CHCC

CORPORATE HEALTH CARE COALITION

October 1, 2015

CC:PA:LPD:PR (Notice 2015-52)
Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, D.C. 20044

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

Dear Secretary Lew and Commissioner Koskinen:

The Corporate Health Care Coalition (CHCC) appreciates the opportunity to comment on Notice 2015-52, regarding Section 4980I of the Internal Revenue Code which was added by the Patient Protection and Affordable Care Act ("ACA"), (Pub. L. 111-148) (the "40 Percent Tax"). Our comments particularly focus on our recommendations that Treasury and the IRS allow for direct payment of the tax, and provide new rules for the age and gender adjustment. We also reemphasize some of our comments regarding Notice 2015-16.

CHCC is a public policy organization comprised of leading companies from varying industries that compete in the global marketplace and sponsor health plans for the benefit of our employees and other beneficiaries. Collectively, CHCC member companies provide health benefits for more than 4 million Americans in every state in the nation. For more than 15 years, CHCC has advocated for public policies to make health care more affordable, accessible, accountable and sustainable.

CHCC is pleased to respond to the request of the Internal Revenue Service ("IRS") for comments on Notice 2015-52. As we stated in our prior comments on Notice 2015-16, guidance on the 40 Percent Tax is critically important to CHCC companies. The details on how the tax is implemented could result in a significantly negative impact on employer-sponsored health care coverage. Additionally, administrative flexibility remains a primary concern for large, self-insured employers; and therefore, consideration of transition rules, "good-faith" compliance standards and safe harbors continue to be critically important. We urge the Department of Treasury and the IRS to recognize the burden that the 40 Percent Tax will create for employers, and that consideration will be given to our comments and authority exercised to make reasonable interpretations of the law.

Payment of the Tax

CHCC companies have a particular interest in how the 40 Percent Tax is paid. Our companies generally use insurance companies as third party administrators of our self-insured plans. Many CHCC companies also give their employees the option to use insured products such as HMOs. With this variety, employers who sponsor health plans that are subject to the tax should be allowed an election to remit the tax payments directly to the IRS or to use their third party administrators to remit the tax.

The statute states that each "coverage provider" must pay the 40 Percent Tax on its applicable share of the excess benefit with respect to an employee. Further, the Code states that the health insurance issuer is liable for paying the share of the 40 Percent Tax attributable to health insurance coverage that it underwrites and the "person that administers the plan benefits" is liable for paying the share of the 40 Percent Tax attributable to "any other applicable employer-sponsored coverage," including self-funded coverage. The Code does not provide a definition for "the person that administers the plan benefits;" however, the statute does state that, "[the] term 'person that administers the plan benefits' shall include the plan sponsor if the plan sponsor administers benefits under the plan."

The Notice 2015-52 attempts to provide guidance by suggesting two different approaches to interpreting these rules. The first approach focuses on which entity is performing certain day-to-day functions with respect to the plan, and such functions anticipated to be performed by the plan's third party administrator. This approach could be confusing, given the split of functions that third party administrators do and those that are performed by the plan sponsor. Accordingly, if this approach is used, we recommend that only one specific function be emphasized, such as claims processing.

The Notice's second approach is better and preferred by CHCC companies. This option would assign liability to the entity that has ultimate authority regarding the administration of plan benefits, including those relating to eligibility, claims, and contracts with service providers – even if that person is not routinely involved in the day-to-day administration of the plan. Such authority is contained generally in the governing documents regarding the plan and, therefore, would lead to less confusion.

For many employers, requiring their third party to administer the tax would be unnecessarily complicated and costly, and would not support ERISA's goals of promoting consistency, simplicity and predictability. Accordingly, an employer should have the flexibility to determine if it is the "person that administers the plan benefits" with respect to its self-funded plans.

Additionally, for those employers that use a third party administrator to administer the 40 Percent Tax, the cost of such administration and any indirect costs (including

both excise and income tax costs) should be excluded when valuing coverage. This treatment is consistent with the statute which states that in determining the cost of 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."[1]

Determination of Reporting Period for Tax

The statute states that the "taxable period" "means the calendar year or such shorter period as the Secretary may prescribe." Some CHCC companies offer one or more non-calendar year plans. Accordingly, plan sponsors should have the flexibility to determine their 40 Percent Tax liability based upon any 12-month consecutive period.

Determination of Age and Gender Adjustment

CHCC companies are concerned about the Departments approach on the age and gender adjustment, which is an important aspect of the calculation of the 40 Percent Tax. The adjustment must be easily administered but also properly benchmarked on national workforce risk characteristics. The seven-step test in Notice 2015-52 for applying the adjustment is complicated, particularly because it would require employers to look at the age and gender characteristics of each employee and assign such employee to a given category for purposes of determining the extent of any adjustment. We hope that you will provide a safe harbor permitting employers to look at their employee workforce as a whole in determining what, if any, age and gender adjustment applies. Additionally, we hope that instead of using the actual claims data with respect to the FEHBP Blue Cross/Blue Shield Standard Option, which may not be an accurate reflection of the full national workforce, the Department will use either (i) national claims data, or (ii) adjust the actual claims data from the FEHBP Standard Option to ensure that the benchmark comparison for purposes of the age and gender adjustment better reflects the age and gender characteristics of the national workforce.

Exemption for 90 Percent "Minimum Value" Plans

The Notice asks for comments regarding the interaction between the 40 Percent Tax, and the employer shared responsibility provisions of Code section 4980H. CHCC continues to believe that the 40 Percent Tax rules should not place an employer in the position of paying for the tax in order to meet the employer shared responsibility provisions of Code section 4980H. We do not believe this is the intention of the drafters of the ACA. Accordingly, as we included in our comments to

[1] Additionally, CHCC believes that, in determining the value of any income tax reimbursements, coverage providers should have the flexibility to utilize a standard rate, as provided by the IRS and Treasury in formal guidance or their actual rate to the extent such rate is higher than the provided standard rate. This rule should also consider not only any indirect tax effects under federal tax law, but also any effects of state and local tax law (including state and local income taxes). All these costs are likely to be passed on to employers who utilize these services.

Notice 2015-16, CHCC companies recommend that the Department provide a safe harbor whereby 40 Percent Tax liability would not be triggered merely for offering a 90 percent "minimum value" plan.

RESTATEMENT OF COMMENTS TO NOTICE 2015-16

We continue to review the implications of Notice 2015-16, and urge Treasury and the IRS to focus on the issues described below

Delay of Implementation

Even as we consider the new guidance in Notice 2015-52, we continue to believe that the new tax is too complex and requires extensive planning before implementation in 2018. Accordingly, we urge the IRS and Treasury Department to immediately postpone the implementation date of the 40 Percent Tax for, at a minimum, a two-year period similar to the delay that was required of the employer mandate. This would permit reasonable time to develop workable policies as well as provide employers time to test, implement and communicate benefit design changes.

Definition of Applicable Coverage

Code section 4980I creates a broad list of "applicable employer-sponsored coverage" potentially subject to the 40 Percent Tax. In the context of the tax, CHCC believes that "applicable coverage" should be narrowed to include only major medical and prescription benefits. We believe that the definition of applicable coverage should exclude wellness programs, on-site medical clinics, employee contributions to a health savings account (HSA), employee contributions to a flexible spending account (FSA), certain Health Retirement Accounts (HRAs), and dental and vision benefits. These benefits are basic and do not represent "high value" coverage. In fact, several of these programs, such as workplace wellness programs and on-site medical clinics, have been instituted to help keep employees healthy.

Workforce Wellness Programs

Workforce wellness programs have been well developed and implemented across the employer community. Employers see these programs as a strategy to engage employees and their families to improve their health because changes in employee behavior may lead to healthier lifestyle choices and a reduction in overall health care costs. Some employers also incorporate incentives and tools that promote health and prevention into their programs to support and recognize employees' efforts toward improving their health.

The Centers for Disease Control and the National Institutes of Occupational Safety and Health have strongly encouraged employers to link their efforts associated with

health promotion with health protection, in what is called the Total Worker Health initiative. In addition, several studies have highlighted the critical role of employers, in concert with other sectors, in achieving national public health objectives, particularly in the area of chronic disease. CHCC believes that including workforce wellness programs in the definition of applicable coverage will discourage further development and expansion of such efforts by employers, and will impede progress in achieving broader national health goals. Therefore, we urge the IRS to exclude from the definition of applicable coverage any wellness programs that provide employees with immunizations, health screenings, tobacco cessation, or other de-minimis services.

On-Site Medical Clinics

Many large employers have established on-site medical clinics for numerous and diverse reasons, including promoting worksite health and safety and managing occupational health services. In many cases these clinics have been limited in scope to treating on-the-job injuries, disability determinations, etc. However, more recently some employers have expanded the role of on-site clinics to include first aid or triage care, immunizations, administering health risk assessments and coordinating preventive screenings and disease management initiatives. The intent of doing so is an attempt to protect employees against disease, reduce absenteeism and control health spending.

Notice 2015-16 cites existing Treasury regulations for COBRA continuation coverage in explaining the circumstances under which an on-site medical clinic does not constitute a group health plan subject to COBRA. The COBRA regulations provide an exception for on-site clinics that consist primarily of first aid for the treatment of a health condition, illness or injury that occurs during work hours, but only if the care is available for current employees and employees are not charged. The HIPAA/ACA excepted benefit regulations provide a general exception for on-site medical clinics but never clearly define the term.

We suggest that where employers provide care through on-site medical clinics that is limited in scope along the lines stated above, such clinics (and the services they provide) should be excluded from applicable coverage. In addition, in cases where the on-site clinic provides substantial services and is not qualified for the exclusion, an employer that has hired a service provider should have the option to use the amounts paid to the service provider to calculate the value of the facility, instead of being required to calculate the value of each of the services rendered.

Vision and Dental – HIPAA Excepted Benefits

Notice 2015-16 suggests that the IRS is considering excluding two types of excepted benefits, including self-insured limited scope dental and vision benefits and Employee Assistance Programs. We strongly support both of these suggestions. Indeed, CHCC urges the Treasury Department and IRS to exclude all benefits that are

treated as excepted benefits from the definition of applicable coverage for purposes of the 40 Percent Tax.

HSAs/FSAs/HRAs

We believe that Health Saving Account (HSA) and Flexible Savings Account (FSA) contributions should be excluded from applicable coverage irrespective of whether the contribution was pre- or post-tax. Although an employer's contributions to an HSA are referenced in the statute, they are referenced only in connection with HSAs that constitute "applicable employer sponsored coverage", which is defined as coverage through a group health plan as defined in Code Section 5000(b)(1). HSAs are individual accounts. The HSA is established pursuant to an agreement between the custodian/trustee and the individual; a contributing employer is not a party to that agreement. Employers who choose to contribute have no control over the use of an account holder's HSA funds. Moreover, account holders may use the HSA funds for nonmedical expenses, subject to income and excise tax consequences and they may use it without excise tax consequences once they become age 65 or become disabled, which makes the HSA a retirement vehicle akin to IRAs. Employees maintain HSAs post termination of employment and employers have no ability to recoup any funds they contributed to the HSA of a terminating employee. In addition, the IRS and Treasury have previously acknowledged that HSAs are typically not "group health plans" because they can be used to pay for both medical and nonmedical expenses. HSAs may, however, qualify as group health plans to the extent they fail to satisfy the "safe harbor" established by the Department of Labor under Field Advisory Bulletin 2004-1 and 2006-2, and we believe that Congress limited the application of Code Section 4980I to such HSAs.[2] Under that safe harbor, an HSA qualifies as a group health plan to the extent the employer's exerts certain control over the HSA; however, in no instance does an employer's decision to contribute to an HSA, by itself, cause an HSA to be a group health plan.

Regardless, HSAs play a vital role in helping individuals offset out of pocket costs; since the contributions are limited, and they encourage wise spending due to the carry over feature of HSAs, they do not contribute towards the growth of health care costs that the 4980I tax is designed to impede. As a result, we encourage the IRS and Treasury Department to exclude all HSA tax-free contributions from the calculation (without regard to whether the HSA is a group health plan or not). If tax-free employer contributions (including pre-tax employee salary reductions) are included in the calculation, employers may hit the tax threshold earlier than expected and, as a result, may limit or cease contributions to the HSA. This will unnecessarily shift out of pocket costs to the individual. Whereas if you exclude them from the calculation, individuals will continue to receive the much needed (albeit limited)

[2] 1 75 FedReg 37188, at 37190 (June 28, 2010). Similar treatment has been accorded for purposes of HIPAA Administrative Simplification and COBRA.

assistance they provide for out of pocket costs without increasing the costs of health care.

For similar reasons, we believe that FSA contributions should be excluded from the calculation of the excise tax, especially where the Health FSA is funded solely with pre-tax salary reductions. The ACA has already significantly limited pre-tax salary reductions made with respect to a Health FSA during the year to $2500 (adjusted for inflation). Even though Health FSAs provide assistance for out of pocket costs, they are too nominal to affect health care costs overall. Nevertheless, they are, like HSA contributions, at jeopardy of extinction if included in the calculation—ultimately at the expense of individuals.

Finally, we believe that retiree-only Health Retirement Accounts (HRAs) that are not integrated with a group health insurance arrangement or a self-insured group health plan should be excluded. Such arrangements are typically only intended to supplement or pay for other coverage not sponsored by the employer—in most cases, Medicare, Medicare supplemental coverage purchased in the individual market or other coverage purchased in the individual market. In addition, unused or roll-over contributions to any HRAs that are not excluded should be excluded from the cost calculation. If a plan sponsor makes a contribution to an individual's HRA and that individual does not spend the entire contribution by the end of the year, the plan may permit the unspent funds to be carried over. If these amounts are included in the calculation, carried over amounts may be double and triple counted each year that the tax is paid. To avoid unfair double counting, CHCC proposes that contributions to an HRA be treated as applicable coverage only in the year that they are made newly available to the participant.

Mandated benefits

We urge the IRS and Treasury Department to exclude from the calculation of "excess benefit" those benefits mandated by the ACA, such as self-insured requirements (e.g., state benefit mandates, no limits on lifetime and out of pocket maximums) and others such as coverage up to age 26 and additional preventive services. CHCC views these as standard benefits and does not believe they should be included in the calculation to assess "excess coverage."

Determination of Cost of Applicable Benefits

As we understand Notice 2015-16, Treasury and the IRS will permit employers the flexibility to calculate applicable benefits by a variety of methods. We support this flexibility, encourage additional flexibility, and oppose efforts to mandate the use of only one approach. In addition to providing employers with the flexibility to use accepted actuarial methods that assess benefit plan cost, CHCC supports allowing employers the option to leverage a third-party actuary to attest that the plan costs do not reach the 40 Percent Tax thresholds.

Additionally, CHCC recommends that employers have the flexibility in the following areas:

- The rules should allow plan sponsors to assess the cost determination on either a retrospective or prospective basis.
- Plan sponsors should be permitted to aggregate across benefit offerings, coverage tiers and populations, such as pre- and post-Medicare retirees. Large employers cover many individuals in many different states and face unique challenges under the 40 Percent Tax. These employers often offer a number of benefit plans, and therefore, should be able to aggregate across plans for determining the "cost" without the process being overly complex. While in some instances benefits may be similar in structure and actuarial value, the actual cost of the plans may vary widely due to demographics such as geographic location, age, and health status. Because of this, CHCC strongly supports an approach that permits plan sponsors to blend across coverage tiers, ERISA plans, benefit packages and populations, such as pre- and post-65 retirees.

Threshold Adjustments

CHCC strongly supports adjustments to the threshold that take into account geographic variations, particularly for high cost areas. Additionally, CHCC sees indexing as area in which the Treasury Department can and should interpret the statute liberally to ensure that the implementation of the tax does not result in unintended consequences. We are concerned that indexing the threshold to CPI-U does not account for the expected increases in medical costs that may not be controllable with some populations. We urge IRS and the Treasury Department to consider a method of indexing that more adequately accounts for medical inflation.

Safe Harbor

The Treasury Department and the IRS should provide safe harbors based on clear and easily ascertainable factors and those that are more closely related to the level of a plan's benefits and less on factors affecting costs that are not under the control of the plan nor its members. Plans already calculate actuarial values under other provisions of the ACA. Tying safe harbors to actuarial value would therefore reduce administrative burdens and tie the determination of the cost of a plan to clear and available metrics. Moreover, using actuarial value levels will reduce the influence of other factors such as geographic differences in the cost of care and age and gender differences in populations, the latter of which are likely to remain even with adjustments permitted in the law. Providing a safe harbor for plans having an actuarial value less than 90% (bronze, silver or platinum level plans on the exchanges), would assure that plans that are not providing "excess benefits" would not be taxed, yet would allow for plans to provide more than the minimum value coverage.

CONCLUSION

Approximately 4 million Americans rely on CHCC companies for their health care coverage. We design our plans carefully to match the needs of our beneficiaries, using the healthiest and most cost effective tools we have at our disposal. This tax, if it is to be retained, must be administered under rules that don't prohibit or discourage plan providers from using these valuable tools. We continue to urge Treasury and the IRS to support flexibility for plan sponsors as we work to comply with the requirements of the ACA. We appreciate your outreach to us and look forward to further commentary and engagement with the IRS and the Treasury Department on issues relating to the 40 Percent Tax.

Sincerely,

The Corporate Health Care Coalition