



October 1, 2015

Internal Revenue Service
1111 Constitution Avenue NW
Washington, DC 20044

Re: Notice 2015-52

To Whom It May Concern:

On behalf of the American Academy of Actuaries'¹ Active Benefits Subcommittee, I offer the following comments regarding Internal Revenue Service (IRS) Notice 2015-52 on Section 4980I Excise Tax on High-Cost Employer-Sponsored Health Coverage under the Affordable Care Act (ACA). Our comments are focused on three sections of the notice—employer aggregation, cost of applicable coverage, and the age and gender adjustment to the dollar limit. We also include a number of potential implications of the application of the excise tax on the small group market.²

Specific Comments on Sections of the IRS Notice 2015-52

Section IV. Employer Aggregation

Section 4980I of the Internal Revenue Code (Code) provides generally that all employers within a controlled group³ under sections 414(b), (c), (m), or (o) of the Code are treated as a single employer for purposes of the excise tax. Aggregating controlled group members up to the highest level⁴ could eliminate volatility in the age and gender distribution among an employer's separate subgroups. However, employers may provide different benefits to different employee populations within a controlled group. As such, treating the underlying groups separately could be a reasonable approach and easier to administer. Allowing disaggregation could:

- better align with how companies administer the health plans for different employee populations within a controlled group;
- better identify the entity responsible for calculating and reporting the excess benefit; and
- provide clearer identification of the employer liable for any penalty. Doing so would better align the excise tax with the employer-shared responsibility requirements—the same employer charged with providing affordable, minimum value coverage also would be responsible for providing the coverage that is measured for the excise tax.

¹ The American Academy of Actuaries is an 18,500+ member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

² The comments specific to the small group considerations were developed by members of the Academy's Individual and Small Group Market Committee.

³ A controlled group is a combination of two or more businesses that are under common control.

⁴ The highest level would be all employees of the control group combined into one census.

Section V. Cost of Applicable Coverage

A. *Taxable Period*

While many employers use a calendar year for the health plan year, there are many employers, including state and local governments, that do not. Employers with health plan years that do not align with the calendar year may change health plan insurers with the commencement of the new plan year. While the IRS anticipates that the taxable period will be the calendar year for all taxpayers, the law permits the Secretary to establish different taxable periods for employers of varying sizes. By aligning the taxable period with the health plan year, the amount of the excise tax can be readily determined and administered by the insurer for the duration of the coverage period. As such, consideration should be given to the administrative burden that would be imposed for small and medium-size employers whose plan years do not coincide with tax years.

B. *Determination Period*

We suggest the IRS consider a determination period that aligns with an employer's current process for establishing its annual budget, employee contributions, and Consolidated Omnibus Budget Reconciliation Act (COBRA) premium rates for employees. This would not only provide for administrative simplicity in establishing the costs for comparison against the Section 4980I statutory dollar limits, but also would allow for the ability to know in advance whether a plan (or plans) offered will exceed the statutory limits. The plan sponsor could then use that information to: (1) make appropriate plan design changes; (2) adjust employee contributions and other financial incentives for employees consistent with those plan changes; and/or (3) offset the cost of plan changes with other forms of employee compensation.

Currently, employers establish their premium rates (if fully insured) or premium rate equivalents (if self-insured) in advance of the plan year and before the open enrollment period. These rates typically use past historical claim and enrollment information and are projected, in compliance with Actuarial Standards of Practice, to reflect expected price inflation, member utilization changes, negotiated provider contracts including volume-based discounts or rebate arrangements, as well as expected enrollment changes due to workforce changes and program modifications. The rates developed from this process are set in conjunction with decisions by employers with respect to plan design changes for the plan year, employee contributions for the plan year, the applicable COBRA rates for qualifying beneficiaries for the plan year, and employee compensation.

Aligning the determination period with the plan year would allow for an employer to know in advance of the plan year whether a health plan offering will trigger the Section 4980I excise tax, especially in conjunction with the design and contribution allowances made for flexible spending arrangements (FSAs), health savings accounts (HSAs), and health reimbursement arrangements (HRAs). Having this information in advance is important to an employer's or plan sponsor's budgeting process.

Aligning the determination period with the plan year is also consistent with the language in the ACA that anticipated use of COBRA premium rates to compare against the excise tax thresholds.

C. *Exclusion From Cost of Applicable Coverage of Amounts Attributable to the Excise Tax*

The Notice proposes that the excise tax reimbursement should be excluded from the cost of applicable coverage, and requests comments on whether the income tax reimbursement should be excluded as well. We agree that if the actual excise tax is excluded from the cost of coverage, as stated in the law, any income tax gross-up also should be excluded from the cost. We also agree that the income tax gross up on any excise tax could create a timing issue if the actual excise tax is not known until after the end of the tax year. This timing issue can be addressed if, as recommended above, the determination period is aligned with the plan year.

We suggest that coverage providers should be able to separately bill for the cost of the excise tax and any income tax gross-up based on their marginal tax rates (as discussed in the next section).

D. *Income Tax Reimbursement Formula*

The Notice proposes a commonly used formula to calculate “tax gross-ups.” We agree with the formula proposed. A key element of the formula is the marginal tax rate that is used to calculate the income tax reimbursement. The Notice indicates the IRS is considering two possible approaches to applying the formula. The first approach is to use the coverage provider’s actual marginal tax rate; the second is to use a standard marginal tax rate developed to reflect typical tax rates of coverage providers. We suggest that the actual marginal tax rate can be administratively simple to implement as follows.

The calculations may be handled differently for self-funded plans and fully insured plans. For self-funded plans, they may be “billed” the additional cost in the monthly fixed-fee cost to administer the plan. The billed amount can be an estimated amount of the tax with a “true-up” after the end of the year for the actual payment. The additional monthly cost and the true-up adjustment will reflect the coverage provider’s best estimate of their marginal tax cost. The self-funded plan sponsor can exclude the monthly fixed-fee component that is attributed to the excise tax from its cost calculations provided that it is separately billed and specifically attributable to the excise tax.

For the fully insured plan, the premium will include an estimate for the excise tax and any income tax gross-up; this will contribute to the total cost of applicable coverage unless billed separately and attributed to the excise tax. The insurance company could provide to its customers the cost of the excise tax included in the premium so that it can be netted out from the premium rate to determine the excise tax for the year. There may be a true-up calculation for the actual excise tax paid depending on the contractual arrangement with the insurance company.

Employers with health insurance from multiple vendors and separate HSA/FSA/HRA administrators will be subject to varying income tax gross-up factors. Some administrators, such as S corporations that provide HSA/FSA/HRA administration services, will not know their marginal tax rate until after the end of their fiscal year. Again, this scenario can be resolved by allowing these coverage providers to provide explicit charges for the excise tax

and any income tax gross-up in their fixed fees for the year and allow administrators to potentially have a true-up calculation after the end of the year to reflect their final marginal tax rate. These charges can then be excluded from cost calculations by the plan sponsor.

Section VI. Age and Gender Adjustment to the Dollar Limit

The statute provides for an age and gender adjustment to the excise tax threshold. This adjustment is equal to the premium cost of the Blue Cross/Blue Shield (BCBS) standard benefit option if priced for the age and gender characteristics of an employer's workforce less the premium cost if priced for the age and gender characteristics of the national workforce. As indicated in the Notice, it is important that the adjustment to the dollar limit reflect not simply the average age of the workforce, but the distribution of the workforce across age and gender.

A. Determination of Age and Gender Distribution

The Notice sets forth approaches on what can be used as a representation of the national workforce and what factors are to be used to determine the age and gender differences with the employer population.

National Workforce

The Notice proposes to use labor force statistics from the Current Population Survey (CPS) as summarized in Table A-8a to establish the age and gender distribution of the national workforce. The table presents monthly information on the number of employed persons by age and gender, seasonally adjusted. However, this table does not appear to provide groupings in five-year age bands as suggested by the notice unless more granular data is available in data not publicly available. An alternative would be to use Table 3 (<http://www.bls.gov/cps/cpsaat03.htm>), also based on the CPS but with counts of employed persons by five-year age bands. This is an annual table so seasonal adjustments are not needed.

Employer Census

The Notice proposes that employers use the first day of the plan year as the date to collect employee census data and determine the age and gender distribution. Because the age and gender adjustment is to be used for the full year, we suggest that employers be given more flexibility regarding the census data that is used for this calculation. In many cases, a point-in-time census approach might be reasonable. However, for some employers, particularly small group employers and employers with high employee turnover rates, a 12-month average may be more appropriate. For example, using a point-in-time census for seasonal industries could misstate the age and gender distribution of employees, and thereby either overstate or understate the appropriate age and gender adjustment. There also might be circumstances in which employers would be able to change the census data they use if their population changes significantly during the year (e.g., through merger, acquisition, or divestiture). We suggest that employers have flexibility to select a date, such as the midpoint of the period, or average over a span of time that they believe will best represent the age and gender characteristics for the plan year. To minimize gaming, the selection of such dates would be a selected census determination period and should not vary year by year.

B. Development of Age and Gender Adjustment Tables

The Notice proposes that the age and gender factors would be developed based on the claims experience of the Federal Employees Health Benefits Plan (FEHBP) Blue Cross Blue Shield standard option. The Notice indicates that claims would be sorted by five-year age bands, gender and coverage unit (self-only versus other than self-only). We have two concerns with this approach. First is whether the patterns of health spending by age and gender in the FEHBP BCBS standard option enrollee population are representative of the total insured population. Second is whether it is appropriate to develop the factors separately by coverage unit (e.g., self-only, other than self-only).

FEHBP Claims Experience

The FEHBP BCBS standard option is one of many plan options available to federal employees. It offers a generous benefit package and a broad network of providers. In most geographic areas, it is the plan option that likely attracts the heavier health care utilizer. In contrast, high-deductible health plan options generally will attract a younger, healthier population as well as an older, more financially secure population that can afford the higher deductibles. HMO options will attract younger families with their more generous benefits for maternity. The availability of these other options will bias the claims experience of the FEHBP standard option claim experience, and not in a way that is consistent across age and gender categories. Certain age and gender groupings could be especially affected by the selection bias. For example, if younger families with high maternity costs are disproportionately absent from the FEHBP standard option claims data because they enroll in an HMO, average young female costs would be understated relative to the young female population enrolled in FEHBP overall.⁵ And, if the high-deductible plan options get healthier, older employees, the costs for the older members in the FEHBP standard option will be overstated relative to the older population enrolled in FEHBP overall. Therefore, it might not be appropriate to apply average standard option plan spending by age and gender category to the typical employer plan.

National Claims Experience

Rather than using the FEHBP BCBS standard option plan to determine average spending by age and gender category, another option would be to use a more generalized population's claims experience, as the age and gender factors underlying the adjustment calculation would be more appropriate if the law allows its use. For instance, one option would be to use the MarketScan data the Center for Medicare and Medicaid Services (CMS) used to develop the minimum value (MV) calculator and the default age rating curve for individual and small group products. For these data to be appropriate for this purpose, gender differences by age would need to be retained and age factors could not be limited based on the ACA age rating restrictions. Another option would be to use datasets on commercial insurance costs (e.g., Health Care Cost Institute). For more information, we would be happy to discuss with you potential datasets and relevant considerations.

⁵ See *Cost by Product Type* section on page 4 in Society of Actuaries study, "Health Care Costs—From Birth to Death," May 2013.

Separate Factors by Coverage Unit

The ACA imposes excise tax dollar thresholds that differ by coverage unit (i.e., self-only coverage and other than self-only coverage). The Notice proposes calculating separate age and gender factors by coverage unit. We believe such a calculation should only be done if it is possible to categorize the national workforce and employer workforce into similar coverage units. Employers could categorize their covered employees into self-only and other than self-only coverage units, but only for employees with coverage. The national workforce population would not be able to be categorized into self-only and other than self-only coverage units. In other words, the national workforce units and employer units would not be comparable.

It may be appropriate, therefore, for the age and gender adjustment calculation to be determined for the total employer workforce and not by coverage unit.

FEHBP Standard Option Premium Rates

As part of the process of calculating the age and gender adjustment to the excise tax thresholds, the ratio of average costs of each age and gender group to the average costs of the population as a whole is multiplied by the FEHBP premium. Effective Jan. 1, 2016, the FEHBP premium rates moved to a three-tier rating structure—self only, self plus one dependent, and self & family. This three-tier rating structure raises the issue of how to adjust the other than self-only dollar limit if the age and gender adjustments are calculated separately for self-only and other than self-only coverage. The 2016 BCBS Standard Option Self Plus One monthly rate is \$1,500.05 while the Self & Family rate is \$1,574.60. Given the small difference between the two rates, one possible solution is to use the Self & Family FEHBP premium rate.

An alternative is to use the 2015 ratio of the other than self-only premium rate and apply this ratio to the self-only premium rate for future years. The 2015 BCBS Standard Option monthly premium rates are \$634.92 for self-only and \$1,434.07 for self and family (a 2.26 relationship). If the 2018 premium rate for self-only coverage is \$700, assume the other than self-only coverage premium rate is \$1,582 ($\700×2.26). If the employer average age and gender factor was 10 percent⁶ greater than the national workforce, the self-only adjustment would be \$840 ($\$700 \times 12 \times 0.10$) and the other than self-only adjustment would be \$1,898 ($\$1,582 \times 12 \times 0.10$).

A second option is to adjust the other than self-only dollar limit by the same ratio as the self-only premium rate was adjusted. Assuming the plan sponsor average age and gender factor is 10 percent greater than the national average factor and the self-only 2018 FEHBP BCBS Standard Option annual premium rate is \$8,400 ($\700×12), the adjustments would be \$840 ($\$8,400 \times 0.10$) for self-only and \$2,265 ($(\$8,400 \div \$10,200) \times 27,500 \times 0.10$) for other than self-only coverage. This alternative will lead to a higher adjustment for the other than self-only coverage unit (\$2,265 versus \$1,898) because the dollar threshold for other than self-only coverage unit is greater than 2.26 times the self-only dollar threshold (2.70 versus 2.26).

⁶ 10 percent was selected to provide a numerical illustration and because it is in the range of expected adjustments based on analysis of large-employer census data.

Proposed Five-Year Age Grouping

The Notice suggests using five-year age bands for the calculation of the age and gender adjustment. The marketplace age table is by single ages, but for large groups, we would not anticipate that the use of five-year age bands would necessarily produce less accurate results, especially given the marketplace age table is not gender-distinct. However, this is not the case for small groups, in which case annual age bands should be considered.

Interaction of Adjustments

Section 4980I(b)(3)(C)(i) of the Internal Revenue Code establishes the 2018 Applicable dollar limits and Sections 4980I(b)(3)(C)(ii)–(v) provides that these dollar limits are subject to adjustment by one or more of the following factors:

- (ii) Health cost adjustment percentage
- (iii) Age and gender adjustment
- (iv) Exception for certain individuals—includes qualified retirees and high-risk professions
- (v) Subsequent years—indexing factor for 2019 and later

Although we agree that these factors reflecting the impacts of inflation and the group-specific composition should be included in these calculations, it is not entirely clear how these adjustments work together or in what order they should be applied.

We recommend that the IRS issue rules that clearly define how these adjustments are applied and how each of the four adjustments interact, as there may be some groups that will apply two or more of the four adjustments. We specifically recommend that the priority of the adjustments be described (e.g., the order of the adjustments) and that IRS indicate how the adjustments are to be applied (e.g., additive adjustments after indexing for inflation).

General Small Group Considerations

There are many issues regarding the excise tax that are unique to the small group market. As currently structured, the application of the excise tax can have significant unintended consequences for small groups, resulting in higher premium rates for employers that do not offer generous benefit plans and, if not for the ACA modified community rating requirements to which they are subject, would not otherwise be subject to the excise tax.

Single Risk Pool

The ACA requires insurers to use a single-risk-pool methodology for small groups (as of Jan. 1, 2016, defined as employers with 100 or fewer employees). The services to be covered for the single risk pool are defined by CMS for each state (i.e., essential health benefits using a benchmark plan). CMS has defined the geographic rating areas for each state as well as the age curve.

Notice 2015-52, as well as Notice 2015-16, would appear to require the excise tax apply to small employers, even those enrolled in fully insured ACA-compliant plans for which rates are developed using the single-risk-pool methodology. It is our understanding that the excise tax is a separate tax that is not part of the premium rating rules under the single risk pool. In other words,

small groups subject to the tax because they have premiums exceeding the excise tax threshold would not affect the premiums of small groups in the same market with premiums below the threshold. Otherwise the cost of this tax would need to be distributed across *all* small group employers, because being subject to the tax is not an allowable rating factor. We would appreciate confirmation of this understanding.

It would be difficult to reconcile the imposition of the excise tax with the concept of the single risk pool. For example, a gold plan's rates might not exceed the threshold on a standalone basis, but an employer choosing the gold plan still might exceed the threshold because of inclusion of additional benefits such as an HSA or FSA. Due to the single-risk-pool rating rules, the insurer cannot charge higher rates on the gold plan to the group with additional benefits triggering excise tax liability. The spreading of the tax to small group employers that do not provide benefits exceeding the threshold would contradict the intent of the excise tax, which discourages employers from providing packages with high dollar benefits. If the tax is spread to additional small groups, the impact is lessened on those groups providing rich plans or additional benefits that exceed the threshold. This also will require an assumption as to the amount of the excise tax to include in the single pool rating, which will be difficult because the composition of each group composing the single risk pool, as well as the benefit plans that will be chosen, are not well known at the time single-risk-pool pricing is set. Such pricing cannot be determined accurately based on average age/gender mix and plan distribution. The formula for the excise tax is dependent on the exact makeup of each group's demographics and plan selection.

Administration of the excise tax in the Small Business Health Options Program (SHOP) environment, in which individual employee choice is available, would be difficult at the group level. For example, if there are five different issuers and they are not aware of other issuers servicing the group, will the SHOP be responsible for aggregating information? Will each of the issuers be apportioned a certain amount of the tax? Further if the excise tax is to be included as "premium," will the anticipated amount need to be grossed-up higher to reflect other charges that are based on premium (e.g., premium taxes, exchange fees, commissions, etc.) The process for gathering demographic information on employees who do not elect insurance would need to be addressed.⁷

Per-Member Rates and Group Demographics

Under current single-risk-pool rules, issuers can bill employers smaller than 100 employees⁸ using one of two approaches. Under the first, the issuer lists the rate applicable to each enrolled employee, based on the age of each employee and dependent enrolled in the plan. This practice is referred to as list billing. Under the second, issuers can use composite rating, in which the premiums shown on the bill represent the average rate for each family size coverage tier offered. The issuer must use the same method for all groups in its small group single risk pool, and if the composite rate option is chosen, it must be left unchanged for the entire year. As a

⁷ The demographic adjustment used to determine applicability of the excise tax is based on all employees, not just insured; however, the SHOP will have only information on insured employees.

⁸ For plan years beginning in 2016, the definition of small employer expands from those with up to 50 employees to include those with up to 100 employees. Many states have adopted the ACA transition program, which allows small employers renewing coverage prior to Oct. 1, 2016, to delay entering the ACA-compliant marketplace until after their 2016 plan year ends.

result of this requirement, most issuers have elected to use list billing in the small group market.⁹

For employers using list billing, it is unclear how the age and gender adjustments would be applied to the excise tax thresholds. Would they be applied separately to each employee and reflect the adjustment applicable to that worker's particular age/gender category? Or would they be based on the age and gender distribution of the group as a whole? The former option would better align to the applicable rating factors. Even under that option, however, there would be a disconnect between the allowable age rating factors, which are limited to a 3-to-1 ratio, and the implicit age rating factors underlying the age and gender adjustments, which likely exceed a 3-to-1 ratio. The rating rules also ban gender rating. These differences would lead to additional complications if excise tax amounts are subject to the single risk pool and need to be spread among all members in the market.

Midyear Benefit/Cost Sharing Changes

Unlike large employers, the prevalence of renewal dates other than Jan. 1 is much greater for small employers. Thus, the prevalence of midyear changes in benefit plans is much greater in the small employer market.

Incentives for Small Groups to Self-Insure or Drop Insurance

Fully insured ACA-compliant small groups are required to offer a very specific scope of services, and cost-sharing provisions are defined by compliance with specific metal levels. Self-funded small groups have more flexibility in both scope of benefits and cost sharing provisions. Unless there are special considerations for small groups in the application of the excise tax, small groups may be incentivized to opt for self-insurance as a means to avoid any excise tax. If the excise tax is required to be spread across all employers in the small group single risk pool, then the employers with lower-cost employees or benefit plans will have additional financial incentives to opt for self-funding. This will, in turn, reduce the participation in the small group single risk pool, which will result in more volatility of rates and exert overall upward pressure on rates.

Small employers generally do not have the internal resources to determine tax liabilities and to administer the various tests/adjustments that it appears will be required under the proposed regulations. Employers with fewer than 50 employees are not subject to the shared responsibility penalties for failing to offer insurance. If the cost of providing insurance increases, either directly by increased premiums or indirectly by increasing administrative costs for tax professionals, employers in this subcategory will have additional financial incentives to self-fund coverage or drop insurance altogether.

⁹ Composite rates cannot be recalculated for new employees or terminated employees. Because new employees and terminated employees can have a significant impact on micro groups, most issuers have elected to use list billing, unless they are required by the state to do so otherwise. Prior to the ACA, issuers typically used composite rating for “larger” small groups—those with 10 to 20 employees and higher. For groups with 50 or more employees, composite rating was almost universal. State-specific requirements further complicate this issue. In a state that has a CMS-approved alternate composite premium method, issuers that offer composite premiums in addition to per-member premiums must use the state-specific method when compositing premiums. If the state requires composite premiums, the state-specific composite premium method is the only billing method allowed. For more detail, see <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html>.

Safe Harbor

The small group fully insured ACA-compliant market is very different than the large group market. As such, we suggest the excise tax be excluded from the premium rates in the single risk pool. This means that the cost of the tax would not have to be spread across all employers. Insurers would be allowed to bill each applicable employer for this tax separately from premium rates. We recognize this approach may not be acceptable to various state departments of insurance that have regulatory authority over premium rates. Another possibility would be to have certain metal levels exempt from any excise tax, such as bronze and silver, because bronze and silver plans by definition do not provide rich benefits. If the excise tax is included in the single risk pool, however, then total exemptions from the tax may not be possible for the reasons cited previously. Further, exemptions of certain metal levels may result in more generous metal levels (i.e., gold and platinum) not being available in the market.

We appreciate the opportunity to provide these comments on IRS Notice 2015-52. If you have any questions or would like to discuss any of these comments further, please contact Heather Jerbi, the Academy's assistant director for public policy (202-785-7869 or jerbi@actuary.org).

Sincerely,



Adam J. Reese, MAAA, FSA, FCA, EA
Chairperson, Active Benefits Subcommittee
American Academy of Actuaries