

September 29, 2015

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

Submitted via email to: Notice.comments@irs.counsel.treas.gov

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

Dear Sir or Madam:

Keller Benefit Services, Inc. is an employee benefits brokerage and consulting firm that has been managing benefit programs for over 30 years in the Washington, D.C. metropolitan area. Our legislative compliance department tracks, interprets and advises over 300 local employers on benefit laws, with a focus on the ACA. We have the following comments and concerns about the potential approaches outlined in Notice 2015-16 and Notice 2015-52 regarding the high cost employer-sponsored health coverage under §4980I:

1. The excise tax is imposed on insured premiums that already include state taxes and mandated ACA taxes and fees. State taxes include premium taxes and exchange taxes; for example, the District of Columbia imposes a 1% tax on all plans in order to fund its ACA exchange. Mandated ACA fees include the PCORI fee, the transitional reinsurance fee, and the industry fee, which have added approximately 5% to insured premiums and approximately 4% to self-insured premium equivalents. **The basis for the “cost of applicable coverage” should not include state and ACA taxes and fees, as these contribute to the high cost of the plan yet are not usable benefits by employees. Otherwise, the IRS is charging an excise tax on mandatory taxes and fees.**
2. The excise tax is imposed on insured premiums (and self-insured premium equivalents) that include new or additional benefits mandated by the ACA. These benefits include removal of pre-existing condition limitations, removal of dollar limits on essential health benefits, inclusion of essential health benefits, and preventive care with no cost sharing. **The basis for the “cost of applicable coverage” should not include the cost of ACA mandated benefits and reforms, as these changes have increased health premiums by an average cost of 3% annually and are not controlled by the employer or covered employees.**

3. The basis for the “cost of applicable coverage” includes all non-taxable benefits, including health FSA contributions, HSA contributions, HRA funding and on-site medical clinics. These benefits support large deductible and other out-of-pocket costs of employees requiring medical care. When employers are forced to reduce medical plan benefits, these key supporting benefits will be eliminated. Lower and middle income employees, in particular, will lose this necessary financial protection at the time when it is most needed. **This phenomenon is referred to as “insured but without coverage.” This will become a commonplace occurrence in 2018, nullifying the purported financial protections of the ACA.**
4. The basis for the “cost of applicable coverage” includes all non-taxable benefits, including health FSA contributions, HSA contributions and HRA funding. However, these account-based benefits generally provide other than self-only coverage even though the participant may be enrolled in self-only health insurance coverage. For example, consider an employee who enrolls in self-only health insurance coverage and elects to contribute to the employer’s health FSA, which covers the out-of-pocket expense for their own claims as well as their dependent children, spouse, or both. The employee has not elected health insurance coverage for the children or spouse because they have other health insurance coverage. When the employer calculates the cost of applicable coverage for this employee, it would unfairly limit or tax the employee’s election unless the coverage is categorized as other than self-only coverage for comparison to the baselines. **If account-based benefits are included in the “cost of applicable coverage”, the resulting total cost must always be categorized as for other than self-only coverage.**
5. The basis for the “cost of applicable coverage” includes both employer and employee pre-tax HSA contributions. An HSA is not a group health plan. It is an individually owned savings account. Whether the contributions are made by the employer with employer funds, by the employer through employee pre-tax payroll deductions, or by the employee directly to the HSA trustee, does not change that an HSA is not a group health plan. **Only group health plans are subject to §4980I, therefore only group health plans should be included in the “cost of applicable coverage”. HSA contributions should not be included in the “cost of applicable coverage”.**
6. If the “cost of applicable coverage” includes health FSA contributions, and the cost must be determined soon after the end of each calendar year regardless of the health FSA’s plan year, then most non-calendar year plans will not be able to calculate the monthly cost of health FSA coverage using the IRS proposal to calculate the monthly cost based on a pro-rate portion of the total annual health FSA election. Participants may change their elections during the plan year if they have a qualifying change in status event. The final annual election cannot be certain until the last deduction for the plan year has been withheld. **The IRS should provide a safe harbor that allows a non-calendar year plan to calculate the monthly cost for the months within each calendar year based on the last effective annual election amount during that calendar year.**
7. The basis for the “cost of applicable coverage” does not include an adjustment for high dollar cost individual claimants. For certain size employer plans, medical plans are rated based on the employer’s own claims experience. Even with available cost control tools and reinsurance protection, the employer does not have overall control of claims usage, in particular on high dollar cost claimants. **The basis for the “cost of applicable coverage” should be reduced by the increased premium due to high dollar cost claimants. Alternatively, the employer should be allowed to use an increased baseline to calculate whether there is an excess benefit amount.**

8. There is well-documented cost of care differential among states and regions encompassing hospitalization, physician, and prescription drug spending. The correlating insurance premium for employees located in these high cost states varies by as much as 45% between lower cost of care states and higher cost of care states (reference 2015 National Conference of State Legislatures, Private Sector Premium Tables By State: <http://www.ncsl.org/research/health/health-insurance-premiums.aspx#Private Sector Premium Tables By State>). **A geographical adjustment should be provided to allow for an increase to the “applicable dollar limit”.**
9. The Code provides for an increase in the “applicable dollar limit” based on “the age and gender characteristics of all employees” of the employer. Notice 2015-52 proposes that in order to use this increase, employers would need to embark on a complicated process to tally up employees in groups based on age-bands, gender, and self-only versus other coverage and then compare each group to a chart to see if the employer can increase the “applicable dollar limit” just within that group. **In order to make age and gender adjustments available to the average American employer, the process should be as simplified as possible.** Potential methods for reducing the employer’s administrative burden: allow for a simple average age and average gender comparison; make the gender adjustment separate from the age adjustment so an employer can utilize one without necessarily calculating the other; widen the age-bands (10 or more years instead of only 5) for fewer categories to be analyzed, any other method that does not necessitate classification of all employees into as many categories as proposed.
10. Small employers subject to ACA Sec. 2701 “fair health insurance premiums” are billed medical insurance premiums based on each covered family member’s age, with the highest premium rates charged for older individuals (up to 3 times the cost of other employees). It not clear if the proposed age adjustments will adequately modify the “applicable dollar limit” for employers that continue to provide employment for older employees or coverage for older spouses.
 - Therefore, basing the age adjustment solely on the FEHBP (large group) rates may not be adequate with regard to small employers’ premium rates for providing coverage to older employees and older dependents. **The age adjustment should take into account that small employers are subject to significantly greater variances in rates than large employers.**
 - **The age adjustment methodology should allow a small employer the option to include the age characteristics of employees’ spouses in determining whether an age adjustment is available.** However, including the spouses’ ages should be optional so that the additional work is not unfairly imposed on all employers.
11. Small employers subject to ACA Sec. 2701 “fair health insurance premiums” with at least 20 employees are also subject to the Medicare Secondary Payer rules, which require employer-sponsored health coverage to be primary for individuals otherwise eligible for Medicare. **The age adjustment should take into account that small employers are billed at the highest rates for working employees and spouses that are also eligible for Medicare but required to be covered by the group plan as primary.**
12. There are only two baseline dollar limits: “self-only” coverage and “other than self-only” coverage. The “other than self-only” coverage limit is less than 2.7 times the limit for “self-only” coverage. In the small group market, due to age-banded premium rates, premiums for “other than self-only” coverage include an individual premium rate for each insured (the employee and each dependent).

For a couple with only young children, the premiums could include up to 5 individual rates. However, for a couple with children over the age of 21 the premiums could include more than 5 individual rates. **An adjustment for family size should be allowed for larger families within the small group or individual market.**

13. If “applicable coverage” includes on-site medical clinics that provide more than de minimis coverage, then employers will close clinics and be dissuaded from establishing new clinics. The purposes of on-site medical clinics include increasing employees’ ability to access healthcare while decreasing the cost of providing such care. By establishing on-site medical clinics, employers are providing greater accessibility to preventative care and disease management, both of which have the potential to reduce the overall cost of healthcare through treatment in a cost effective office setting rather than through expensive emergency services. **If the “applicable coverage” must include on-site medical clinics, then there must be an exception for de minimis coverage, the definition of de minimis will need to be clearly defined, and the definition should be as broad as possible to reduce the likelihood of losing this valuable cost containment tool.**
14. Employers subject to §4980H will likely be forced to reduce benefits below ACA minimum value in order to remain below the baseline for the “cost of applicable coverage”. Starting in 2018, employers will ultimately need to decide to either pay the 40% excise tax or pay §4980H penalties for not offering minimum value coverage. Small employers not subject to §4980H and potentially larger employers will drop all employer-subsidized coverage. **To avoid the loss of employer-sponsored plans, the excise tax should only apply to plans that are valued at the platinum level (actuarial value 90%) or higher.**
15. Employers offering health coverage are already subject to onerous state and federal benefits laws, including ACA reforms, PCORI fee and transitional reinsurance fee filing, §4980H mandate, §6055 and §6056 reporting, Form 5500 filing and other ERISA requirements, COBRA administration and HIPAA privacy/security requirements. Notice 2015-16 indicates an additional form, intricate calculations and more fees required of employers. Notice 2015-52 further indicates the potential for a tight turnaround time frame during what is already a difficult compliance time of the year for employers. **The average employer does not have the financial capacity, nor the human resources, accounting, actuarial or legal staff necessary to handle additional and onerous ACA requirements. If the rules and regulations are overly complex, otherwise unclear, or do not allow sufficient time, employers will be unable to comply.**

Thank you for your consideration of these comments.

Respectfully,

A handwritten signature in black ink, appearing to read "Margaret", followed by a long horizontal line extending to the right.

Margaret Flickinger
Managing Principal/CEO