the nation’s largest companies are also active members. Therefore, we are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large. Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business – manufacturing, retailing, services, construction, wholesaling, and finance – is represented. These comments have been developed with the input of member companies with an interest in improving the health care system.

¹ The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (2010).

OVERVIEW

First and foremost, the Chamber appreciates the careful and collaborative process that the Treasury and IRS seem to be taking as they promulgate rules to implement the Internal Revenue Code's §49801. We appreciate both the opportunity to comment on this initial Notice, as well as the indication that a second notice will be issued in the future after which comments will be reviewed before a subsequent Proposed Rule is put forth. We understand the challenges that the Administration faces given some of the statutory language in this provision as added by the ACA's §9001, but urge the regulators to strongly consider and evaluate the inconsistencies in terminology within this provision, as well as the inconsistencies in overall ACA policy that may result without additional flexibility and safe-harbors. We urge Treasury and the IRS to cautiously deliberate on the following general concerns and carefully explore ways to alleviate them. We also urge Treasury and the IRS to consider our recommendations in greater specificity to provide critical flexibility for employers and to protect the dual goals of expanding meaningful health care coverage and access to health care services.

GENERAL CONCERNS

The Chamber is concerned that the Excise Tax will have sweeping and unanticipated adverse impacts on plan designs that Congress likely did not believe were either high cost or overly generous, including high deductible health plans offered with health savings accounts (HSAs), as well as minimum essential coverage that employers are required to offer under §4980H of the ACA. We urge Treasury and the IRS to carefully promulgate rules that only impose the tax on the plans that Congress intended – the excessively generous group health plans – and not group health plans that merely provide the minimum required level of coverage. To better explore which plans Congress intended to tax it is worth noting that as the law was being enacted, an analysis by the Joint Committee on Taxation estimated that only a small subset of plans would be affected by the tax. Instead, roughly 30 percent of all employers will be subject to the tax in 2018 and between 50-60 percent will be hit in 2022.²

With this in mind, we urge Treasury and the IRS to consider how to advance the underlying policy goals of the law and provide consistency as to what the law is attempting to encourage employers to do – offer minimum essential coverage. The opening sentences of the provision suggest this approach in order to only subject an “excess benefit” to the tax. How can any group health coverage that is merely satisfying the minimum coverage requirements be scrutinized as an “excess benefit” and taxable?

The Chamber urges Treasury and the IRS to promulgate rules that:

- Protect the employer-sponsored system by creating a safe harbor to exempt any group health plans that meet the minimum essential coverage requirement from the Excise Tax;
- Provide certainty to employers so that, as with the Shared Responsibility Requirement, they can avoid this tax penalty; and

² See Mercer Press Release, *National Survey of Employer-Sponsored Health Plans*, Nov. 19, 2014, available at <http://www.mercer.com/content/mercerglobal/all/en/newsroom/modest-health-benefit-cost-growth-continues-as-consumerism-kicks-into-high-gear.html#>.

- Properly define “health coverage” by excluding all benefits that are either offered separately or could be offered separately from major medical coverage.

The Chamber offers several specific and technical recommendations to further inform Treasury and the IRS in order to: appropriately alleviate these general concerns; further advance the overarching goals of the ACA; fulfill the assurance that the ACA will build on (and not dismantle) the employer-sponsored system; and, as promised, permit people to keep the plans they have if they like them.

SPECIFIC RECOMMENDATIONS

1. SAFE HARBOR TO EXEMPT MINIMUM VALUE COVERAGE

The Treasury and IRS should establish a safe harbor to assure employers that are complying with the shared responsibility requirements in Code §4980H and offering minimum value coverage, in order to avoid facing a “free-rider” penalty, that such compliance with this tax provision will not then trigger another tax liability for offering “excess benefits.” The Chamber recommends that Treasury and the IRS exempt employers that offer a plan that covers the minimum benefits including preventive services required to avoid triggering a §4980H tax from the Excise Tax.

Under §4980H(a), an “applicable large employer [that] fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage” may be subject to a significant tax. Further, under §4980H(b) and §36B, the ACA stipulates that for applicable large employers to avoid a secondary tax penalty, the minimum essential coverage offered to all full-time employees must be both affordable and provide “minimum value.” The statute further explains what constitutes minimum value in §36B(2)(C)(ii) and sets the floor at 60% actuarial value.³ This value also corresponds with the lowest cost option offered in the small group market. Additionally, under §2713, all group health plans must also provide coverage of preventive services with no cost-sharing, perhaps in recognition of the contribution that prevention makes to health care efficiency. These services include screenings for cancer and many other medical conditions, a wide range of immunizations, and tobacco cessation counseling and interventions, among others.

These minimum levels of coverage were floors set by the ACA as to what health care coverage must constitute in the small group and employer-sponsored arenas. In setting this floor, the ACA set minimum levels for health coverage and insurance under the auspices of ensuring that individuals purchasing health care coverage would have access to health care services. Unless this safe harbor is created, employers and issuers complying with these base level coverage requirements will be taxed due to the provision’s inconsistencies and poor indexing.

Therefore, it is critical to create a safe harbor exempting all employer-sponsored plans that are merely offering the minimum required coverage for a variety of reasons. First, failure to exempt these plans would mean that, due to the inadequate indexing methodology, all employers

³ (ii) Coverage must provide minimum value. Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan’s share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

offering coverage will at some time in the future (and depending on geographic location, sooner for many) be placed in the position of not being able to offer satisfactory coverage for purposes of the employer shared responsibility requirements without triggering a corresponding Excise Tax liability under Code §4980I. Any effort to reduce a plan's costs for purposes of Code §4980I has a corresponding adverse effect of negatively affecting a plan's minimum value status. It would be inconsistent to require that employers provide such benefits and then effectively penalize them when these mandated benefits and coverage levels drive plan spending above the Excise Tax thresholds. Certainly this dilemma could not have been intended by Congress, nor does it seem appropriate from the perspective of tax equity.

To ensure that employers are able to continue to comply with their employer shared responsibility requirements without fear of triggering a Code §4980I Excise Tax, we urge Treasury and the IRS to promulgate a safe-harbor rule that would exempt employers that offer plans with minimum value status from Excise Tax liability.

2. ASSESS COVERAGE BASED ON PLANS OFFERED, NOT PLANS ELECTED

In addition to creating a safe harbor, the Chamber urges Treasury and the IRS to interpret the provision to revolve around the coverage offered by an employer. Just as the shared responsibility requirement and related taxes under §4980H(a) and §4980H(b), this tax was intended to be a tax that employers could avoid. Just as the provisions in §4980H(a) and §4980H(b) focus on the employers' requirement *to offer* the requisite coverage, this provision can also be read to suggest that the Excise Tax could be assessed based on the coverage offered or made available to the employee, rather than the plan into which an employee enrolled.

Specifically, Code §4980I(b)(1) defines "excess benefit" with respect to "coverage made available" to an employee. Similarly, Code §4980I(d)(1)(A) defines "applicable employer-sponsored coverage" to mean "coverage under any group health plan made available" to an employee which is (or would be) excludable under Code §106. Lastly, Code §4980I(b)(3)(B) provides that the annual limitation that applies to an individual for a month is determined based on the type of coverage "provided" to the employee. Given the language contained in Code subsections (b)(1) and (d)(1)(A), this reference to "provided" coverage could certainly be construed to mean the coverage that is offered or otherwise made available to the employee.

In addition to the argument in favor of consistency (i.e. that all ACA provisions involving an employer's coverage requirement hinge on an avoidable tax assessed on the coverage offered), we also believe there are very real and practical reasons to interpret the provision this way. Requiring employers to look to the plans that employees actually enroll in would ultimately require individual calculations for each employee, which results in a very convoluted calculation of the cost of coverage across an employee population. Such individual calculations would result in significant expenditures of time and money.

Further, evaluating liability based only on the coverage in which employees enroll will ironically encourage employers to only offer plans that best mitigate their tax exposure. Instead of offering multiple plan options or multiple benefit packages that would allow employees greater choice, as many historically have, employers will likely simplify and streamline a plan offering to avoid the tax exposure that they would risk with such employee choice.

For a variety of reasons, including administrative simplification, statutory consistency, and good

policy, we urge Treasury and the IRS to use the sufficient statutory authority it is given, as well as the administrative discretion it is afforded, in order to alleviate these very important concerns. By determining the employer's Excise Tax liability based on the coverage that is offered to (and not merely enrolled in by) an employee, employers would be permitted to utilize a simpler methodology for determining any Excise Tax liability and employees would be able to continue to benefit from a variety of plan offerings.

3. APPROPRIATE DEFINITION OF HEALTH COVERAGE

Employers offer a variety of additional benefits that are outside of the employer's benefit plan to supplement or facilitate the employee's ability to finance major medical coverage and the benefits it covers. Many of these benefits are not part of major medical coverage and in many instances, are offered or purchased separately. It is inappropriate to include these supplemental or excepted benefits when evaluating the health coverage offered by an employer for purposes of the Excise Tax. In addition to exempted benefits, as well as disease specific and hospital indemnity coverage, there are five general categories of benefits (employee assistance programs, wellness programs, on-site clinics, dental and vision coverage, and tax preferred accounts or financing arrangements funded by the employee) that do not constitute major medical coverage and should therefore be excluded from the Excise Tax's coverage determination.

A. Employee Assistance Programs Should Be Exempt

As the Notice suggests, the Chamber supports the exclusion of employee assistance programs ("EAPs") that qualify as excepted benefits from the definition of "applicable employer-sponsored coverage." The majority of EAPs typically do not: (i) provide significant benefits in the nature of medical care; (ii) coordinate benefits with any other group health plan, or; (iii) charge any employee premium or employee contribution. These types of EAPs, by definition, cannot provide significant medical care. Additionally, the costs of determining the value of any minimal medical care provided by the EAP would be time-consuming and likely would result in significant financial expense - both of which would likely lead many employers to stop offering these programs.

B. Employer Workplace Wellness Programs Should Be Excluded

The Chamber urges Treasury and the IRS to exclude employer activities aimed at improving health outcomes, including wellness programs, from the definition of "applicable employer-sponsored coverage." These activities and programs are designed to help improve employee health and given that the purported goal of the Excise Tax is to reduce unnecessary utilization and costs, it seems inconsistent to include workplace wellness programs when evaluating coverage for purposes of this tax.

In addition to general policy reasons, it is worth noting the numerous incentives that the ACA created to encourage employers to continue to provide these programs, most notably §2705 (j)(3) of the Public Health Service Act ("PHSA"), as added by ACA's §1201. This provision permits premium variation in certain instances to encourage participation in these workplace wellness programs and further, §10408 permits the Secretary to award grants for small businesses to provide comprehensive workplace wellness programs. These programs are popular among employees and have been widely adopted by employers. Roughly 98 percent of large employers (those with 200 or more workers) and 73 percent of smaller employers (those with between 3 and

199 workers) offer at least one wellness program.⁴

Given the shared goals and value of these programs, the Chamber recommends that Treasury and the IRS include a broad exception for any plan, arrangement, or other activity that is intended to improve the general health, well-being or health outcomes of participants. The activities listed above should be excluded for purposes of the Excise Tax.

In addition to these policy reasons, we believe that Treasury and the IRS can also rely on the fact that the Department of Health and Human Services (“HHS”) adopted a similar approach in the Medical Loss Ratio (“MLR”) rules of §2718 of the PHSA. Under §2718, a minimum percentage of the premium charged with respect to individual and group insurance coverage must be utilized for the provision of benefits. However, for purposes of PHSA §2718, expenditures for activities that improve health care quality are excluded from the denominator as part of the MLR calculation. “Activities that improve health care quality” were construed by the agencies to mean, *inter alia*, “activities designed to implement, promote, and increase wellness and health activities,” including “(1) wellness assessments;[and] (2) wellness/lifestyle coaching programs designed to achieve specific and measurable improvements”

In the interest of consistency, we urge Treasury and the IRS to adopt a similar rule with respect to Code §4980I to exclude plans, arrangements, or benefits that are intended to improve health outcomes. This interpretation is generally supported by Congress’s intentions in enacting the ACA and is supported by good policy.

C. On-Site and Near-Site Clinics Should Be Excluded

The Chamber urges the Treasury and IRS to exclude on-site and near-site clinics from the calculation for purposes of the Excise Tax, provided that they do not provide major medical care on a continuous basis. On-site and near-site clinics that provide *de minimis* medical care, including immunizations, injections of antigens provided by the employees, provisions of a variety of aspirin and non-prescription pain relievers, and the treatment of injuries caused by accidents at work.

A growing number of employers have established on-site or near-site clinics for their employees. Generally, the scope of these clinics vary depending on the workforce, the company and the nature or risks of the work being done on-site. Some manufacturers have more extensive sites to treat machine-related injuries while others provide more *de minimis* services. Many employers have added services to their clinics because they have realized that they may be better able to reduce costs through providing certain services to their employees during working hours (such as flu shots). Again, given that the goal of the Excise Tax is to reduce unnecessary costs and over-utilization, it seems inconsistent to include any clinics that do not continuously provide major medical services to employees at no cost.

The Notice requests comments as to whether such clinics should be excluded from applicable employer-sponsored coverage, while acknowledging that when Congress enacted Code §4980I,

⁴ Kaiser Family Foundation, *Employer Health Benefits: 2014 Annual Survey*. 2014, The Kaiser Family Foundation, Menlo Park, CA; Health Research & Educational Trust, Chicago IL.

it appeared to pull in certain on-site clinics. However, as also stated in the Notice, the Joint Committee on Taxation (“JCT”) indicated in its technical explanation that Congress did not intend to subject on-site clinics providing only de minimis medical care to the Excise Tax. The Chamber urges the Treasury and IRS to measure the standard of de minimis against group health plans generally. Most on-site clinics do not provide comprehensive major medical benefits. Therefore, we urge the Treasury and IRS to exclude on-site and near-site clinics from the Excise Tax.

D. Dental and Vision Coverage Should be Excluded

The Chamber urges the Treasury and IRS to exclude both insured and self-funded limited-scope dental and vision coverage from the definition of “applicable employer-sponsored coverage.” In order to consistently implement the language which explicitly excludes “any coverage under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye,” this type of coverage should be excluded regardless of how it is administered. There is no policy reason to treat self-funded coverage differently from insured coverage and to do so would only result in employers restructuring the administration of their dental and vision benefits. This will do nothing to reduce costs or over-utilization and in fact, it will add administrative costs to the system overall.

E. HSAs and Archer MSAs Should Be Excluded

The Notice states that Treasury and the IRS anticipate future proposed regulations providing that (1) employer contributions to HSAs and Archer MSAs, including salary reduction contributions to HSAs, are included in applicable coverage and (2) employee after-tax contributions to HSAs and Archer MSAs are excluded from applicable coverage.

Employer contributions to HSAs, including salary reduction contributions, should not be included in determining the cost of applicable coverage unless the HSA is a group health plan. If Treasury and the IRS do not exclude these contributions, they should provide for interim relief (such as a three year non-enforcement safe harbor) in order to assist employers who wish to still offer these services to their employees.

Specifying that applicable coverage will include salary reduction contributions to HSAs will be problematic for many plans. HSAs are vehicles consumers can use to enhance their awareness of the cost of health care and to make them more judicious in spending health care dollars. The goal of HSAs and other similar products is to push health care costs down through provider competition and services selection based on value and quality – goals that are very much in keeping with the policy behind the Excise Tax. Including employee contributions for purposes of the Excise Tax will provide a disincentive to employees wishing to contribute to HSAs and to employers wishing to offer high deductible health plans.

Further, HSA contributions made on an after-tax basis and then deducted under §223 are clearly not included in the statutory definition of applicable coverage. Including pre-tax employee contributions, but excluding contributions made on an after-tax basis and then deducted, is an artificial distinction that only adds more complexity to HSA administration and further discourages their use.

It is also problematic that employer contributions are taken into account for purposes of defining applicable coverage. HSAs are unique vehicles that permit account holders to exercise control over how the funds are used, as opposed to typical health plans where enrollees are only entitled to the benefits under the plan. If employer and employee contributions to HSAs are included in the definition of applicable coverage, HSAs will hit the dollar limit imposed by §4980I whereas plans with smaller deductibles and richer benefits will not. The result of this rule will be that employers will stop offering HSA plans to employees – an outcome that contradicts the purpose of the Excise Tax.

In stating that employer contributions, including salary reduction contributions, to HSAs will be included in applicable coverage, the Notice does not distinguish between HSAs that are group health plans and those that are not. Under the plain language of §4980I(a)(1) and (d)(1), however, the Excise Tax may only be applied to employer-sponsored coverage provided under a group health plan. Treasury and the IRS must clarify that only contributions made to HSAs that qualify as group health plans can be included in the Excise Tax.

HSAs are typically not considered “group health plans.” Rather, HSAs are tax advantaged trust or custodial accounts established and maintained by individuals with an approved trustee or custodian. HSAs belong to the individual account holder, not the employer, and if an employer makes contributions to an employee’s HSA and the employee terminates employment, the employee is generally able to keep those contributions for future use. Funds in an HSA may be used for both medical and non-medical expenses (subject to additional tax).

Treasury and the IRS have not issued formal guidance addressing whether an HSA is a “group health plan” under Code §5000. They have, however, stated in the preamble to the regulations on prohibitions on lifetime and annual dollar limits that “HSAs generally are not treated as group health plans because the amounts available under the plans are available for both medical and nonmedical expenses.” Similar treatment has been accorded by other agencies for purposes of HIPAA Administrative Simplification and COBRA.

It is possible for an HSA to qualify as a group health plan under ERISA. The Department of Labor has issued guidance describing situations in which an employer can cause an HSA to become a group health plan, including when an employer controls investment opportunities or informs employees that the HSA is an employee benefit plan maintained by the employer. The fact that an employer contributes to an HSA has never, on its own, been enough to qualify an HSA as a group health plan.

In light of the language in §4980I(a)(1) and (d)(1) Treasury and the IRS should clarify that only contributions made to an HSA that qualifies as a group health plan will be included in calculating the amount of the Excise Tax. Such clarification would lend meaning to the language in §4980I(a)(1) and (d)(1), which when read together, provide that only group health plans can be subject to the Excise Tax, as well as to the language in §4980I(d)(2)(C) which does seem to contemplate that certain contributions to HSAs should be included in determining the cost of applicable coverage. Making such a clarification will also largely avoid the needless complication, discussed above, of having individuals deduct contributions to an HSA under §223 rather than simply make the contributions on a pre-tax basis.

We believe that Treasury and the IRS have the authority to provide relief for HSAs that are not group health plans even taking into account the statutory language in § 4980I(c) and (d). If

Treasury and the IRS believe that their authority is constrained, however, it would certainly be well within their regulatory authority to create safe harbors for valuing HSA contributions or to provide other limited interim relief.

F. Limited Scope FSAs or HRAs Should Be Excluded

The Chamber urges Treasury and the IRS to exclude limited scope flexible spending accounts (“FSAs”) or limited scope health reimbursement arrangements (“HRAs”) from the Excise Tax. As discussed in the Notice, per the express statutory language of Code §4980I, Congress intended to exclude from the Excise Tax stand-alone dental and vision coverage. Accordingly, any proposed and final rulemaking should also exclude from the scope of the Excise Tax health FSAs or HRAs that only reimburse dental or vision benefits as set forth in Revenue Ruling 2004-45. Such a rule aligns with Congressional intent and will ensure that limited scope dental or vision benefits, regardless of whether provided through an FSA, HRA or otherwise, receive equal treatment under federal tax law.

4. AGGREGATION AND DISAGGREGATION

The complicating ramifications of aggregation and disaggregation rules are tremendous. We urge Treasury and the IRS to afford employers the utmost flexibility when making aggregation and disaggregation decisions and the opportunity to change methodology as they see fit. To the extent that employers may elect, we encourage Treasury and the IRS to permit aggregation based on benefit offerings, regardless of the employee’s age, retirement status and location. To do so would allow employers to combine all employees that are eligible for similar benefit package offerings.

5. DEMOGRAPHIC ADJUSTMENTS

The Chamber also recommends that Treasury and the IRS establish a safe harbor that appropriately adjusts the dollar limit thresholds for employee populations with different demographics than the national average. We believe a safe harbor would mitigate the impact on employers with mature workforces, as well as create a more fair application across the country where the costs for services and coverage vary considerably. The safe harbor should provide for a simple calculation that will not require employers to expend significant resources on an actuarial analysis of their population.

6. ENTITY LIABLE FOR THE TAX

While the provision states that “the person that administers the plan” shall pay the Excise Tax, the Chamber urges Treasury and the IRS to permit employers to pay the tax directly if the employer so chooses. We believe employers who sponsor group health plans subject to the tax, and are ultimately responsible for the calculation, should have the flexibility to remit the tax payments directly to the IRS or to use their third party administrators to remit the tax. This will simplify both the calculation and compliance process, as well as avoid unnecessary costs.

7. TIME TO COMPLY

Although Treasury and the IRS are engaging stakeholders now, there is still a lot of uncertainty for employers. While many employers may be a mere year and a half away from open

enrollment for 2018, others are in the process of negotiating collective bargaining agreements and are doing so without knowing the specifics of how this significant tax provision will be implemented. Regardless of where employers are in evaluating their plan offerings for 2018, they are making decisions NOW to try to mitigate their liability under a tax provision that is still unclear. We implore Treasury and the IRS to take a compliance assistance approach when enforcing the Excise Tax.

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 request that regulations provide a one year period when an employer's good faith efforts to determine and allocate the cost of applicable coverage will avoid the penalties potentially assessed under §4980I(e).

8. REQUISITE ECONOMIC ANALYSIS

When Treasury and the IRS issue proposed rules, as well as when they issue final regulations regarding the Excise Tax, compliance with Executive Orders 12866 and 13563 will require inclusion of a regulatory economic analysis addressing the costs and benefits of the regulation. Regardless of whether the estimates that the annual compliance cost will exceed or be less than \$100 million, Treasury and the IRS will be obligated to publish its analysis and demonstrate the basis for its conclusion. In the past, Treasury and the IRS have dismissed this regulatory analysis obligation by claiming that the cost is under \$100 million. We remind the Treasury and IRS that the \$100 million annual cost threshold applies only to the obligation to submit its analysis to OMB/OIRA for pre-publication review. This threshold does not relieve Treasury and the IRS of the obligation under the Executive Orders to conduct a regulatory economic impact analysis.

As a part of the required regulatory economic impact analysis, the Treasury and IRS must:

- Compare the costs and benefits of alternative regulatory approaches considered. In particular, the Treasury and IRS should examine and present the cost differentials arising from alternative definitions of applicable coverage.
- Recognize in its cost analysis that record keeping, reporting and administrative costs may be imposed on individuals and companies that do not pay the Excise Tax. All potentially affected employers will incur costs to determine and document their tax liability status, even if the liability is none.
- Realize that lack of discretion does not excuse the agency from analyzing costs. Even if the agency believes that a compliance cost is required by the underlying statute, the agency should identify and include the cost in its regulatory economic analysis. Congress and the public depend on the agency's compliance cost analysis to identify cost issues that may need to be considered for legislative mitigation.
- Carefully consider the initial compliance costs of modifying information systems and procedures to facilitate recordkeeping and reporting requirements of the regulation, and consider alternative implementation schedules to mitigate the costs of systems transitions.

CONCLUSION

We urge Treasury and the IRS to continue to work carefully, pragmatically and cooperatively with the numerous stakeholders to minimize burdens placed on employers and to provide flexibility as employers work to comply with the law. We look forward to continuing to work together in the future.

Sincerely,



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