***Submitted electronically to:***
Notice.comments@irscounsel.treas.gov

October 1, 2015

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

***Re: Comments on Notice 2015-52***

Dear Ladies and Gentlemen:

In Notice 2015-52, the Department of the Treasury (Treasury) and the Internal Revenue Service (Service) (collectively, the "Departments") request comments on the issues addressed therein as well as other issues under Internal Revenue Code Section 4980I (referred to herein as the "Excise Tax" and commonly called the "Cadillac Tax"), including issues addressed in Notice 2015-16. We appreciate the effort by the Departments to obtain input from affected parties so that any guidance may properly reflect the policies and intended purpose of the underlying the law, as well as provide a workable basis for plans and employers to comply without adding excessive administrative costs to the health care system. We note that the Excise Tax has three intended purposes: to address the cost of employer-sponsored health insurance; to help finance the Affordable Care Act (ACA); and to reduce employer incentives to overspend on health plans and employee incentives to overuse services encouraged by these high-cost plans.

**Background Information about Cheiron**

Cheiron, Inc. provides actuarial and consulting services to sponsors of single employer, multiemployer and governmental group health plans. Cheiron does not give tax advice or provide legal services. Our services include:

- Projecting expected monthly cost expenditures
- Guidance on plan design
- Assistance with plan design and administration
- Assistance with regulatory changes (including the Affordable Care Act ("ACA"))
- Assisting trustees/sponsors to implement benefit changes
- Assistance with business partner, e.g., medical networks, selection and negotiations
- Postretirement liability accounting, reporting and funding, i.e., we help clients establish funding objectives and develop a plan to fund these liabilities.
- Developing COBRA premiums

In addition, Cheiron maintains its own group health plans, consisting of:

- Fully insured group medical
- Self-insured FSA – Employees can elect to contribute, on a pre-tax basis, up to $2,550 per plan year. For employees who also have coverage under the HRA, the FSA can be used for medical expenses only after the HRA is fully exhausted. Prior to such time, the FSA can only be used for vision, dental benefits, and non-covered medical benefits such as over-the-counter prescribed medication.
- Self-Insured HRA - Cheiron contributes $3,750 (single) and $7,500 (family) to an integrated HRA. The HRA is used for the reimbursement of the deductible for covered in-network and out-of-network benefits under the insured plan. It does not roll over from year-to-year. It cannot be used for dental and vision benefits or balance billing for out-of-network providers.
- Stand-alone dental - Excluded from the Excise Tax
- Employee Assistance Program - Excluded from the Excise Tax
- Discounted Gym Memberships – Excluded from the Excise Tax

## Comments on Notice 2015-52

Cheiron respectfully submits the comments contained herein, which are listed in the order requested in Notice 2015-52:

***Person Liable for the Excise Tax***

Section 4980I(c) (1)[1] provides that each coverage provider shall pay any excess benefits tax. For a self-insured plan that is not a health savings account or Archer MSA, the coverage provider is *the person that administers the plan benefits*, which is not a defined term in the statute. Section II.B of the Notice lays out two different alternatives for determining the identity of that person. Under the first alternative, the coverage provider would be the person who conducts the day-to-day administration of the plan. Under the second alternative, the coverage provider would be the person who has ultimate authority to decide administrative issues such as eligibility, claims, and employ service providers. Notice 2015-52 specifically asks for comments regarding application of these proposals to multiemployer plans.

*a. Multiemployer Plans*

For a multiemployer plan, the board of trustees is ultimately responsible for plan administration. It is also the board that has all the information regarding the benefits provided under the plan, selects all service providers to assist in the administration of the benefits, and designs the benefit packages that are offered participants. Individual service providers may be retained to assist in administering and managing some of the drug and medical claims, but these entities will not know all of the costs or all of the services that are used to manage the costs for all parts of the plan as a whole. Accordingly, we recommend that *the person that administers a multiemployer plan's benefits* be the board of trustees of the plan.

[1] All references are to the Internal Revenue Code.

*Other Plans*

Notice 2015-52 is unclear whether in the case of a group health plan that provides some benefits through insurers, it is the plan sponsor, the insurer, or both that are responsible for any Excise Tax. If a plan sponsor provides health benefits partly through insurance and partly through self-funding, the plan is not an insured plan. Any insurer through which the plan sponsor decides to provide benefits may not be responsible for the design of the package. If the rules were to provide that an insurer or day-to-day administrator was responsible for the Excise Tax, the cost would be increased not only for the cost of the tax, but for the administration of aggregating benefits, *e.g.*, medical, FSA, and HRA. The insurer or day-to-day administrator would insist that the plan sponsor make it whole for the tax, including any amount needed to compensate for additional income taxes stemming from the reimbursement. This could raise the costs significantly. In instances where collective bargaining agreements govern a plan's benefit levels and rates of contributions, the plan will not be able to readily increase its revenues or cut benefits to pay for the extra administrative costs and extra taxes on top of the Excise Tax.

Accordingly, we recommend the rules to provide that for plans that are partly insured and partly self-insured, the plan sponsor is the entity responsible for paying any Excise Tax, i.e., the *person that administers the plan benefits*.

***Aggregation of Employers***

*a. Multiemployer Plans*

Section 4980I (f) (9) provides that all employers within a controlled group are treated as a single employer. Each employer is responsible for calculating the amount of the excess and informing the coverage provider(s) of the results. Section 4980I(c)(4)(B) contains a special rule that requires that plan sponsor of a multiemployer plan to make the calculations and provide notice to the coverage provider with respect to the amount of the excess benefits provided by the Plan. That section reads: "*In the case of applicable employer-sponsored coverage made available to employees through a multiemployer plan (as defined in section 414(f)), the plan sponsor shall make the calculations, and provide the Notice, required under subparagraph (A).*" (Emphasis added). For a multiemployer plan, the plan sponsor is the board of trustees. See 29 USC 1002(16). Note: the quoted language applies only to coverage "made available ...through the multiemployer plan." It does not require the plan sponsor to make the calculations for other coverage. Furthermore, unlike other plans, section 4980I(b)(3)(B)(ii) provides that the annual dollar limit for determining excess benefits for all participants in a multiemployer plan is the other-than-self-only limit.

The effect of the law is to treat the multiemployer plan as both the coverage provider and the employer for purposes of the Excise Tax under section 4980I. Thus, the law recognizes that a multiemployer plan is a separate entity from its contributing employers and treats the benefits provided by the plan separately for purposes of determining the Excise Tax under section 4980I.

This special treatment is not only warranted but is necessitated by the circumstances of a multiemployer plan. If a multiemployer plan were required to determine the cost of benefits on

an employer-by-employer basis, it would require a separate analysis of the demographics of each individual employer. The cost of doing this for many employers could be staggering (a multiemployer plan may have hundreds or thousands of employers), involving both additional administrative functions and actuarial analysis. The determination of the cost of benefits for each employer's employees requires an analysis of the demographics of those employees because the cost of coverage will vary depending of the population's characteristics. Moreover, if the age and gender adjustments in the annual limits were to be applied on a controlled group basis, as contemplated by Notice 2015-52 for single-employer plans, the trustees would need to know the legal structure of each contributing employer and the demographics of employees of every entity in that contributing employer's control group. We estimate that the costs of collecting and analyzing this information could easily add excessive administrative cost especially for multiemployer plans with a lot of very small employer such as exist in the building trade industries. Moreover, the employers would likely resist providing so much private information to the plan, so it is unlikely that the plan would even be able to perform a valid analysis. These administrative costs would exist just for the plan to prove that it does not owe any Excise Tax

We are aware that the Excise Tax is determined on a month-by-month basis. We regard it as unlikely that many employees will be provided health coverage in a given month by both a multiemployer plan and another entity. That possibility, however, does not lessen the administrative issues and expense that will result if the plan needed to make its calculations reflect separate data from each employer. The more burdensome that this process is the less likely that employers will want to participate in a multiemployer, which in-turn will impact the total compensation, not just the health benefits, of America's working class.

Accordingly, we recommend that rules clarify that a multiemployer plan is treated as a separate employer for all purposes under section 4980I.

With respect to individual employers that offer supplemental coverage to their employees in a multiemployer plan, we suggest that the coverage be treated completely separately. The multiemployer plan would not need to know anything about the extra benefits and would not be impacted in any way. This treatment would greatly help small employers to provide high quality affordable care to their employees that they otherwise may not be able to provide without having to greatly increase administrative costs.

*b. Governmental Systems*

Frequently, large governmental and quasi-public systems, often found in the transportation and medical industries, are comprised of multiple systems with multiple separate employers. These systems often engage in collective bargaining with multiple unions. There is a lack of guidance for applying the controlled group rules to government entities. In this regard, section V .D. of the preamble to the final section 4980H regulations (TD 9655) states: "The final regulations continue to reserve on the application of the employer aggregation rules under section 414(b), (c), (m) and (o) to government entities, as well as to churches or conventions or associations of churches (as defined in § 1.170A–9(b)). Until further guidance is issued, those entities may apply a reasonable, good faith interpretation of section 414(b), (c), (m) and (o) in determining their status as an applicable large employer."

We believe for purposes of the ACA, that a reasonable good faith application of the controlled group rules to governmental entities or quasi-public systems is one that determines controlled group status based upon the entity with the ultimate authority for determining the health care benefits. For example if State Agency A determines the benefits for Subdivision B, and Administrative Branch C and then the Agency, Subdivision and Administrative Branch would be considered as part of the same controlled group. No other criteria would be relevant for the aggregation of governmental entities for ACA purposes. Accordingly, absent common control based upon health care benefits, each governmental/quasi-public employer would be treated as a separate employer.

Certainly where there is a separate authority that decides what benefits will be provided by a given government entity, there is little reason to aggregate that entity with another government entity. Moreover, aggregation of health plans covering fire or police departments with other divisions within a given governmental authority seems awkward at best, especially given the adjustment to the annual limit for high risk workers contained in section 4980I(b)(3(C)(iv).

To the extent that multiple governmental/quasi-public employers participate in a single plan that is established through collective bargaining, that plan would be designated as a multiemployer plan and, similar to the rule applied for other multiemployer plans, applicable cost would be calculated based upon the "other than self-only" limit.

*c. Aggregation for Purposes of Determining the Age and Gender Adjustment*

The age and gender adjustment to the annual limit contained in section 4980I(b)(3)(C)(iii) should be applied separately to each group of employees covered by a given group health plan. The costs of health benefits depend on the characteristics of the covered population. Accordingly, absent evidence of abusive practices, the aggregation rules should not apply in determining the age and gender adjustment to the annual limit.

***Exclusion from Cost of Applicable Coverage of Amounts Attributable to the Excise Tax***

Notice 2015-52 states that it is contemplated that if the coverage provider assessed the Excise Tax is not the employer, the coverage provider will seek reimbursement of the Excise Tax from the employer. The Excise Tax is not deductible, and the reimbursement would be taxable income. The notice anticipates that the reimbursement will be "grossed-up" to compensate for the fact that it is taxable income. The notice states that any reimbursement of the Excise Tax is not to be taken into account in determining the cost of applicable coverage, and that Treasury and the IRS are considering excluding any additional amount used to compensate the provider for the tax it must pay on the reimbursement. The notice observes that the marginal tax rate will vary from provider to provider and that it often will not be possible to determine a provider's marginal tax rate until sometime after the date for determining the Excise Tax. It asks if a standard formula utilizing a standard tax rate should be used to estimate the portion of the reimbursement that compensates for the taxable nature of the reimbursement.

The objective of the proposal discussed in the notice is to make sure that any reimbursement to the coverage provider to compensate for the Excise Tax does not affect the determination of the

cost of applicable coverage. This is accomplished only if the entire amount of the reimbursement is excluded. It should not matter when the reimbursement is calculated and paid so long as it is not used as a subterfuge to make additional premium payments. As stated in the notice, use of a standard marginal tax rate to determine the portion of any reimbursement that compensates a coverage provider for additional income taxes will result in some instances where the amount determined does not equal the reimbursement. Any arrangement to make a coverage provider whole for the Excise Tax will be based on a formula that includes a marginal tax rate. Accordingly, the rules should provide that any amount paid to reimburse the coverage provider for the Excise Tax is not included in the determination of the cost of applicable coverage, provided that the reimbursement is determined using the formula contained in the notice and the marginal tax rate of the coverage provider.

The complication pointed out in this section further goes to provide rationale for our recommendation of having the multiemployer plan considered as the coverage provider and the plan sponsor considered as the coverage provider for a group plan offering any self-insured benefit options.

***Cost of Applicable Coverage***

*a. Exclusion for Self-Insured Excepted Benefits*

Section 4980I(d)(1)(B)(ii) excludes from applicable coverage "any coverage under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye." (Emphasis added.) We urge the Departments to extend this exception to self-insured stand-alone dental and vision plans that qualify as excepted benefits under the Affordable Care Act, as they provide the same dental and vision services as their insured counterpart stand-alone plans.

*b. Exclusion for Excepted Benefits Provided by Account-Based Plans*

Section 4980I(d)(2)(B) provides that for health FSAs the cost of applicable coverage is equal to the sum of salary reduction contributions plus the amount determined under the general calculation rule with respect to any reimbursement under the arrangement in excess of the salary reduction contributions. Thus, the cost of applicable coverage under a health FSA includes employer flex contributions used for the health FSA.

Section 4980I(d)(2)(C) provides for HSAs and Archer MSAs that the cost of applicable coverage "shall be equal to the amount of employer contributions under the arrangement." For this purpose, employer contributions include salary reduction contributions.

Health FSAs, HSAs, and Archer MSAs (account-based plans) may be used to pay for coverage and services under stand-alone dental and vision plans. The following hypothetical demonstrates a common dental expenditure under a health FSA:

> As noted above, until an employee's HRA account balance is exhausted, the Cheiron FSA can only be used for dental, vision and non-covered medical expenses. Assume a Participant's covered dependent will need braces during the 2018 calendar year for which Cheiron's stand-alone dental plan covers only the first $1,000 of cost. During the 2017 open enrollment, Participant elects a $2,550 contribution under the FSA account, all of which is used during the 2018 calendar year for the orthodontic services provided under the dental plan.

In accordance with Section 4980I(d)(1)(B)(ii), which excludes from applicable coverage any coverage under a dental separate policy, we believe the entire amount of this FSA reimbursement should be excluded from the applicable cost calculation under the Excise Tax.

We urge the Departments to clarify that the exception for stand-alone dental and vision benefits set forth in Section 4980I(d)(1)(B)(ii) extends to expenditures from account-based plans for coverage and services provided under such stand-alone dental and vision plans. We believe any other conclusion would be contradictory to the plain meaning of Section 4980I(d)(1)(B)(ii).

***Age and Gender Adjustment***

Section 4980I(b)(3)(C)(iii)(II) provides that the annual limits for self only and other-than-self only coverage are increased by the excess of the what the premium cost would be if the participants in the employer's plan were covered under the Blue Cross/Blue Shield standard benefit option of the Federal Employees Health Benefit Plan ("FEHBP"), over what the premium cost for that coverage would be if priced for the age and gender characteristics of the national workforce.

*a. Determination of Employer Demographics*

In order to calculate the adjustment, it is necessary to determine the age and service distribution of the employer's covered workforce. The notice indicates that this is to be done as of the first day of the plan year.

In a large plan (regardless of whether it is a multiemployer plan, a single-employer plan, or a government/quasi-public plan), groups of employees enter and leave the plan throughout the year. Thus, the distribution as of the first day of the plan year will not be representative of the distribution throughout the year. In particular, in some industries such as building trades, agricultural, and education, a point in time could be extremely skewed. Accordingly, we suggest that the age and gender distribution be determined using a method similar to that allowed for transitional reinsurance fee calculations, e.g., once each quarter using the population for one month in that quarter with the month chosen, whether first, second or third, the same for each quarter. This would also allow for seasonal work patterns to be considered.

*b. Development of Age and Gender Adjustment Tables*

The notice describes a methodology under which the covered workforce is divided into age and gender groups, and a hypothetical premium is determined for each group. The hypothetical premium for a group is determined using the employees covered by the FEHBP and comparing the average claims cost for that group to the average claims cost for the entire covered population under the FEHBP standard option. The notice asks whether the methodology should use national claims data reflecting plans with a design similar to that of the FEHBP standard option.

The FEHBP demographics are unlikely to match the demographics of most group health plans. Moreover, the claims experience for the FEHBP is likely to be more volatile than the claims experience for a larger national claims database. Accordingly, we recommend that the determination of the average claims be based on national claims data reflecting plans with a design similar to that of the FEHBP standard option.

***Comments on Notice 2015-16***

We submit the following comments under Notice 2015-16, relating to several issues under the Dollar Limit Adjustments. We fully understand that the Departments' scope of authority is limited to the promulgation of regulations and guidance necessary for the implementation of section 4980I. However, we urge consideration of the following changes, some of which are statutory in nature, in order to limit the impact of the Excise Tax to "high-cost" health plans (to be consistent with a primary legislative purpose of the statute):

- Section 4980I(b)(3)(C)(ii) provides that a "health cost adjustment percentage" will be applied to the baseline per-employee dollar limits for 2018 to determine the actual applicable dollar limits for that year, and § 4980I(b)(3)(C)(v) provides that, for taxable years after 2018, a cost-of-living adjustment will be applied to determine the applicable dollar limits. Going forward, to prevent the Excise Tax from negatively affecting health plans that are not rich in nature, we urge revision to § 4980I(b)(3)(C)(v) to provide a health cost adjustment percentage for taxable years after 2018. We believe the health care cost adjustment percentage should be tied to the annual inflation level for health care costs. A recent Forbes article predicts that by 2029 approximately 76% of all group health plans will be subject to the Excise Tax under the current indexing scheme (and assuming a conservative 6% increase in healthcare spending per year). *See*, Forbes, "Obamacare's 'Cadillac Tax' Could Help Reduce The Cost Of Health Care," by William H. Frist, M.D. (February 26, 2014).

- Section 4980I(b)(3)(B)(ii) states that any coverage provided under a multiemployer plan (as defined in § 414(f)) is treated as other-than-self-only coverage.
    - We urge extension of the other-than-self-only limit to all collectively bargained group health coverage regardless whether the coverage is provided under a multiemployer plan.
    - We ask the Departments to clarify the applicable dollar limit to use under an account-based plan (e.g., a FSA or HRA), sponsored by a participating employer,

for a single-coverage employee who has group coverage under a multiemployer health plan. Presently, the account-based plan is required to use the self-only limit and the multiemployer plan is required to use the other-than-self-only coverage. It would follow that the account-based plan coverage should be allowed to use the other-than-self-only limit in this circumstance.

- In determining the impact of high-risk groups, we ask that where high-risk groups are the minority, they will be able to disaggregate or use a weighted average adjustment to the Dollar Limits. Otherwise, this could result in multiemployer plans limiting the type of unions within a fund, which could greatly impact unions such as Teamsters and the Building Trades.

Regarding the rules on aggregating benefit packages, we urge flexibility in aggregating or not aggregating benefit options as this could greatly impact multiemployer and small employers such as Cheiron. For example, Cheiron is able to give a group of employees a cost effective option such as Kaiser but can only do that in certain locations because of the marketplace availability. If young employees elect that option, it can cause the cost of premiums for the other option to increase. If Cheiron is required to use all employees to determine the Age and Gender Dollar Limit, then Cheiron might not be able to offer the Kaiser option to any employees. Furthermore, if Cheiron is restricted to making a selection of methodology only once every five years, it could greatly restrict our options to provide the most cost effective health care to our employees, since the marketplace changes a lot more frequently than once every five years.

***Potential Impact of the Excise Tax***

Our final observation in support of the foregoing comments is that absent significant revision to both the statute and carefully crafted proposed guidance thereunder, Code section 4980I will have a negative impact on the quality of employer-provided health care under "non-Cadillac" plans. The cost of administering the provision alone is likely to far outweigh any revenues collected from the tax. Absent such revision, we agree with the legislative and public calls for the repeal of the Excise Tax.

*a. Negative Impact on Plans Not Among the Targeted Group of Rich Plans*

Studies based on the 2015 Kaiser/HRET Employer Health Benefits Survey (EHBS) (The Henry J. Kasier Family Foundation, "How Many Employers Could be Affected by the Cadillac Plan Tax?", Claxton, Levitt (Aug. 25, 2015) estimate that about 16 percent of employers offering health benefits would have at least one health plan that would exceed the $10,200 HCPT self-only threshold in 2018, 22 percent by 2023, and 36 percent by 2028. This is conservative, based upon the Forbes article cited above, which predicts that 76% of all group health plans will be subject to the tax by the year 2029.

*b. Legislation to Repeal*

As stated by Congressman Joe Courtney (CT-2), who introduced legislation to repeal the Excise Tax on April 28, 2015:

> "The Excise Tax is a poorly designed penalty that will put a dent in the pocketbooks of many families and businesses with health insurance plans that do not resemble the 'Cadillac' plans originally targeted when this policy was adopted—instead, the Excise Tax will punish people living in higher cost areas, with 'Ford Focus' level plans."

On September 24, 2015, Presidential candidate Bernie Sanders and a group of Senate Democrats introduced a bill to repeal the excise Tax. In his announcement, Sanders stated:

> "Some have said that this tax only falls on 'Cadillac' healthcare plans, but the reality is that the plans this bill will tax are more like Chevrolets," he says. "The tax not only punishes hard working Americans, it is simply bad policy."

***Summary of Recommendations***

Section 4980I(g) provides that "[t]he Secretary may prescribe such regulations as may be necessary to carry out this section." Based on the analysis contained in these comments, we respectfully urge that the Treasury and Service provide that:

1. The Board of Trustees is the *person that administers a multiemployer plan's benefits,* i.e., the person responsible for determining whether there is an excess benefit with respect to the benefits provided by the plan.
2. The determination of whether there is an excess benefit for participants in a multiemployer plan be made by treating the benefits under the multiemployer plan as separate from any other health benefits the participating employers may provide.
3. This determination may be made on an aggregate basis without the need to disaggregate participants' and beneficiaries' by individual employer.
4. In the cases where a plan is partly insured and partly self-insured, the responsibility for paying any tax is the plan sponsor's and not any insurance company that provides a policy to the plan.
5. Large governmental and quasi-public systems should be subject to aggregation based only upon the decision maker for health care coverage; a single plan covering multiple governmental employers that is a creature of collective bargaining should be accorded multi-employer plan status.
6. The marginal tax rate used to determine the excludable portion of any reimbursement for the Excise Tax, that includes an amount to compensate a coverage provider for additional income taxes, be the marginal tax rate of the coverage provider.
7. The TPA under an account-based plan is permitted to separately track the expenditures made for stand-alone dental and vision plan services, and report only the medical expenditures as applicable cost for purposes of the Excise Tax.
8. The age and gender adjustment is done by averaging the adjustment over the year.
9. A broader national claims database be utilized to determine the age and gender adjustments.

10. Clarify that the applicable dollar limit for all benefits provided to a single-coverage employee who has group coverage under a multiemployer health plan is the "other-than-self" limit, even if the supplemental benefits are sponsored by a single employer.
11. Allow flexibility in calculating high-risk adjustments.
12. Allow flexibility in aggregating and disaggregating benefit options.

In addition to the recommendations for regulatory guidance, we suggest the following changes to the statute, absent outright repeal of the Excise Tax:

1. To prevent over-reach of the Excise Tax to non-rich plans, a "health cost adjustment percentage" (tied to inflation rates for medical cost) should apply for taxable years after 2018.
2. The other-than-self-only limit should apply for all collectively bargained group health coverage regardless whether such coverage is provided under a multiemployer plan.

Thank you for this opportunity to submit comments.

Respectfully Submitted,
Cheiron, Inc.

JoAnn Butler

Jo Ann Butler, JD
Legislative and Regulatory Advisor

Gerald E. Cole

Gerald E. Cole, LLB
Chief Research Counsel