Notice 2015-16

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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 - Excise Tax on High Cost Employer-Sponsored Health Coverage

Ladies and Gentlemen:

Thank you for the opportunity to comment on Notice 2015-16 regarding the excise tax on employer-sponsored health coverage under the Affordable Care Act.

Buck Consultants LLC, a Xerox Company, is pleased to submit these comments in response to Notice 2015-16 concerning the excise tax imposed by section 4980I of the Internal Revenue Code.

Buck is a leading global employee benefits, actuarial and human resources consulting firm that provides assistance to employers that sponsor health plans for their employees. Most of our clients will be materially affected by this excise tax and the issues discussed in the Notice.

A. Definition of Applicable Coverage (Section III of the Notice)

- Health Savings Accounts (HSAs)

  The Notice states that Code Section 4980I "provides for health FSAs that the cost of applicable coverage is equal to the sum of salary reduction contributions plus the amount determined under the general calculation rule with respect to any reimbursement under the arrangement in excess of the salary reduction contributions." Therefore, for FSAs the statute specifies that both employee salary reduction contributions and employer contributions are in the cost of applicable coverage.

  The Notice further states that "for HSAs and Archer MSAs that the cost of applicable coverage 'shall be equal to the amount of employer contributions under the arrangement.'"

  While employee salary reduction contributions are treated as employer-sponsored coverage for tax purposes for both health FSAs and HSAs, the statutory language makes a distinction between the two for purposes of determining the cost of applicable coverage. For health FSAs the statute specifically refers to "the amount of employer contributions under any salary reduction election," while for HSAs the statute only directly refers to "the amount of employer contributions under the arrangement." This distinction can be supported by several factors:

- HSAs have traditionally not been treated as health benefits and are not subject to most ACA requirements

- While the Notice states that the Treasury anticipates that future regulations will exclude employee after-tax HSA contributions, if an employer does not allow employees to make pre-tax contributions, employer contributions will be subject to the comparability rules under Code Section 4980G. This will likely result in employers reducing or eliminating employer contributions.

The inclusion of employee salary reduction contributions to HSAs in the cost of applicable coverage will result in employees and employers contributing less to HSAs, subject employees to significantly higher out-of-pocket medical expenses and will have a very negative impact on these programs. For this reason, Buck recommends that employee salary reduction contribution be excluded from applicable coverage.

- On-site Medical Clinics

Code Section 4980I does not directly address or include on-site medical clinics in the definition of applicable coverage. However, the Notice states that Treasury and IRS "anticipate that the forthcoming proposed regulations will provide that applicable coverage does not include on-site medical clinics that offer only *de minimis* medical care to employees." The Notice references the section 54.4980B-2 of the COBRA regulations which state that the provision of health care services at an employer's on-site clinic does not constitute a group health plan if:

- The health care consists primarily of first aid provided during the employee's working hours for treatment of a health condition, illness, or injury that occurs during those working hours;

- The health care is only available to current employees; and

- Employees are not charged for the use of the facility.

Treasury and IRS are also seeking comment on the treatment of clinics that meet the COBRA criteria but also provide additional services such as:

- Immunizations

- Injections of antigens

- Provision of aspirin and other nonprescription pain relievers

- Treatment of injuries caused by accidents at work

Buck recommends that on-site clinics providing the above services also be treated as offering only *de minimis* medical care and not treated as applicable coverage.

- Limited Scope Dental and Vision Benefits

Code Section 4980I excludes from applicable coverage "any coverage under a separate policy certificate, or contract of insurance which provides benefits substantially all of which are for the treatment of the mouth or for treatment of the eye." The Notice states that "whether coverage is insured or self-insured is not relevant for purposes of §4980I" and that the Treasury is considering

exercising its regulatory authority to exclude from applicable coverage self-insured limited scope dental and vision coverage that qualifies as excepted benefits. Buck supports this exclusion.

- Limited Scope Dental and Vision FSAs and HRAs

  Similar to the proposed treatment of self-insured limited scope dental and vision benefits, we recommend that limited scope dental and vision FSAs and HRAs also be excluded from applicable coverage.

- Employee Assistance Programs (EAPs)

  The Notice states hat Treasury and IRS are considering excluding from applicable coverage "EAPs that qualify as excepted benefits pursuant to recently issued regulations." Buck supports this exclusion.

- Medicare Advantage and EGWPs

  The Notice does not address whether employer-sponsored Medicare Advantage plans or EGWPs are applicable coverage. Since these programs are considered Medicare coverage and the majority of the funding comes from the federal government, Buck recommends that these programs not be included in the definition of applicable coverage.

B. Determination of Cost of Applicable Coverage (Section IV of the Notice)

- Aggregation by Benefit Package and Permissive Disaggregation

  The Notice discusses a potential approach for determining groups of similarly situated employees by aggregating all employees covered by a benefit package. The Notice discusses requiring aggregation of all employees enrolled in a benefit package across an entire controlled group. We recommend that each employer member of a controlled group be given the option of aggregating only its own employees enrolled in a benefit package, even when employees across a controlled group may be enrolled in same benefit package.

  This approach is also consistent with the Permissive Disaggregation that the Notice states that Treasury and IRS are considering. We also support the option of permitting employers to further disaggregate based on bona fide employment-related criteria, and suggest that that be expanded to include members of the controlled group.

- Permissive Aggregation within Other-than-self-only Coverage

  As the Notice discusses, Code Section 4980I does not require that the cost of applicable coverage be determined separately based on the number of individuals enrolled in other-than-self-only coverage in addition to the employee. The Notice states that for that reason, Treasury and the IRS are considering an approach that would permit an employer to treat all employees with other-than self-only coverage in the same benefit program as similarly situated regardless of the number of family members enrolled. Buck supports this permissive aggregation rule. It is consistent with many employers' employee contribution strategies and is less likely to disrupt current coverage for dependents.

- Actuarial Basis Method

The Notice asks for comments on whether regulations should require accreditation of individuals making actuarial estimates. Buck recommends that employers be given the option of having a determination of cost certified by a member of the American Academy of Actuaries, but that this certification not be required. This certification should provide a safe harbor for the employer.

The Notice also asks for comments on whether it would be preferable to specify a list of factors that must be satisfied to make an actuarial determination. Buck recommends that a list of factors and safe harbor assumptions be provided as an alternative to the certification discussed above. The guidance should provide a list of factors to be considered, and where appropriate optional assumptions that employers can use in determining cost. For example, under the past cost method, the GNP deflator is used to project costs. A similar safe harbor assumption that can be used under the actuarial basis method would be helpful to employers.

Employers should retain the flexibility to determine costs under other reasonable actuarial methods and assumptions, but the above two options should be provided as safe harbors.

- HRAs

The Notice anticipates that HRAs will be applicable employer-sponsored coverage and discusses several possible methods for determining the cost of coverage. Under one method, cost would be based on the amounts made newly available to a participant each year. Under the second method, cost would be determined by adding together all claims and administrative expenses attributable to HRAs for the period. Under a third method, employers would use the actuarial basis method to determine the cost of HRA coverage. The Notice mentions that Treasury and IRS are concerned that making available multiple methods could increase administrative complexity and is considering providing only one method.

Buck disagrees with limiting the number of methods. Currently employers use all of these methods to determine cost for COBRA purposes, and providing only one method would increase complexity by requiring many employers to use a new method or to use different methods for COBRA and the excise tax. Also, depending on the HRA design, one method may be more appropriate than the other method. So Buck recommends the employers have the option of methods.

Buck also recommends that HRAs used only to fund an employee's or retiree's contributions for employer coverage, or for coverage in a public marketplace or private exchange not be considered applicable coverage. Similarly, HRAs that can only be used for excepted benefits such as limited scope dental and vision benefits, should not be considered applicable coverage.

- Treating Pre-65 and Post-65 Retirees as Similarly Situated Beneficiaries

Code Section 4980I states that "in the case of applicable employer-sponsored coverage which provides coverage to retired employees, the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries."

The Notice does not address how this provision will be administered and additional guidance is needed. Because the design of employer-sponsored coverage for pre-65 retirees and Medicare retirees is usually very different, the benefit package approach discussed in the Notice would not

be appropriate. Buck recommends that employers be given broad flexibility in determining when pre-65 retirees and retirees eligible for Medicare can be treated as similarly situated.

Clarification is also needed on how the applicable dollar limits will apply. We assume that this provision allows the employer to combine the pre-65 and Medicare benefit programs together in determining the applicable cost, but that the applicable dollars limits for qualified retirees and Medicare retirees would still apply.

C. Applicable Dollar Limit (Section V of the Notice)

- Employees with Both Self-only and Other-than-self-only Applicable Coverage

  The Notice discuss situations where an employee could simultaneously have both self-only coverage and other-than self-only coverage. For example, an employee could have employee only medical coverage but also a health FSA that covers the employee and the employee's family.

  The Notice outlines two possible approaches for determining the applicable dollar limit in these situations. One approach would base the applicable dollar limit on the coverage that accounts for the majority of the aggregate cost of the applicable coverage. The second approach would apply a composite dollar limit by prorating the dollar limits.

  For administrative ease and simplicity, Buck recommends that the first approach be adopted so that the coverage that accounts for the majority of the cost be used to determine the applicable dollar limit. Alternatively, the employer could be given the option of using either approach.

These comments reflect the combined input from a number of Buck Consultant colleagues. If further information would be helpful, please feel free to contact the below.

Sincerely,

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