Notice 2015-16

WageWorks

May 14, 2015

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

Re: Notice 2015-16

To Whom It May Concern:

WageWorks, Inc. appreciates the Department of Treasury ("Treasury") and the Internal Revenue Service ("Service")1 issuing Notice 2015-16 in order to provide advance guidance to employers, insurers, and other stakeholders on potential approaches to calculating the Excise Tax on High-Cost Employer-Sponsored Health Coverage ("Excise Tax" or "Tax") under the new Section 4980I of the Internal Revenue Code ("Code").2 We also appreciate the opportunity to provide our comments on the proposed approaches outlined in Notice 2015-16 in advance of rulemaking to implement the Excise Tax.

WageWorks, Inc. is a leading national provider of tax-preferred benefit services to employers, including consumer-directed health care solutions. Our company, the more than 45,000 employers we serve, and the in excess of 4.5 million employees they cover through tax-advantaged accounts are concerned about the impending Excise Tax, the impact the Tax will have on employer-sponsored health coverage generally, and consumer-directed benefit account arrangements specifically.

In short, the Excise Tax threatens the future of the employer-sponsored health system, which currently provides quality and affordable health coverage to close to 160 million Americans. The prospect of paying the Excise Tax – as it is passed through in some form to the employer and its employees – is leading many employers to re-evaluate whether they should continue to offer employer-provided health coverage.

More importantly, the statute currently requires employers to calculate the amount of the Excise Tax due, and also notify the Service and the entities responsible for paying the Tax. This effectively requires the employer to serve as the "assessor" of the Excise Tax, along with the means through which the Service can enforce the Tax. Based on this burdensome requirement, employers are currently asking

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[1] For simplicity, we address or otherwise refer to the Service, rather than both Federal entities.
[2] Section 4980I was added to the Internal Revenue Code ("Code") under the Patient Protection and Affordable Care Act ("ACA"). [*see* Section 9001, Pub. L. No. 111-148, 124 Stat. 119, 848 (2010)].

whether they should simply exit the employer-sponsored health system as an alternative to acting in this capacity.

For those employers who may decide to maintain their employer-sponsored coverage, the uncertainty of the application of the Excise Tax is likely to result in the elimination of an employee's ability to contribute to tax-advantaged accounts as a safety net against high out-of-pocket liability that exists in many employer-provided health plans. While we recognize that many of the defects of the Excise Tax are beyond the scope of the Service's implementation duties, we urge the Service to do everything within its authority to ensure that the Tax is implemented in a way that reduces administrative complexity for employers, and minimizes the impending disruption of the existing employer-based health system. In particular, we respectfully ask the Service to provide flexibility in implementing those aspects of the Excise Tax that are expected to have an adverse impact on consumer-directed benefit account arrangements, including the requirement to include in the calculation of the Tax employee contributions to a health Flexible Spending Arrangement ("Health FSA") and employee contributions to a health savings account ("HSA") made through a Code section 125 cafeteria plan.

The Excise Tax on High-Cost Employer-Sponsored Health Coverage and Its Impact on Employer Behavior

How Is the Excise Tax Impacting Employers Currently Offering Employer-Provided Health Coverage and Those Employees Receiving Such Coverage?

In our opinion, Congress gave the Secretary of Treasury the requisite authority to implement the Excise Tax in a manner that minimizes disruption and provides needed flexibility for employers to continue to offer health benefits to its employees.[3] In the absence of building the necessary flexibility into the calculation of the Excise Tax, this new provision of the law will negatively impact a significant percentage of employer plans. For example, the industry-leading Towers Watson's annual survey found 48 percent of employers' plan offerings are projected to exceed the Excise Tax's dollar thresholds in 2018, and 82 percent could trigger the Tax within the next five years.[4] More conservative estimates suggest more than a third of large employers will trigger the Excise Tax in 2018, and close to 60 percent of these employers will exceed the Excise Tax's dollar thresholds by 2022.[5]

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[3] *See* Code section 4980I(g).

[4] TowersWatson, *2014 Health Care Changes Ahead Survey* (Sept. 2014).. More recent estimates have found that the majority of employer plans will immediately exceed the statutory thresholds in 2018. *See, e.g.*, Segal Consulting, *Practical Research for Multiemployer Plans* (Winter 2014).

[5] American Health Policy Institute, *The Impact the Health Care Excise Tax on U.S. Employees and Employers* (November 2014); *see also*, Mercer, *National Survey of Employer-Sponsored Health Plans* (November 2014).

Leading surveys also indicate that the median cost of health insurance is already approaching – or exceeding – the dollar thresholds set forth in statute. According to the most recent estimates, the average cost of medical and pharmacy coverage for a single employee exceeds $11,000.[6] As a result, these surveys are finding the majority of employer plans will be subject to the Excise Tax within the first few years of its effective date. Far more than Congress anticipated or intended during 2009/2010 health care reform debate and the negotiations leading to the enactment of the Patient Protection and Affordable Care Act ("ACA").[7]

It is important to point out that in 2009, a political decision was made that the Excise Tax should not fall directly on an employee, but rather, the "incidence of tax" should be imposed on (1) the insurance carrier, (2) the administrator of any self-funded benefits, and (3) the employer (in the case of, among other things, employer HSA contributions and employee HSA contributions made through a Code section 125 plan). Virtually every economist – including the Congressional Budget Office ("CBO") and the Joint Committee on Taxation – will explain excise taxes imposed on a particular entity will ultimately be passed through to the consumer.[8] In the case of the Excise Tax, the consumer who will receive the pass-through of the Tax is both the employer offering health coverage, along with the employee actually receiving the health insurance coverage. Thus, in reality, the employer and employee will *indirectly* pay the Excise Tax.

Because the Excise Tax is regressive in nature – and because the Tax will be passed through as described above – employees with lower incomes would actually be hit with a tax penalty as compared to higher-income employees who would still maintain some sort of tax benefit. To illustrate, a highly compensated executive whose marginal tax rate is above 40 percent still receives a tax subsidy on each dollar of coverage exceeding the Excise Tax's thresholds, whereas lower-paid employees with lower tax rates are assessed a tax penalty on each dollar of coverage.[9] This essentially occurs as the Excise Tax is

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[6] Alegeus Technologies, *Understanding the Consumer Directed Healthcare Movement* (2015), http://www.alegeus.com/alegeus-insights/infographics/understanding-the-consumer-directed-healthcare-movement?utm_source=MCOL&utm_medium=email&utm_content=infographic&utm_campaign=media.

[7] During Senate debate, a lead proponent of the provision, Sen. Kent Conrad, explained, "There are very few people in the country who have plans of that [threshold] value today, and there will be very few who will have plans of that value in 2013." [Statement of Senator Kent Conrad, 155 CONG. REC. S11854 (Nov. 20, 2009)].

[8] *See* The Congressional Budget Office and Joint Committee on Taxation, *Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, November 30, 2009, pages 15-16 at http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf.

[9] CHRISTOPHER J. CONOVER, AMERICAN HEALTH ECONOMY ILLUSTRATED 54 (2012) ("Consider a low wage worker earning $16,000 and a management worker earning $100,000 whose employer provides a health plan that would qualify it for the 40% tax. . . . the high income worker in this example who is in a $12,000 employer plan for single coverage still is going to get the 51% discount coupon for every penny of those premiums. The excise tax merely requires that worker to essentially give back 40% of the $1,800 difference between the cost of the plan and the $10,200 threshold. Put a different way, the excise tax simply reduces the subsidy from 51% to only 11%. This individual still will be receiving a $198 subsidy for what the government has declared is a gold-plated health benefits plan! But now consider the low wage worker. That worker still

passed through to the employee, thus producing a perverse result where the tax benefit afforded under Code Section 106 all but disappears for a lower-paid employee, while a higher-paid employee still maintains some sort of tax benefit (albeit significantly smaller than the original tax benefit otherwise received). A result Congress surely did not intend.

Based on this, even in advance of January 1, 2018, public- and private-sector employers – along with unions with collectively bargained health and welfare plans – are being forced to take action to avoid paying the Excise Tax, along with taking steps to shield their employee participants from paying the Tax. This is adversely affecting low- and middle-income workers and forcing employers and unions to shift more cost onto their employees/members. In some cases, employers are considering eliminating tax-advantaged accounts that actually help consumers with higher out-of-pocket liability and foster better health care consumerism. Another result Congress never intended.

How Is the Requirement to Calculate and Administer the Excise Tax Impacting the Employer-Sponsored Health System?

Although Notice 2015-16 does not address procedural issues relating to the calculation and assessment of the Excise Tax, we wanted to briefly highlight the administrative burdens that will be placed on employers in advance of forthcoming guidance addressing these matters. As discussed, in the case of the Excise Tax, the "incidence of tax" falls on (1) the insurance carrier, (2) the administrator of any self-funded benefits, and (3) the employer in certain cases. To ensure a tax structured in this manner could be determined and actually paid to the IRS, a policy decision was made to require the employer – and not the Service – to (1) calculate the amount of the Tax owed, and then (2) notify the Service and those entities technically required to pay the Tax. This effectively means the employer will serve as the "assessor" of the Tax, along with the means through which the Service can enforce the Tax.

Specifically, the employer is required to determine whether the aggregate amount of health coverage exceeds the Excise Tax's dollar thresholds for *each* employee. In other words, the employer will be required to determine – on an employee-by-employee basis – (1) the different types of health coverage for a particular employee, (2) the aggregate cost of that coverage, and (3) the amount, if any, that exceeds the Excise Tax's dollar thresholds.

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would get their 15.3% discount via the tax exclusion on the entire $12,000 premium, but would have to pay the identical 40% penalty on the $1,800 in "excess" premiums above the threshold. Whereas the high-paid worker simply will have the size of their discount coupon reduced by about 80% (from 51% to only 11%), the low wage worker will see his or her discount coupon converted into an actual 25% penalty. In short, the Cadillac tax will repeatedly create the following bizarre situation across employers with gold-plated health plans: two workers receive identical health benefits, yet in one case, the higher-paid worker will get a 10% subsidy from Uncle Sam while another lower-paid worker will pay a penalty of 25%.").

It is important to point that each employee is unique – with, for example, his or her own self-only or family major medical plan, and different employee contribution amounts to various account-based plans – where some employees may have health coverage that exceeds the dollar thresholds, and other employees with health coverage under the dollar thresholds. Requiring an employer to engage in this employee-by-employee examination will be extremely time-consuming. This requirement will also place a significant burden on employers (1) trying to offer quality health coverage and (2) seeking to provide flexibility for employees by allowing them to choose *certain* types of health coverage that best fits their needs and preferences.

Then, to add to the administrative burdens associated with calculating the Excise Tax on an employee-by-employee basis, the statute requires the employer to effectively send a "Tax Bill" to, for example, an insurance carrier and/or the administrator of self-funded benefits, and even the employer itself in certain cases. The Service must also be notified of the Tax Bill sent to each of these entities, specifying the amount of the Excise Tax payable by each entity. WageWorks has been informed by our employer partners that these looming burdens associated with calculating and administrating the Excise Tax could lead them to simply exit the employer-sponsored health system as an alternative to attempting to comply in the first place, or at the very least, eliminate any benefits other than "minimum essential coverage" so as to eliminate the possibility of triggering the Excise Tax. Again, a result that Congress never intended.

The Excise Tax on High-Cost Employer-Sponsored Health Coverage and Its Impact on Consumer-Driven Health Care

Put simply, the Excise Tax will have a chilling effect on consumer-directed benefit account arrangements solely based on how employers are required to calculate the Tax. Specifically, in addition to the premium costs of an ACA-compliant major medical plan and certain other types of health coverage, employer contributions made to a Health Reimbursement Arrangement ("HRA") – and *both* employee and employer contributions made to a Health FSA – are counted for purposes of the Tax.[10] While employee contributions to an HSA made directly to a custodian on an after-tax basis are excluded from the Excise Tax, employee contributions to an HSA made through a Code Section 125 cafeteria plan are *included* in the calculation of the Tax, in addition to employer HSA contributions.[11]

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[10] Code Section 4980I(d)(1)(A), (d)(2)(B); see also, Notice 2015-16, Section IV, A.2.(4).

[11] Code Section 4980I(d)(2)(C). Employer contributions to an Archer medical savings account ("MSA") are also counted towards meeting the single and family coverage thresholds.

In cases where employers offer these account-based plans, these employers may take steps to avoid paying the Excise Tax and simply eliminate the consumer-directed benefit account options (e.g., HSAs and Health FSAs) made available to employees. Specifically, an employer may choose not to make a Health FSA available to employees, thereby eliminating the requirement to count employee and employer Health FSA contributions when calculating the Excise Tax. Similarly, employers may opt against allowing their employees to make HSA contributions through a Code Section 125 plan, and also discontinue making employer HSA contributions on behalf of employees. In fact, these changes in employer behavior were predicted by the Congressional Budget Office in its analyses of the Excise Tax.[12] However, it does not appear Congress ever intended this adverse impact on Consumer-Driven Health Care arrangements.

To avoid this negative result, we believe the Service has the authority to, at a minimum, provide an exception for employee Health FSA contributions and employee contributions to an HSA made through a Code Section 125 cafeteria plan, and to treat these employee contributions as something other than "applicable employer-sponsored coverage." We recognize developing such an exception may be viewed as a departure from how the Service has historically treated these employee contributions (i.e., salary reduction contributions) for tax purposes under a Code Section 125 plan. For example, the Service has long held the position that employee salary reduction contributions made under a Code Section 125 plan – which may include employee salary reduction contributions to a Health FSA or an HSA – are to be treated as "employer contributions."[13] This legal fiction was created so these employee contributions may be shielded from income and FICA taxes just like employer contributions for premiums for an "accident and health plan" (e.g., an ACA-compliant major medical plan) are not taxed.

We also recognize when Congress was developing the Excise Tax, the baseline on which the drafters operated was any "contributions" for health coverage excluded from income under Code Section 106 *must* be counted toward the calculation of the Excise Tax. On account of this – and because of the Service's long-held position that employee Health FSA contributions and employee HSA contributions made through a Code section 125 plan are to be treated as "employer contributions" – a decision was made to count these employee contributions toward the Tax. However, we believe it is reasonable to interpret the statute in such a way where these employee contributions are not considered "applicable employer-sponsored coverage," and therefore, not included in the calculation of the Excise Tax.

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[12] Jenny Gold, *'Cadillac' Insurance Plans Explained*, KAISER HEALTH NEWS, Jan. 15, 2010, *available at* http://kaiserhealthnews.org/news/cadillac-health-explainer-npr/.
[13] Prop. Treas. Reg. Section 1.125-1(r)(2).

Employee Contributions to an HSA Made Through a Code Section 125 Cafeteria Plan May Reasonably Be Excluded From the Calculation of the Excise Tax

The term "applicable employer-sponsored coverage" means, "coverage under any *group health plan* made available to [an] employee by an employer which is excludable from the employee's gross income under [Code] Section 106."[14] It is well-accepted that an HSA is *not* a "group health plan." For example, formal guidance relating to HSAs issued to date has never indicated an HSA would be considered a "group health plan."[15] In addition, the preamble of Interim Final Regulations implementing the ACA's annual limit restriction provision specifically states "HSAs generally are not considered group health plans because the amounts available under the plans are available for both medical and non-medical expenses."[16] As a result, because an HSA is not considered a "group health plan," an HSA should *not* be considered "applicable employer-sponsored coverage" for purposes of the Excise Tax.

In addition, although employee contributions may be made to an HSA through a Code Section 125 cafeteria plan, the Service has never indicated a Code Section 125 cafeteria plan itself is a "group health plan." Therefore, it is reasonable to conclude a Code Section 125 plan – which is not considered a "group health plan" – would similarly not be considered "applicable employer-sponsored coverage" for purposes of the Excise Tax. This would especially be true in cases where the Code Section 125 plan is simply facilitating contributions to an arrangement that itself is not a "group health plan" (e.g., an HSA). As a result, we believe the Service has the authority to interpret the term "applicable employer-sponsored coverage" as not including employee contributions to an HSA made through a Code Section 125 plan, thus permitting this arrangement to fall outside of the purview of the Excise Tax.

However, we recognize the Service may be constrained by how the statute requires the "cost" of "applicable employer-sponsored coverage" to be determined. For example, in the case of HSAs, the "cost of such coverage" is required to equal the "employer contributions" shielded from tax under Code Section 106(d).17 Notwithstanding this rule – and notwithstanding the Service's long-held position that employee salary reduction contributions under a Code section 125 plan are to be considered "employer contributions" (which would include employee HSA contributions made through the 125 plan) – we believe that the Service can reasonably exclude employee contributions to an HSA made through a Code Section 125 plan from this "cost of coverage" determination because, as stated above, neither the HSA nor the Code Section 125 plan are "group health plans," and thus, not "applicable employer-sponsored coverage" for purposes of the Excise Tax.

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[14] Code section 4980I(d)(1)(A).
[15] *See, e.g.*, Notice 2004-2 and Notice 2004-50.
[16] 75 Fed. Reg. 37188, 37190 (June 28, 2010).
[17] *Code section 4980I(d)(2)(C).*

Actual contributions coming directly from the employer, however, may be distinguished from employee HSA contributions made through a Code Section 125 plan. Therefore, these "employer contributions" may still be included in the "cost" of "applicable employer-sponsored coverage." This thereby allows the Service to fulfill its duties in implementing the statute as written. The Service made a similar distinction when implementing the "minimum value" rules. In this case, the Service explicitly provided employer contributions for the current year to an HSA *may* be counted toward satisfying the "minimum value" test, while it does not appear that employee HSA contributions made through a Code Section 125 plan are to be counted for these purposes.[18]

Employee Contributions to a Health FSA May Reasonably Be Excluded From the Calculation of the Excise Tax

Similar logic may be applied to develop an exception for employee contributions to a Health FSA. Specifically, a Health FSA (as defined under Code Section 106(c)(2)) is an "excepted benefit," and thus generally not treated as a "group health plan."[19] Therefore, if a Health FSA (as defined under Code Section 106(c)(2)) is generally not considered a "group health plan," this type of Health FSA should *not* be considered "applicable employer-sponsored coverage" for purposes of the Excise Tax. As a result, we believe it is reasonable for the Service to interpret the term "applicable employer-sponsored coverage" as not including employee contributions to a Health FSA (as defined under Code Section 106(c)(2)), thus permitting this arrangement to fall outside of the purview of the Excise Tax.

However, the manner in which the statute requires the "cost" of "applicable employer-sponsored coverage" to be determined specifically references "salary reduction contributions" to a Health FSA (defined under Code Section 106(c)(2)), which in reality are employee contributions made to the Health FSA.[20] Notwithstanding this requirement, we believe it is still reasonable to conclude employee contributions made to a Health FSA (defined under Code Section 106(c)(2)) – which should not be considered "applicable employer-sponsored coverage" in the first place – should not be counted toward the "cost of coverage" for purposes of the Excise Tax. Employer Health FSA contributions, on the other hand, may be distinguished from employee Health FSA contributions, and therefore, included in the "cost" of "applicable employer-sponsored coverage," thereby allowing the Service to fulfill its duties of implementing the statute as written.

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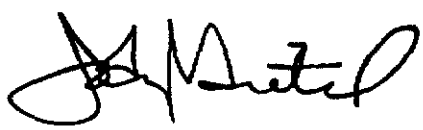
[18] Prop. Treas. Reg. section 1.36B-6(c)(3); *see also*, 45 C.F.R. section 156.135(c).
[19] Treas. Reg. section 54.9831-1(c)(3)(v).
[20] *Code section 4980I(d)(2)(B)(i).*

Why Should the Service Exclude From the Calculation of the Excise Tax Employee Health FSA Contributions and Employee HSA Contributions Made Through a Code Section 125 Plan?
Eliminating consumer-directed benefit account options and Health FSAs would undermine many of ACA's central goals to affording Americans greater financial security, encouraging everyone to have "skin in the game," making individuals more informed consumers of health care, and making health care more affordable for all Americans. HSAs and Health FSAs put consumers in charge of budgeting and spending their own health care dollars, empowering them to operate as consumers in the marketplace. Consumers typically use Health FSAs and HSAs to defray the costs of co-pays, to obtain prescription drugs and medical supplies, and to purchase such items such as walkers and other medical equipment. Not surprisingly, consumer-directed benefit account arrangements are among the many recent innovations in health care proven to slow the growth of medical spending.[21] By counting employee Health FSA contributions and employee HSA contributions made through a Code Section 125 toward the Excise Tax, the Service would effectively cut off the opportunity for consumer-directed benefit account arrangements to advance these fundamental objectives.

Conclusion
WageWorks urges the Service to implement the new Code Section 4980I in a way that minimizes the negative effects of the Excise Tax. We recognize much of the design flaws of the Excise Tax are statutory in nature, and we remain hopeful Congress will revisit the provision. However, we urge the Service to do everything under its regulatory authority to implement the Excise Tax in a flexible manner to minimize the administrative burden to employers and disruption to the existing employer-based health system. We believe the recommendations in our comment letter describe how the Service can accomplish this.

Once again, we appreciate the opportunity to provide comments on Notice 2015-16, and we look forward to reviewing future guidance and regulations regarding the implementation of the Excise Tax. Should you have any questions about our comments, please do not hesitate to contact Jody Dietel, Chief Compliance Officer, at (650) 577-6372 or Jody.Dietel@wageworks.com.

Sincerely,



Jody L. Dietel, ACFCI, CAS
Chief Compliance Officer
WageWorks, Inc.

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[21] *See, e.g.*, Amelia M. Haviland et al, *Do "Consumer-Directed" Health Plans Bend the Cost Curve Over Time?* NAT'L BUREAU ECON. RESEARCH, Working Paper No. 21031, at 26-27 (Mar. 2015).