BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

October 1, 2015

The Honorable John Koskinen
Commissioner
Internal Revenue Service
CC:PA:LPD:PR (Notice 2015-52)
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Submitted via E-Mail to: Notice.comments@irscounsel.treas.gov

RE: Notice 2015-52, Section 4980I — Excise Tax on High Cost Employer-Sponsored Health Coverage

Dear Commissioner Koskinen:

The Blue Cross and Blue Shield Association ("BCBSA") appreciates the opportunity to provide comments to the Internal Revenue Service ("IRS") on Notice 2015-52, Section 4980I — Excise tax on High Cost Employer-Sponsored Health Coverage ("the Second Notice" or "the Notice").

BCBSA is a national federation of 36 independent, community-based, and locally operated Blue Cross and Blue Shield Plans ("Plans") that collectively provide health care coverage for 105 million – one in three – Americans. Blue Cross and Blue Shield Plans offer coverage in every market and every ZIP Code in America. Plans also partner with the Government in Medicare, Medicaid, the Children's Health Insurance Program, and the Federal Employees Health Benefits Program.

The Second Notice, along with Notice 2015-16 ("the First Notice"), assists employers and health insurance issuers in understanding how the excise tax on high cost employer-sponsored health coverage ("excise tax") will operate. As expressed in our comments on the First Notice, BCBSA is concerned that the excise tax could have sweeping and unanticipated adverse impacts on plan designs that Congress likely did not believe were either high-cost or overly generous.

BCBSA also continues to be concerned that issuers and administrators will be responsible for paying an excise tax on products that are not high-cost or overly generous simply because an employer chooses to offer additional applicable coverage to its employees. For example, additional coverage, such as providing dental or vision coverage to employees and their dependents, or allowing employees to contribute their own funds through contributions to a

health savings account ("HSA") or a flexible spending account ("FSA"), which have been used prevalently in health benefits for years and in many cases decades, would now be included in determining what coverage is subject to the excise tax. All of the above examples are in conflict with previous public health policy goals advanced by Congress and we encourage Treasury and the IRS to use their best judgment to avoid unintended consequences and to reduce the administrative burden as much as possible in promulgating regulations related to the excise tax.

BCBSA supports the proposals in the Second Notice designed to alleviate adverse consequences resulting from contributions to HSAs, Archer MSAs, FSAs and HRAs, especially as they relate to FSAs with employer flex credits, and continues to urge Treasury and the IRS to adopt, wherever possible, rules that alleviate the adverse impact of the excise tax on consumers. This approach is necessary to ensure that employers are not forced to adopt higher cost-sharing plans (*e.g.,* bronze plans) without HRAs, HSAs, or FSAs, or drop coverage altogether as a result of a "squeeze" between providing affordable minimum value coverage and triggering the excise tax. In addition, BCBSA requests that Treasury and the IRS make administration of the excise tax as simple and inexpensive as possible, including providing alternatives for employers and health insurance issuers wherever possible.

Key Recommendations

Our key recommendations are as follows:

- *Person Liable for the Excise Tax:* Impose liability for the excise tax for self-insured plans on "the person that administers the plan benefits," which should be defined as the person that has ultimate authority with respect to the administration of plan benefits (including arrangements with service providers and the authority to terminate service provider contracts), even if such authority is not routinely exercised. *See* I, below.

- *Determination Period:* Allow four months for the employer to calculate the amount of the excise tax. *See* III, below.

- *Exclusion from the Cost of Applicable Coverage:* Exclude excise tax, income tax, and state and local tax reimbursements from the cost of applicable coverage. *See* IV, below.

- *Age/Gender Adjustments:*

    - Calculation of the employer's premium cost using the age and gender tables should use enrolled employees rather than all employees and flexibility should be provided for the snapshot date for the employer determination of the composition of its employee population. *See* VIII, below.

    - Use five-year age-bands up to age 75 for age and gender adjustment tables. *See* IX, below.

    - Use national claims data from plans with designs similar to the FEHBP standard option to determine the average cost of coverage. *See* X, below.

  - Do not use the age rating scale for the individual and small group markets for the age and gender adjustment for the large group market, although it may be appropriate to use the age rating scale for adjustment in the small group market. *See* XI, below.

  - Provide flexibility in the period of time to determine the age and gender characteristics of an employer's population. *See* XII, below.

- *Geographic Variations:* Permit the cost of coverage to be calculated based on the lesser of the costs plans would actually incur providing the plan's benefits to a standard population in a standard-cost region of the country or the plan's actual costs. *See* XV, below.

- *Standardized Employer Reporting Forms:* Require employers to use a standardized reporting form that is electronically delivered to report to the IRS and coverage providers the extent (if any) that the cost of applicable coverage exceeds the relevant dollar limit during a coverage period and the amount of any excise tax owed. *See* XVII, below.

Additional recommendations and detailed comments are attached.

We appreciate the opportunity to provide comments regarding the Notice on the excise tax and look forward to continuing to work with Treasury and the IRS as they issue guidance on implementing this tax. If you have any questions, please contact Richard White at Richard.White@bcbsa.com or 202.626.8613.

Sincerely,

Kris Haltmeyer
Vice President
Health Policy Analysis
Blue Cross Blue Shield Association

BCBSA Detailed Comments and Recommendations on Notice 2015-52, Section 4980I — Excise Tax on High Cost Employer-Sponsored Health Coverage

I. Person Liable for the § 4980I Excise Tax

Issue:

Internal Revenue Code ("IRC") Section 4980I(c)(1) and (2) specifies that in the case of applicable coverage that is not insured and is not an HSA or Archer MSA "the person that administers the plan benefits" is the entity that must pay the excise tax. The statute does not define the term "person that administers the plan benefits." The Second Notice discusses two alternative approaches to determining the identity of the person that administers the plan benefits and is thus liable for the excise tax. The first approach looks to the entity performing day-to-day functions with respect to the plan. The second approach looks to the entity that has ultimate authority regarding the administration of plan benefits.

Recommendation:

Adopt the second approach discussed in the Notice. Under that approach, the person that administers the plan benefits would be the person that has ultimate authority with respect to the administration of plan benefits (including arrangements with service providers and the authority to terminate service provider contracts), even if such authority is not routinely exercised.

Treasury and the IRS should clarify that for purposes of the ultimate authority test, the term "service provider" means third party administrators, pharmacy benefits managers, and other similar parties responsible for administration of plan benefits and *not* health care providers. If Treasury and the IRS do not clarify that health care providers are not service providers, the rule should be that employers always have ultimate responsibility with respect to the administration of plan benefits.

Regardless of which approach is adopted, Treasury and the IRS should make clear that health insurance issuers merely providing administrative services are never "the person that administers the plan benefits" and thus cannot be liable for the excise tax.

Rationale:

The second approach contemplated in the Notice, which looks to which party has ultimate authority over plan benefits, is the preferable approach for several reasons.

First, in adopting the "ultimate authority" approach, Treasury and the IRS would permit plans to define the person that administers the plan in a way that most easily fits with current plan filing and reporting requirements under ERISA and the Internal Revenue Code, *i.e.,* the ERISA plan administrator.

Additionally, the second approach is less likely than the first to result in confusion among parties as to which entity bears liability for the excise tax. The second approach would, at least as an initial matter, allow one to look to the four corners of the plan document to determine which entity is the "person that administers the plan benefits," rather than having to try and determine

which entities may actually be wielding authority over various provisions of plan administration. The likelihood of ending up with multiple responsible parties is reduced when the test is "ultimate" authority rather than day-to-day plan administration.

Identifying the correct entity liable for the excise tax is also important to help to mitigate the effects of the excise tax that create an unlevel playing field among health insurance issuers based on the fact that the excise tax affects employers differently depending on the income tax status of health insurance issuers. The unlevel playing field exists because some health insurance issuers are exempt from income tax and do not need to be reimbursed for income tax when they collect amounts reflecting the excise tax while other issuers (such as Blue Cross Blue Shield Plans) are subject to income tax and face income tax consequences for collecting additional amounts reflecting the excise tax. Identifying the correct parties liable for the tax will avoid making the playing field even more unlevel.

Further, health insurance issuers are not only in competition with each other, but with decisions by employers to self-fund benefits rather than insuring them in order to avoid built in tax expenses for which issuers must be reimbursed by employers. Identifying the proper party liable for the excise tax helps health insurance issuers compete based only on the actual expenses they face, not liability imposed by an interpretation of the law that will increase expenses and drive more employers into self-funding.

Lastly, we note that that identifying the correct entity liable for the excise tax is important given the complexity of administration of the excise tax under existing state and federal laws, especially for small groups.

- *Definition of Premium:* Most states have broad definitions of premium that may make it difficult to collect amounts to recoup the excise tax outside the premium. The typical definition provides that "premium" includes the consideration for insurance, by whatever name called, such as assessments or fees. Even without these state insurance code definitions, financial reporting requires recognition of premium on a gross basis (*see* NAIC Statement of Statutory Accounting Principles No. 54, which state laws require insurers to follow).

- *Unfair Discrimination:* State unfair discrimination statutes prohibit making or permitting in any manner unfair discrimination between individuals of the same class and of essentially the same risk. These statutes may be a barrier to estimating whether small group health plans will trigger the excise tax and to adding an amount reflecting the estimated tax to all group health plan premiums because some of those groups did not actually trigger the excise tax.

- *Midyear Rate Change Restrictions:* While taxes may be considered in setting small group rates, federal law prohibits group health plan level rate adjustments in the small group market of more than once a year (although the index rate, reflecting claims costs, may be adjusted quarterly). 45 C.F.R. § 156.80(d)(2), (3). Since issuers will not know in advance whether an employer plan will trigger the excise tax they must base their recoupment of the tax on estimates of the cost of an employer's plan.

II. Taxable Period

Issue:

The excise tax is applied for high-cost coverage during a "taxable period." The statute defines a taxable period as the calendar year or such shorter period as Treasury and the IRS may prescribe. The statute permits different taxable periods for employers of varying sizes. The Second Notice states that Treasury and the IRS anticipate that the taxable period will be the calendar year for all taxpayers, regardless of whether the applicable coverage operates on a calendar year or non-calendar year basis.

Recommendation:

Provide transition relief so that plans with non-calendar year plan years beginning in 2017 and ending in 2018 are not subject to the excise tax for the months of the 2017 plan year that fall in calendar year 2018.

Rationale:

Issuers, administrators, and employers have already begun planning for the excise tax but still lack any guidance on which they can rely. Even if proposed regulations are issued in a timely manner, issuers, administrators, and employers will be operating under intense time pressure to quickly comply with rules that will no doubt be tremendously complex. They should not risk incurring an excise tax liability which they could not have reasonably avoided.

Non-calendar year plans will be at a competitive disadvantage if they are forced to anticipate Treasury and IRS rules months in advance of identical plans that operate on a calendar year basis. The absence of transition relief would greatly increase the chances that non-calendar year plans would incur an excise tax liability in 2018. Treasury and the IRS have the authority to provide limited transition relief and have done so numerous times in implementing the Affordable Care Act. Providing transition relief for non-calendar year plans for their 2017 plan years would put non-calendar year plans on the same footing as their calendar-year counterparts as called for by general equitable principles of sound tax policy.

III. Determination Period

Issue:

To calculate the amount of any excise tax owed, an employer must determine the extent, if any, to which the cost of applicable coverage exceeds the relevant dollar limit during a coverage period. The employer must then notify both the coverage provider and the IRS of the amount of the excise tax that must be paid by the coverage provider. The Second Notice states that Treasury and the IRS anticipate that employers will be required to determine the cost of applicable coverage provided during a taxable year sufficiently soon after the end of that taxable year to enable coverage providers to pay any excise tax owed in a reasonably timely manner.

For HSAs, FSAs, HRAs, and other account based products, the cost of coverage may often only be determinable after the end of a run-out period during which employees can submit claims for reimbursement.

Experience-rated plans often provide for payments to be made to or from an insurer, or premium discounts offered by an insurer, after the end of a coverage period – requiring settlements between insurers and employers many months after the end of the coverage period. Rules issued by Treasury and the IRS implementing the excise tax must instruct employers how to calculate the cost of applicable coverage for account based products and for experience-rated products, including the time frame in which employers will be required to determine the cost of the plan and notify the coverage provider of any excise tax owed.

Recommendation:

Establish a reporting and payment timeline that does not unduly add to the already considerable burdens employers face under existing Affordable Care Act ("ACA") reporting requirements. Sufficient time must be provided after the end of the taxable year for the calculation, noticing, and payment of any excise tax liability, including the calculation of liabilities associated with experience-rated plans. The timeline should allow the employer four months after the end of the determination period to notify the liable parties of the amount of excise tax that must be paid.

Additionally, Treasury and the IRS should permit the cost of applicable coverage for insurance products with experience-rated features to be determined using the relevant COBRA premium.

Rationale:

Employers will play a central role in administering the 40 percent excise tax regime for the IRS. Under IRC section 4980I(c), the employer must determine the extent of any 40 percent tax with respect to an employee, provide notice to any responsible parties of their share of such tax (*e.g.,* carriers with respect to insured coverage), and remit any 40 percent tax for which it is itself responsible (*e.g.,* with respect to HSA contributions, or if it is the "person that administers plan benefits" with respect to self-funded coverage).

The complex administration of section 4980I is particularly daunting given that employers are already confronting a host of ACA-imposed tax reporting requirements that occur soon after the close of the taxable year – including Form W-2 reporting, and sections 6055 and 6056 reporting. Additionally, employers have responsibility for resolving any questions responsible parties may have with the employer's calculation of any 40 percent tax liability for such parties.

In light of these employer burdens, it is imperative that the Department establish a reporting and payment timeline that recognizes the existing burdens imposed upon employers by the ACA and provides sufficient time following the close of the taxable period for the calculation, noticing, and payment of any 40 percent tax liability, especially considering the many parties involved.

In addition, permitting experience-rated plans to use the COBRA premium for purposes of determining the cost of applicable coverage would help facilitate compliance with and administration of the excise tax since employers are already familiar with calculating COBRA premiums. With respect to experience-rated plans, an approach permitting the use of the past-

cost method currently used to calculate COBRA premiums would allow employers, with the assistance of their insurers, to determine the cost of coverage for the taxable year after accounting for any payments or rebates.

IV. Exclusion from the Cost of Applicable Coverage

Issue:

If a person other than the employer is liable for the excise tax that person will likely pass through the costs associated with the excise tax to the employer. The amounts that might be passed through include not only amounts that are attributable to the excise tax itself (referred to in the Second Notice as "excise tax reimbursements") but also amounts attributable to the indirect income tax effects to the coverage provider (referred to in the Second Notice as "income tax reimbursements").

The Second Notice contemplates permitting excluding both excise tax reimbursements and income tax reimbursements from the cost of applicable coverage, but only if the reimbursements are separately billed and identified as attributable to the cost of the excise tax.

Recommendation:

Exclude both excise and income tax reimbursements from the cost of applicable coverage (as contemplated in the Second Notice).

Treasury and the IRS should permit excluding both excise tax reimbursements and income tax reimbursements from the cost of applicable coverage even if those amounts are included in premiums for purposes of state law. When state law prohibits separate billing, Treasury and the IRS should provide a means by which the amount attributable to the excise tax can be identified and reported to employers and the IRS and excluded from the cost of applicable coverage.

Treasury and IRS should also permit the exclusion of state and local taxes from the cost of applicable coverage, including state and local income taxes to the extent they are attributable to the excise tax.

Rationale:

Excluding direct and indirect amounts attributable to the excise tax from the cost of applicable coverage is supported both by the statutory language and general principles of tax policy. Code section 4980I(d)(2)(A) states that in determining the cost of applicable coverage, "*any* portion of the cost of such coverage which is *attributable to the tax* imposed under this section shall not be taken into account" (emphasis added).

Excluding income tax reimbursements also may help to mitigate effects of the tax that create an unlevel playing field among health insurance issuers and place group health plans in a "squeeze" between market regulations and the excise tax. As stated previously, (*see* I, above), the unlevel playing field exists because some health insurance issuers are exempt from income tax and do not need to be reimbursed for income tax when they collect amounts reflecting the

excise tax while other issuers (such as Blue Cross Blue Shield Plans) are subject to income tax and face income tax consequences for collecting additional amounts reflecting the excise tax. Excluding income tax reimbursements would create a more competitive marketplace.

Excluding income tax reimbursements would also help alleviate the "squeeze" created by market regulations and the excise tax. For example, the agencies that regulate health insurance markets made it clear that limits on out of pocket costs (self-only coverage, $6,850; other than self-only coverage, $13,700) apply to all non-grandfathered group health plans for plan years beginning in or after 2016. Meanwhile, a recent Aon Hewitt survey found that 33 percent of employers were considering reducing their exposure to the excise tax by increasing out of pocket costs. Excluding income tax reimbursements would help health insurance issuers avoid this "squeeze."

Excluding income tax reimbursements, as well as the costs associated with state and local taxes, is also supported by general principles of tax policy. Not excluding amounts attributable to the excise tax would result in double taxation of the same amount, because if the coverage provider passes through the cost of the excise tax and receives reimbursement for its costs those reimbursements will be additional taxable income to the coverage provider. Further, under Code section 4980I(f)(10), the additional income is not offset by a deduction. Not permitting amounts attributable to the excise tax to be excluded would result in penalizing parties multiple times for the same excess benefit.

As described above (*see* I), state insurance laws contain complex rules relating to rates, premiums, and billing and may make it infeasible for insurers to separately identify amounts attributable to the excise tax. Unless Treasury and the IRS either provide that separate billing is not required to the extent it conflicts with state law and makes available another means by which the amount attributable to the excise tax can be identified to the employer and the IRS, or preempts state law by regulation, insurers, employers, and employees will experience the excise tax differently depending on where they live and do business. Not only is this result inequitable, it also increases the risk that insurers will decrease their offerings in states with laws that do not allow for separate billing. Insurers operating in states that do not allow separate billing will likely be at a disadvantage anyway since amounts attributable to the excise tax will increase premiums, thus potentially increasing other state and federal taxes. Treasury and the IRS should do everything in their power to reduce the inequitable effects of state and local law with respect to the excise tax.

V. Income Tax Reimbursement Formula

Issue:

The Second Notice proposes a formula for calculating the amount of income tax reimbursement that can be excluded from the cost of applicable coverage. Treasury and the IRS request comments on whether, in determining the value of any income tax reimbursements, coverage providers should be required to use their actual marginal tax rates or whether a standard rate should be used that would apply across all coverage providers.

Recommendation:

Exempt amounts collected to recoup the excise tax from income tax due to the great complexity surrounding income tax reimbursement. If Treasury/IRS feel they cannot do this, they should include the income tax reimbursement formula in the Second Notice in regulations and permit coverage providers to use a reasonable estimate of their marginal tax rate based on federal, state, and local taxes to determine the amount of the income tax reimbursement excluded from the cost of coverage.

Rationale:

Use of the actual marginal tax rate is not workable because coverage providers will not know that rate prior to the calendar year that Treasury/IRS propose to use as the taxable period and will not be able to recoup the excise tax and any income tax resulting from the recoupment. Allowing coverage providers to use a reasonable estimate of their marginal tax rate builds in flexibility that makes administration of the excise tax easier. It also allows coverage providers to consider all federal, state, and local taxes in estimating their marginal tax rate.

VI. Allocation of Contributions to HSAs, Archer MSAs, FSAs, and HRAs

Issue:

Both the First and the Second Notices indicate that Treasury and the IRS anticipate future proposed regulations providing that salary reduction and employer flex contributions to health FSAs will be included in determining the cost of applicable coverage.

Recommendation:

Provide relief by excluding salary reduction and employer flex contributions to FSAs from the definition of applicable coverage, in order to encourage employers to continue offering consumer driven health funding vehicles long available to employees.

If a permanent exclusion is not possible given the statutory language of the provision, interim relief (such as a three year non-enforcement safe harbor) should be provided in order to assist employers who wish to still offer FSAs to their employees and to assist consumers – many of whom have chronic health needs – that rely upon health FSAs.

In the absence of permanent relief, Treasury and the IRS should implement the approach discussed in the Second Notice under which contributions to account-based plans would be allocated on a pro-rata basis over the period to which the contribution relates (generally, the plan year), regardless of the timing of the contribution during the period.

Rationale:

Like HSAs, FSAs increase consumers' awareness of their health spending and since amounts in an FSA can be rolled over from year to year participants have an incentive to spend the amounts in their FSAs wisely.

With passage of the ACA, Congress signaled its approval of FSAs by encoding them in statute. If, however, FSAs are included in the definition of applicable coverage, the effort involved in valuing the cost of each individual FSA, in addition to the complications inherent in determining the value of an FSA, would make the cost of administration prohibitive. If FSAs are included in the definition of applicable coverage we expect that most employers will simply stop offering FSAs altogether. This result would be in stark contrast to Congressional intent.

The Congressionally mandated cap on FSA contributions ensures that were such contributions excluded from the definition of applicable coverage, FSAs would not create an end-run around the purpose of the excise tax.

Even if Treasury and the IRS believe their authority is constrained in providing relief for FSAs given the statutory language in Section 4980I(c) and (d), it would be well within their regulatory authority to create safe harbors for valuing FSA contributions or to provide other limited interim relief.

If FSAs are included in applicable coverage, all efforts should be made to reduce the complexity of valuing the coverage they provide. FSAs are notional accounts and as such there is no uniform standard for when contributions are made. Allocating contributions on a pro-rata basis over the plan year should result in the same valuation at the end of the taxable period while significantly easing administrative burdens associated with calculating the value of account based plans.

VII. Cost of Applicable Coverage under FSAs with Employer Flex Credits

Issue:

Code section 4980I(d)(2)(b) states that in valuing health FSAs, the cost of coverage for purposes of the excise tax is equal to the sum of: (i) the amount of any pre-tax contributions made by an employee under a salary reduction election plus, (ii) the cost of applicable coverage under the generally applicable rules for determining the cost of applicable coverage with respect to any reimbursement under the arrangement in excess of the contributions made under the salary reduction agreement.

Under this general rule, in determining the portion of the cost of applicable coverage attributable to non-elective flex credits contributed to an FSA by an employer, the cost of the non-elective flex credits would be the amount that is actually reimbursed in excess of the employee's salary reduction election for that plan year. With respect to amounts carried over to a subsequent year, the rule would take such amounts into account in a later year if the reimbursements in the subsequent year exceeded the amount of employee salary reduction in the subsequent year. This approach could lead to double counting since amounts could be taken into account both in the year of contribution and in later years.

To avoid double counting, in the Second Notice Treasury and the IRS propose a possible safe harbor under which the cost of applicable coverage would be the amount of an employee's salary reduction, without regard to carry-over amounts. This safe harbor would be available to

FSAs with employer flex credits as long as the amount elected by the employee for the FSA was less than or equal to the maximum amount permitted under Code section 125(i) ($2,550 for 2015, subject to annual indexing).

Recommendation:

Adopt the safe harbor discussed in the Second Notice for FSAs with and without employer flex credits. Treasury and the IRS should clarify that the safe harbor applies to both types of FSAs (that is, those with and those without employer flex credits) and that the FSAs are valued by only looking at salary reduction contributions as long as the salary reduction contribution are less than or equal to the maximum amount permitted under Code section 125(i).

Rationale:

Providing the safe harbor will help reduce administrative burdens associated with the excise tax and facilitate taxpayer compliance.

VIII. Age and Gender Distribution of the National Workforce

Issue:

Code section 4980I(b)(3)(C)(iii) provides for an increase in the statutory dollar limit based on the age and gender characteristics of all employees of an employer. As a general rule, the cost of applicable coverage differs based on age and gender. On average, older individuals have higher health costs than younger individuals and younger women have higher health costs than younger men. As the Second Notice points out, some employers may have higher health costs than other employers under identical benefits plans simply due to the makeup of their workforce. Under the statute, the age and gender adjustment increases the dollar limit by an amount equal to the excess of the premium cost of the Blue Cross and Blue Shield Service Benefit Plan standard option under the Federal Employees Health Benefits Plan ("FEHBP") if priced for the age and gender characteristics of all employees of an individual employer, over the premium cost for providing this coverage if priced for the age and gender characteristics of the national workforce.

In order to compare the employer's premium costs with the national premium costs, the age and gender characteristics of the national workforce and the age and gender of the employer's workforce must be determined. In the Second Notice, Treasury and the IRS provide a framework for how they might approach the determination of age and gender distributions.

Recommendation:

BCBSA generally supports the approach to determining age and gender distributions provided in the Second Notice. Treasury and the IRS should, however, provide details regarding how the proposed approach will actually work in practice. The calculation of the employer's premium cost using the age and gender tables should use enrolled employees rather than all employees and flexibility should be provided for the snapshot date for the employer determination of the composition of its employee population.

Rationale:

Absent specific details about how the approach discussed in the Second Notice will be implemented, such as which employees will be taken into account when determining distributions, it is impossible to evaluate how complicated and costly the age and gender determinations will be to administer. The employer's actual cost is only impacted by its enrolled employees, so the use of all employees may skew the calculation. The use of the first day of the plan year as a snapshot date may not adequately capture the actual age and gender composition of an employer, especially smaller employers or employers with high turnover of employees.

IX. Age and Gender Adjustment Tables – Age Bands

Issue:

Treasury and IRS are considering using the Current Population Survey as summarized in Table A-8a, published annually by the Department of Labor Bureau of Labor Statistics for determining age and gender distributions. The Notice states that this table provides the number of individual participating in the labor force by five-year age-bands up to age 75 and over and ratio of male to female workers in each band.

Recommendation:

BCBSA supports the use of a table with five-year age-bands. However, Table A-8a as viewed on the DOL website does not appear to have five-year age-bands and the highest age bracket is "55 and older" without breaking these ages down into five-year age brackets. We recommend the use of a table that has the five-year age-bands up to age 75 as described.

Rationale:

Five-year age bands up to age 75 should be sufficient to calculate the national workforce characteristics for the age gender adjustment, but the brackets shown in Table A-8a are not sufficient due to lack of five-year age brackets and no five-year age brackets after age 55. The table cited by the Notice is especially deficient because cost increases rapidly for employees 55 and older.

X. Age and Gender Adjustment Tables – Claims Data Source

Issue:

Treasury and the IRS anticipate formulating adjustment tables to facilitate and simplify the calculation of the age and gender adjustment. As part of the development of the tables, Treasury and the IRS would determine the average cost of FEHBP coverage. The Notice states that two approaches to determining the average cost of FEHBP coverage are being contemplated. The first approach would rely on actual claims data from the FEHBP Blue Cross

and Blue Shield Service Benefit Plan standard option. The second approach would rely on national claims data reflecting plans with a design similar to that of the FEHBP Blue Cross and Blue Shield Service Benefit Plan standard option.

Recommendation:

Look at national claims data from plans with designs similar to the FEHBP standard option to determine the average cost of coverage; specifically, Treasury and IRS could use a nationally representative database of employer claims for a data source for the age and gender claims curve.

Rationale:

Looking at claims from plans offered nationwide will provide a more accurate reflection of the national workforce than would simply looking at claims from the FEHBP Blue Cross and Blue Shield Service Benefit Plan standard option. There is some concern that the population covered under the FEHBP Blue Cross and Blue Shield Service Benefit Plan standard option is relatively older, does not reflect the gender balance of the national workforce, and includes the impact of adverse selection due to older or higher cost individuals (or both) selecting this plan which is among the richest in benefits in the FEHBP offering. Thus, the Blue Cross and Blue Shield Service Benefit Plan standard option age and gender claims curve will not be representative of a national workforce claims curve.

XI. Age and Gender Adjustment Tables – Age Rating

Issue:

Treasury and IRS seek comments on whether the approach to the age and gender adjustment should take into account the age rating scale adopted in regulations for the individual and small group markets.

Recommendation:

Do not use the age rating scale for the individual and small group markets for the age and gender adjustment for the large group market. However, it may be appropriate to use the age rating scale for adjustment in the small group market.

Rationale:

The large group market cost of coverage for a specific group includes the impact of age and gender. However, gender may not be considered in the cost of coverage for a small group (42 U.S.C. § 300gg(a)(1)(B); 45 C.F.R. §§ 147.102(a)(2), 147.104(e)) and the age adjustments are mandated by the small group age rating scale (42 U.S.C. § 300gg(a)(1)(A)(iii); 45 C.F.R. §§ 147.102(a)(1)(iii), 147.104(e)).

XII. Age and Gender Adjustment Tables – Time to Determine Age/Gender Characteristics

Issue:

To determine the age and gender of a particular employer's population, Treasury and IRS are considering a requirement to use the first day of the plan year as a snapshot date.

Recommendation:

Provide flexibility in determining the period of time to determine the age and gender characteristics of an employer's population. Particularly for small groups, the age and gender composition can change dramatically during the year due to new entrants and terminations.

Rationale:

The small group market is largely per member rated, with older members rated at up to three times younger members, and new entrants or exits can dramatically impact the average cost of coverage and the age and gender composition.

XIII. Notice of Calculation of Applicable Share of Excess Benefit

Issue:

Under the statute, employers are required to determine the extent of any excise tax liability, to provide notice to any responsible parties of their share of the excise tax, and to notify the IRS of the amount so determined for each party. Treasury and the IRS are considering both the form in which, and the time at which, the required information must be provided.

Recommendation:

Establish reporting and payment requirements that: 1) allow for sufficient time following the close of the taxable period for the calculations, noticing, and payment of the excise tax; 2) permit responsible parties to ask questions of the employer regarding the calculation of the excise tax; 3) provide a time period in which parties notified of an excise tax liability may dispute the employer's calculations; and 4) allot sufficient time for payments to be made to the IRS. Additionally, notices provided by employers to responsible parties should be standardized and should be required to be provided electronically (*see* XVII, below).

Employers should have four months following the taxable period to calculate the excise tax.

Rationale:

Employers and coverage providers will need sufficient time in which to calculate, provide required notifications, and pay the excise tax. Treasury and the IRS should make every effort to reduce the administrative burden associated with this already incredibly complex and costly tax.

XIV. Payment of the Excise Tax

Issue:

The Second Notice provides that Treasury and the IRS are considering designating the filing of Form 720, Quarterly Federal excise tax Return, as the appropriate method for the payment of the excise tax. Under the contemplated approach a particular quarter of the calendar year would be designated for the use of Form 720 to pay the excise tax.

Recommendation:

Designate Form 720 as the appropriate method for the payment of the excise tax and allow consolidated filing of Form 720. Form 720 should be filed annually, but when the filing is due and when the excise tax should be paid should depend in part on how and when the cost of applicable coverage is determined, how long the employer has to calculate and inform the parties of their share of the excise tax, and how long the health insurance issuers are allowed to review and question employers' calculation of the excise tax. For example, how Treasury and the IRS require experience-rated plans to take into account payments and rebates will determine in part how soon after the end of the taxable year the cost of coverage can be determined.

Rationale:

Employers and other parties including issuers are already familiar with Form 720 and thus using it for paying the excise tax will ease some of the administrative burden imposed by the statute. Since the excise tax will be collected annually, one filing per year should be sufficient for administration of the excise tax.

Health insurance issuers and employers should be allowed to file consolidated returns using Form 720. Currently Form 720 cannot be filed on a consolidated basis. An issuer or employer with numerous affiliates would have to file Form 720 for each affiliate that owes a tax. Filing a consolidated return would ease administration of the tax and lower costs for filers.

XV. Geographic Variation

Issue:

The cost of applicable coverage must be determined under rules "similar" to the rules for calculating COBRA applicable premiums. The statute provides two baseline per-employee dollar limits (for self-only and for other-than-self-only coverage) as well as several upward adjustments to increase the baseline amounts in various circumstances. There are, however, no explicit upward adjustments for geographic variation.

Recommendation:

Permit the cost of coverage to be calculated based on the lesser of the costs plans would actually incur providing the plan's benefits to a standard population in a standard-cost region of the country or the plan's actual costs. This would promote equity between employees, employers, and insurers in different markets and would be consistent with how other adjustments are applied in only an upward direction. It would also allow distinctions that have traditionally been made in the group market thus causing relatively less disruption to the existing marketplace.

This approach could be grounded in the statute's direction to Treasury to determine the cost of coverage in a manner similar to COBRA, which specifically allows for the consideration of geographic variation in cost. It would allow national aggregation approach for determining the cost of coverage so that plans in high cost areas could adjust expected costs based on national averages using standard population tables prepared and published by Treasury and the IRS. This is not dissimilar from an employer with a large employee population that operates in 50 states and chooses to set COBRA rates for its self-insured plan based on its overall claims experience rather than setting rates based on geographic areas.

Rationale:

Although the statute does not list geography as one of the specifically enumerated factors for an upward adjustment to the dollar limits specified in § 4980I(b)(3), it is within Treasury's and the IRS' regulatory authority to permit plans to limit the effects of geographic location in determining the underlying cost of coverage as described in § 4980I(d)(2).

The cost of coverage varies significantly from region to region due primarily to differences in provider reimbursement rates. Not accounting for geographic variation in determining the cost of coverage will inevitably lead to inequitable results for insurers, employers, and consumers in high-cost areas. It would make no sense for a gold level plan offered on a SHOP Marketplace in New York to be subject to the excise tax when an identical plan offered on a SHOP Marketplace in Alabama is not. Administering the excise tax without accounting for geographic variation in the cost of coverage would unfairly increase the cost of plans in already high-cost areas. As a result, employers will likely impose more cost sharing on employees or drop coverage altogether in greater proportions in certain high-cost geographic areas.

Therefore, Treasury and the IRS should permit the cost of coverage to be calculated based on standard population measurements, normalizing the cost for the impact of geography in high-cost areas. Issuers should be permitted to determine the cost of coverage under Code section 4980I by either electing to look at costs based on their geographic service areas, or by looking at standardized claims expenditures for national standardized populations. The standardized claim expenditures should be included in tables published by the IRS and could be developed by using publicly available databases or by working with actuarial firms that have access to additional data sources.

Section 4980I(d)(2)(A) clearly contemplates that it is within Treasury's and the IRS's sole authority to develop rules for determining the cost of applicable coverage. While those rules must be "similar" to the COBRA rules, the language of the statute instructs Treasury and the

IRS to structure the requirements for determining the cost of coverage in such a way as to best carry out the intent of the section. *See* § 4980I(g). As will be demonstrated below, it is possible for Treasury and the IRS to develop rules that are both similar to COBRA and lessen the impact of geographic variations on the cost of health coverage for purposes of the excise tax.

Code section 4980I(d)(2)(A) states that the cost of coverage should be determined under rules similar to COBRA. COBRA rules clearly allow for some geographic smoothing. In particular, COBRA allows a self-insured employer to determine COBRA premiums on either a "plan as a whole basis" or on a "geographic-specific" basis. In the case of a very large self-insured employer this effectively permits the establishment of COBRA premiums on a national average basis.

The COBRA "applicable premium" is the "cost to the plan for [the period of continuation coverage] of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether the cost is paid by the employer or the employee)." Code § 4980B(f)(4). The COBRA regulations define "similarly situated" beneficiaries to mean "the group of covered employees, spouses of covered employees, or dependent children of covered employees receiving coverage under a group health plan maintained by the employer or employee organization who are receiving that coverage for a reason other than the rights provided under the COBRA continuation coverage requirements and who, based on all of the facts and circumstances, are most similarly situated to the situation of the qualified beneficiary immediately before the qualifying event." Treas. Reg. § 54.4980B-5.

The legislative history of Code section 4980B states that "[i]n general, similarly situated individuals are those individuals defined by the plan (consistent with Treasury regulations) to be similarly situated and with respect to which no qualifying event has occurred. The Secretary of Treasury is to define similarly situated individuals by taking into account the plan under which the coverage is provided (*e.g.,* high or low option), the type of coverage (single or family coverage) and, if appropriate, *regional differences in health costs*." H. Conf. Rep. No. 453, 99th Cong., 2nd Sess. 565-566 (emphasis added).

Based on the above, it is clear that when calculating the applicable COBRA premium, a multi-state employer with a self-insured plan may, at a minimum, treat employees in different regions as similarly situated and calculate the cost of coverage across the plan as a whole. Treasury and the IRS have the authority to develop guidance allowing the cost of insured and self-insured coverage to be calculated for excise tax purposes using rules "similar" to the COBRA rules for self-insured coverage.

While the COBRA "plan as a whole basis" approach works well for large national groups, it works less well for smaller and regional groups. Treasury and the IRS should afford COBRA-like flexibility under Code section 4980I to all plans, and this flexibility should not hinge on whether health coverage is offered through a regional insurer, national insurer, or on a self-funded basis. The flexibility should not hinge on whether the covered employees are employed by a small local employer, or a large national employer in all 50 states.

All parties potentially liable for the excise tax should be given the chance to operate on a level playing field. Thus, an issuer should be permitted to determine the cost of coverage under Code section 4980I by either electing to look at costs based on its geographic service areas, or

by looking at standardized claims expenditures for national standardized populations using tables established by the IRS.

XVI. Small Group Rating Issues

Issue:

Small group rating restrictions and single risk pool rating rules will result in the tax being pooled among small group customers and will be charged to groups that do not have any tax liability based on their benefit plans.

Recommendation:

Exempt small group plans that are gold metal level or lower from the excise tax. In addition, large group plans with actuarial values that are less than or equal to a gold metal level plan should also be exempted from the excise tax.

Rationale:

If the tax is recouped through premiums, small group rating rules require that the expense be pooled. The rating rules allow administrative cost variations at the plan level, but employers choosing the same plan will have different excise tax liabilities depending on the other benefits they offer. The premium for a particular plan is not allowed to vary between small groups based on their excise tax liability. The impact of the excise tax is lessened on a particular employer and will be less effective in discouraging the provision of additional benefits because the cost is spread to other employers.

The excise tax is an incentive to reduce overly rich benefits. Platinum plans are the richest plans, followed by gold, silver and bronze. Issuers selling on the SHOP are required to offer silver and gold plans, but not platinum. The actuarial value for gold plans is 80 percent (+/- two percent), which is not overly rich given historical employer offerings. If this policy is adopted for small group plans it should be considered for large group plans as well.

XVII. Standardized Employer Reporting Forms

Issue:

There is no standardized reporting format for employers to use in reporting their calculations to the IRS and coverage providers of the extent (if any) that the cost of applicable coverage exceeds the relevant dollar limit during a coverage period and the amount of any excise tax owed.

Recommendation:

Regulations should require a standardized reporting form that is electronically delivered for use by employers to report their calculations to the IRS and coverage providers of the extent (if any)

that the cost of applicable coverage exceeds the relevant dollar limit during a coverage period and the amount of any excise tax owed.

Rationale:

A standardized reporting form will make it easier for all parties to understand how an employer arrived at its determinations as to whether applicable coverage exceeds relevant dollar limits and which coverage providers owe how much of the excise tax. Electronic delivery will be faster than delivery on paper and eliminate the possibility of error in manually transferring data. These efficiencies will help ease the administration of what will be a complex process in resolving any questions or discrepancies in employer calculations.