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VIA ELECTRONIC SUBMISSION TO Notice.comments@irscounsel.treas.gov

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CC:PA:LPD:PR (Notice 2015-52)
Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
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RE: **Notice 2015-52**
Section 4980I – Excise Tax on High Cost Employer-Sponsored Health Coverage

To Whom It May Concern:

Thank you for the opportunity to provide comments on Notice 2015-52 regarding Excise Tax on High Cost Employer-Sponsored Health Coverage.

Cigna Corporation, together with its subsidiaries (either individually or collectively referred to as "Cigna"), is a global health services organization dedicated to helping people improve their health, well-being and sense of security. Our subsidiaries are major providers of medical, dental, disability, life and accident insurance and related products and services.

Our previous comments on the implementation of Affordable Care Act (ACA) regulations and guidance have reflected our commitment to expanding access to a breadth of quality, affordable health care options for all individuals. As a leading provider of health insurance services, Cigna has a keen interest in the implementation of the ACA and we are pleased to provide the following comments on Notice 2015-52 related to Internal Revenue Code ("Code") section 4980I – Excise Tax on High Cost Employer-Sponsored Health Coverage. The Excise Tax on High Cost Employer-Sponsored Health Coverage ("excise tax") will have a significant impact upon the Cigna companies and the clients and customers we serve. We therefore appreciate the Department of the Treasury's and the Internal Revenue Service's ("Department" or "Treasury") willingness to receive comments on this very important subject.

Our detailed comments are below.

I. Persons Liable for the Excise Tax

Currently, the "coverage provider" liable for the excise tax is defined as: (a) the insurance carrier in the case of insured coverage; (b) the employer with respect to contributions to a Health Savings Account (HSA) or Archer Medical Savings Account (MSA); and (c) the "person that administers the plan benefits" for all other coverage.

Regarding the "person that administers the plan benefits," we recommend the Department define the "person that administers the plan benefits" as the employer or plan sponsor for self-funded or self-insured plans because these entities determine the plan benefits. A third party administrator, who only administers the plan on behalf of the plan sponsor, will only charge the tax back to the employer or plan sponsor, so it seems logical that the financially responsible party, which is the employer or plan sponsor, should be responsible for the tax.

Another consideration to weigh is that some plan sponsors contract with multiple third party administrators to administer their group health plan. Ascertaining which third party administrator would have responsibility for paying the excise tax by segmenting day-to-day functions to determine what constitutes administration of plan benefits could prove challenging. Assigning responsibility to the employer or plan sponsor avoids this unnecessary administrative complexity in determining excise tax liability.

II. Employer Aggregation

An employer for purposes of the excise tax is defined to include all employers treated as a single employer under subsections (b), (c), (m) or (o) of Code section 414 (26 USC §414), which apply to controlled groups of corporations, partnerships and proprietorships under common control, and affiliated service groups. Under Code section 4980I(d)(1)(A), the "applicable coverage" subject to the excise tax is the coverage "made available" to the employees by the employer. The Department is considering whether to apply the tax based upon the employees offered the coverage or just those employees actually enrolled (see: IRS Notice 2015-16, discussion at page 12). We believe the more appropriate statutory interpretation is to apply the excise tax to the coverage in which the employee is actually enrolled. Employers face significant administrative challenges in determining the aggregate cost of applicable coverage, calculating the amount of any excise tax liability, and allocating any such liability among the appropriate coverage providers. These challenges would be exacerbated if employers were required to look to the cost of the coverage offered rather than the coverage in which an employee is actually enrolled.

Therefore, we recommend greater flexibility for employers in aggregating coverage for purposes of the excise tax. Specifically, employers should aggregate coverage on a controlled group basis, member company basis, or an ERISA group health plan basis. Employers should not disaggregate based upon like benefits packages. Employers currently structure benefits for employees within controlled groups in a myriad of ways. We believe that providing employers flexibility aggregating coverage will allow them to calculate excise tax liability taking into account the realities of how they structure benefits, rather than requiring them to create artificial distinctions in coverage solely for purposes of this new tax liability.

III. Cost of Applicable Coverage

Code section 4980I(f)(8) provides that the taxable period is the calendar year or such shorter period as may be described by the Secretary of the Treasury. The Department is recommending the calendar year be used for the taxable period and is considering how to implement a determination period for establishing the cost of coverage. We note some group health plans do not use a calendar year as the plan year and as such, using the calendar year could create some administrative challenges in determining the excise tax liability for potentially two different plans in the calendar year. We bring this to the Department's attention as a matter to consider.

The determination period should be the end of the calendar year with a run-out period. This will allow for consistency with health care spending accounts, such as Health Savings Accounts, Archer Medical Savings Accounts, health Flexible Spending Arrangements, and Health Reimbursement Arrangements. Employers should notify the insurer or coverage provider of the excise tax liability a minimum of one quarter in advance of the payment due date of the excise tax.

We recommend providing a reduction in the cost of coverage in situations where a premium rebate is provided to the group policyholder based on experience-rated insurance contract. In general, an experience-rated insurance contract refunds premiums to the group policyholder if the claims experience is less than expected. For example, a health insurer underwrites a policy with an expected claims experience of $1,000,000. If the actual claims experience for the year is $900,000, the insurer refunds the excess premium to the policyholder.

IV. Exclusion from the Cost of Coverage of Amounts Attributable to the Excise Tax

The Department does not expect the coverage provider to bill for the excise tax until the coverage provider pays the tax, which would be well after the policy year has ended. However, we feel it would create an unnecessary economic mismatch to require a coverage provider to assume the liability for its portion of the excise tax, but then prevent it from funding that liability at the time it is incurred. Such a requirement would subject the coverage provider to unnecessary risk associated with potential nonpayment of the additional premium by the policyholder after the policy year has ended. Accordingly, we urge the Treasury to allow coverage providers to reflect the total estimated cost attributable to the excise tax in the base premium that is collected throughout the policy year rather than delaying until after the tax is paid.

Code section 4980I provides that the cost of coverage does not include any amounts attributable to the excise tax and the Department is examining ways for coverage providers to determine how much of the coverage cost may have been increased due to any excise tax amounts. For insured medical plans, we believe the total cost attributable to the excise tax consists of three components:

1) The estimated amount of the excise tax itself
2) The income tax associated with the reimbursement for the excise tax
3) The additional cost related to any other expense that varies with premium (includes the ACA's health insurance industry fee, state premium tax and commissions)

Insurers may decide to incorporate a charge into their premium to cover the entire cost attributable to the excise tax. The full amount of the premium, inclusive of any charge to cover the cost attributable to the excise tax, would then be reflected in what is billed to the policyholder. We believe that all three of the above components can and should be calculated and then subtracted from the total premium to determine the cost of coverage exclusive of the cost attributable to the excise tax.

This amount can then be subtracted from the full premium amount to calculate the cost of coverage associated with the insured medical plan.

The Department proposed a potential formula for determining the amount of any income tax reimbursement to be excluded from the cost of coverage:

Income Tax Reimbursement = [excise tax amount ÷ (1.0 - marginal tax rate)] – [excise tax amount]

Should the Department choose to use its proposed formula, we recommend the actual marginal rate of the insurer be used since presumably the marginal rate is what insurers will use to determine the appropriate premium charge. We disagree with the suggestion in the Notice that this approach would be administratively challenging because the insurer would not be able to determine its actual marginal tax rate until after the end of the taxable period. Coverage providers can reliably estimate their marginal tax rates prior to the taxable period. As noted above, we would ideally exclude the entire portion of the premium attributable to the excise tax. This would include the tax itself, the associated income tax, and all other incremental expenses that result from having to load the premium to cover this cost to include any expenses that vary with premium.

Finally, we do not believe the portion of the premium attributable to the excise tax needs to be billed separately to be excluded from the cost of coverage. This amount is calculable at the same time premium rates are calculated, in accordance with the formula noted above. As a result, coverage providers can provide this information to policyholders when premium rates are established at the outset of a given policy year.

V. Contributions to HSAs, Archer MSAs, FSAs, and HRAs

Including contributions to these tax-preferred savings accounts will likely result in some employers ceasing to afford employees the opportunity to make pre-tax contributions to these accounts. This will result in lower overall savings that would be available to help employees pay for the out-of-pocket expenses incurred in plans with higher employee cost sharing. Low- and moderate-income families could be left without the financial resources to satisfy their out-of-pocket expenses, which is not aligned with the overarching goal of the ACA to improve affordability and access to care. We note in this regard an August 25, 2015 article by The Henry J. Kaiser Family Foundation, which suggested that employers should consider capping or eliminating tax-preferred savings accounts to reduce their costs in order to avoid the tax. We continue to recommend Treasury exclude HSA, FSA, HRA and Archer MSA contributions made by the employee from the cost of employer-sponsored coverage. If, however, such contributions are counted, for purposes of calculating the costs of the plan, we recommend the HSA, FSA, Archer MSA and HRA contributions be treated in a manner consistent with how they are treated in other ACA regulations (such as the MLR, the MV or AV calculations). The Department should consider only current year contributions (or a percentage of them) in the calculation and exclude any carryover balance from prior year contributions from the calculation.

While we reiterate our position that employee contributions should not count toward the cost of employer-sponsored coverage, we, nonetheless, support a pro-rata allocation. The methodology set forth in Notice 2015-52 for determining costs with respect to medical savings accounts, under which contributions to these account-based plans would be allocated on a pro-rata basis over a 12-month period, regardless of the timing of the contributions or usage during the period, seems appropriate.

The Department also indicated in the Notice a desire to avoid double counting of health FSA salary deferrals with respect to any amounts carried over from one plan year to the next. We support the Department's consideration of a safe harbor under which the cost of applicable coverage for a plan year is the amount of the salary reduction without regard to any carry-over amounts from prior plan years. However, Cigna believes that this approach could result in an increased valuation given the amount of forfeitures from these accounts that Cigna experiences year after year. The Department should consider a method that takes the forfeiture amounts

into account to offset subsequent year valuations or to claim a refund with respect to an excise tax incurred and paid with respect to a particular calendar year.

VI. Excess Reimbursement Amounts

In certain situations, highly compensated individuals under a self-funded plan that discriminates in favor of such individuals are taxed on the excess reimbursements under the plan (i.e., the excess reimbursement is not excluded from income under Code section 105). The Notice indicates that currently the amount of any excess reimbursement is excluded from a cost of coverage reported on the individual's Form W-2. The Department anticipates modifying the W-2 requirements to include the amount of the excess reimbursement. It is unclear why these amounts would be included in W-2 reporting or in the excise tax valuation since these amounts are already subject to income tax payable by the highly compensated employee.

VII. Age and Gender Adjustments

The age and gender characteristics of an employer's workforce as compared to the characteristics of "the national workforce" will be considered when determining the cost of coverage. The IRS is considering using the Department of Labor's Current Population Survey (Table A-8a Employed Persons and Employment-Population Ratios by Age and Sex, Seasonally Adjusted) as the source of data for the age and gender characteristics of the national workforce. The language around the use of the formula seems to imply all employees will be included to determine the age adjustment for an employer and not necessarily just those employees who are offered coverage or actually enrolled for coverage. If so, we feel employers for which a relatively large percentage of their workforce is comprised of younger, part-time workers (especially males) will be disadvantaged, since their age and gender adjustment will be understated relative to the demographic makeup of the employees who are actually covered by the health plan. For this reason, we recommend basing the age and gender adjustment only on eligible employees instead of all employees.

The Department is also considering whether an employer should be required to use the first day of the plan year as a snapshot date for determining the age and gender composition of its workforce. We recommend the Department consider how the use of a single snapshot date could bias, either positively or negatively, employers with a large percentage of seasonal workers.

VIII. Notice and Payment of the Excise Tax

Code section 4980I(c)(4)(A) requires employers to notify each coverage provider of their share of any excess benefit amount that will be subject to the excise tax and provide that information to the Secretary of the Treasury. The Department is considering using Form 720 (Quarterly Federal Excise Tax Return) as the method for coverage providers to report and pay the excise tax and would designate a particular quarter of the calendar year for filing Form 720 with respect to the tax. The Patient-Centered Outcomes Research Institute Fee also uses the Form 720 and is due with the second quarter filing on July 31. For consistency, if the Form 720 will be used, we recommend the same due date. If the second quarter Form 720 is used to remit the tax, employers should notify the coverage provider by March 31 to allow time for evaluation by the insurer prior to the due date. Additionally, we recommend the IRS consider proposing a process for insurers who may find discrepancies with an employer's determination of the excess benefit amount.

IX. Coordination between Code Sections 4980H and 4980I

The Department requested comments on the circumstances in which the interaction between Code sections 4980H and 4980I may raise concerns and on whether and how these provisions might be coordinated. Cigna is very concerned about the potential for a direct conflict between these provisions, which we believe is inevitable.

The requirement in Code section 4980H to offer coverage with a minimum value of 60% establishes a floor on the value of coverage that employers must offer in order to avoid having to pay a penalty. Meanwhile, the thresholds on the dollar value of coverage established in Code section 4980I represent a ceiling on the value of coverage that employers can offer and still avoid liability for the excise tax imposed under that section. These two provisions are on a collision course because it costs more each year for an employer to offer coverage that meets the requirements of Code section 4980H, but the dollar thresholds in Code section 4980I do not increase at the same pace because the indexing of the thresholds is tied to ordinary inflation (CPI-U), rather than medical inflation. Over time, this "provision collision" will occur for every employer-offered plan.

One additional factor the Department should consider is the effect of applying the maximum annual limitation on cost-sharing requirement to each individual, regardless of whether the individual is enrolled in self-only coverage or in other than self-only coverage. This policy, often referred to as an "embedded out-of-pocket limit," will only serve to increase the value of coverage as calculated for purposes of the Code section 4980I excise tax, thus speeding the arrival of the collision of that provision with Code section 4980H.

The Department could avoid the inevitable conflict between a slowly rising floor and quickly dropping ceiling by allowing a similar measure to be used for both purposes. The easiest way to accomplish that would be to create a permanent safe harbor from liability for the Code section 4980I excise tax for plans that meet the Code section 4980H definition of what is minimally acceptable for an employer to offer to avoid having to make shared responsibility payments. Such a safe harbor should be based on the value of coverage, which is the standard applicable to employers, rather than the cost of coverage, which is rife with inequities and subject to great variation (that may have nothing to do with the value of coverage). When one provision tells employers what they are minimally responsible for offering their employees if they do not want to pay a penalty, it seems counterintuitive that the next provision would punish them financially through the imposition of an excise tax for offering the coverage that got them out of paying the penalty in the previous provision. Congress could not have meant these two provisions to work at such cross-purposes, but the Department is in a position to bring order to the administration of these two provisions and avoid a harmful result. The Department is able to protect consumers by establishing a safe harbor to protect the employer-sponsored coverage roughly half of Americans currently enjoy.

X. Cost of Coverage and Geography

Although the Department did not specifically solicit comments on this topic, Cigna urges Treasury to use its regulatory authority to allow the cost of coverage to be adjusted for geography. Treasury should provide a rule that would permit employers to calculate the cost of coverage based on a standard population in a standard-cost region of the country. This approach is consistent with the methodology that large multi-state employers with self-insured plans use to calculate the cost of their health care coverage, including the COBRA rates.

The cost of health care coverage varies significantly based on geography due primarily to differences in provider reimbursement rates. For example, as currently drafted, a plan offered in New York (a higher cost state) would be subject to the 40 percent excise tax but the identical plan offered in Montana (a lower cost state) would not. This result seems inconsistent with the concept of targeting "excess benefits" because the benefits in this example are identical and only geography varies. Failing to account for the geographic variation in the cost of coverage simply increases the cost of coverage in already high-cost areas without getting at the issue of overly generous coverage.

Code section 4980I(d)(2) provides that the cost of coverage is determined based on rules similar to the COBRA rules in Code section 4980B(f)(4). The COBRA rules provide Treasury authority to adjust the cost calculation for employers in high cost geographic areas.

The COBRA "applicable premium" is defined as the cost to the plan for coverage for "similarly situated" beneficiaries. The legislative history of Code section 4980B is instructive on this issue:

> "[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).

Cigna urges Treasury to use its authority to take into account the very real differences in the cost of providing coverage around the country. The Department should adopt a rule that would allow employers in higher cost areas to smooth the cost of coverage by treating employees in high-cost areas as similarly situated to the standard population in a standard-cost region of the country.

Thank you for your consideration of these comments.

Respectfully,

David Schwartz