

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

By email: Notice.comments@irsounsel.treas.gov

October 1, 2015

Subject: Mercer comments on Notice 2015-52 (Excise Tax on High Cost Employer-Sponsored Health Coverage)

Ladies and Gentlemen:

Mercer welcomes the invitation in Notice 2015-52 to provide input to the Treasury Department (Treasury) and the Internal Revenue Service (IRS) on key Affordable Care Act (ACA) issues concerning the excise tax on high cost employer-sponsored health coverage (Internal Revenue Code section 4980I).

Mercer helps advance the health, wealth and careers of our clients' most vital asset – their people. In the United States, Mercer provides consulting and actuarial services to more than 4,800 health and benefit clients, serving employers of all sizes, with varying employee demographics, in all parts of the country. Mercer also offers a private exchange providing access to health and other benefits to more than 800,000 employees and retirees.

As Mercer stated in its May 2015 comments on Notice 2015-16 (Mercer's May comment letter), we are concerned that the excise tax, while intended to discourage overly rich benefits in employer-provided coverage, may have unintended impacts on plans whose high costs are driven by factors other than plan design, such as participants' geographic location and age. This potential for unintended impacts makes calculation of the application of the dollar limit adjustments in 4980I a crucial piece of the excise tax regulation. We appreciate the opportunity to suggest approaches to age and gender adjustment that provide simple, efficient mechanisms for plans to perform this calculation that ensure alignment with established actuarial principles.

Page 2
October 1, 2015
CC:PA:LPD:PR (Notice 2015-52)
Internal Revenue Service

Procedural issues will also have a direct impact on the actual amount of the excise tax as well as the administrative costs of compliance. Examples of these issues include who will actually pay the excise tax for a self-insured plan and who in a controlled group of employers is responsible for calculation, payment, and reporting of the excise tax for different group members. We value the opportunity to have ongoing input on these important implementation questions.

As Mercer's May comment letter highlighted, the excise tax is on a certain collision course with ACA's employer shared responsibility requirement. Employers avoid shared responsibility assessments under 4980H by offering affordable coverage with a minimum actuarial value of 60 percent to full-time employees and minimum essential coverage to their dependent children. However, even coverage with an actuarial value of 60 percent will over time surpass the dollar limit coverage thresholds for the excise tax under 4980I. Appendix I includes a graph based on Mercer survey data illustrating when plans with a 60% actuarial value could hit the excise tax's cost thresholds.

One approach that would align the purposes of 4980H and 4980I is an actuarial value safe harbor. Mercer believes this is a workable approach that will simplify determining the cost of coverage and still encourage employers to reduce overly generous benefits.

Mercer has projected that about one-third of large employers (those with 500 or more employees) will have to pay the tax in 2018 absent significant changes to their current plans. Employers are seriously considering changes to their current plans that could include taking away such highly valued benefits as employer-sponsored health savings accounts and onsite clinics, both of which are components of employers' cost control strategies. Mercer recommendations in this and our May comment letters, if adopted, could enable employers to keep these valued designs.

Mercer recognizes that the IRS and Treasury may have limited regulatory authority to make optimal changes to the excise tax. While Mercer supports legislative changes to the excise tax, short of Congressional action Mercer offers the following recommendations for future regulations. Mercer's specific recommendations in each of three areas are listed here and discussed in detail in the remainder of this comment letter.

A. Implement the excise tax's age and gender adjustments by using simplified methodologies and accurate data sources:

1. Allow separate age and gender adjustments for the employee subgroups used to determine the cost of coverage for the excise tax.
2. Base age and gender adjustments on the age and gender characteristics of a plan's actual enrollees. The same demographic adjustment should apply for employees enrolled in self-only and "other than self-only" coverage (with an additional adjustment for cost of dependents enrolled in the "other than self-only" tier).
3. Develop or add to Current Population Survey (CPS) data to allow for a more accurate approach to age and gender adjustment.
4. Allow employers to determine age and gender adjustments in advance of the plan year rather than on the first day of the plan year.
5. Use a broader set of Federal Employees Health Benefit Program (FEHBP) claims data for FEHBP offerings beyond the Blue Cross/Blue Shield Standard Option (Standard option) in developing age and gender adjustment tables.
6. Do not base the age-adjustment factors for the excise tax on the age rating scales that apply to coverage in the individual and small group market.

B. Provide a more simplified approach for payment and calculation of the excise tax.

1. Give employers the option to pay the entire excise tax for their self-insured arrangements.
2. Permit disaggregation of a controlled group into separate employers for all excise tax purposes.
3. Adopt the approach set out in Notice 2015-52 for allocating contributions to health savings accounts (HSAs), health flexible spending arrangements (FSAs), and health reimbursement arrangements (HRAs).

4. Allow employers to use FSA safe harbors that provide the flexibility to determine the cost of coverage in advance of the calendar year for which the excise tax may be owed.
- C. Provide for an actuarial value safe harbor to ensure that 4980H and 4980I are coordinated, and employers can offer coverage as rich as a public exchange plan without incurring an excise tax.**

Discussion

- A. The regulations should allow employers the flexibility to make age and gender adjustments using the methodologies and data source recommended below.**

Section VI of Notice 2015-52 requests comments on several issues involving assessment of an employer's age and gender demographics. However, determining the best methodologies and data sources to use for this purpose requires resolving several uncertainties. Mercer's comments on the age and gender adjustment issues raised in Notice 2015-52 reflect our recommended responses to these open questions:

- Will an employer make only a single threshold adjustment based on the age/gender characteristics of the employer as a whole?
- Will the adjustment take into account age and gender demographics of all employees or only those actually enrolled in coverage?
- Will employers have to evaluate demographic differences between employees enrolled in self-only versus "other than self-only coverage" and develop two separate adjustment factors for each tier? Or will employers develop a single adjustment factor for the self-only tier and then apply the same factor to the "other than self-only tier"?

1. Allow separate age and gender adjustments for the employee subgroups used to determine coverage cost for the excise tax.

The stated purpose of the excise tax is to discourage the use of high cost plans. Many employers have a range of plans tailored to diverse subpopulations of employees with very different demographics. For many fully-insured plans, premiums are based entirely on the cost and/or demographics of enrolled employees and dependents. Premiums set using this method typically drive COBRA rates, which presumably will directly influence the coverage cost for excise tax purposes. While methods vary for setting self-funded plan costs, the same concepts apply. Mercer recommends that the age/gender adjustments reflect the subgroups of enrolled employees used to determine the plan's cost for excise tax purposes.

For a fully-insured plan option the demographic factor would be based solely on the plan option's enrollees. For self-funded plan options, the demographic factor should be applied based on the enrollees who generated the expenses used to determine the costs of the relevant plan options for the excise tax. For example, if an employer offers one plan option for plant employees at Location A, which has older employees, and thus a higher cost, but a different plan option covering employees in Location B and/or in separate lines of businesses, which has younger employees, the same age/gender adjustment should not apply to both groups. That approach would disproportionately harm many older workers as employers are forced to cut benefits to avoid the excise tax.

Note that if final regulations allow employers to use permissive pooling of experience across all self-insured options to calculate the cost of coverage for the excise tax, as Mercer recommended in its May comment letter, employers should be allowed to use the same subgroupings of employee experience for age and gender adjustments.

2. Base age and gender adjustments on the age and gender characteristics of a plan's actual enrollees rather than all employees. A single demographic adjustment factor should apply for employees enrolled in self-only and other than self-only coverage, with a separate adjustment determined for dependents.

As mentioned in Mercer's May comment letter, Mercer supports an approach that determines the age and gender adjustment by comparing employees *enrolled* in employers' health plans to the demographics of the national workforce. We believe that this is the better point of comparison since the enrolled employee drives the cost of coverage under Section 4980I. A comparison that instead uses all employees (those enrolled and those who waive coverage), would assume that each employer's enrolled/waived distribution in total and by age/gender is similar to the national workforce average. This distribution could vary widely by employer.

While Mercer recommends using only enrollees as the basis for age and gender adjustment for both the employer and national workforce data, if IRS and Treasury determine that data specific to the enrolled population cannot or should not be obtained for the national workforce, Mercer still believes that using only employees enrolled in an employer-sponsored health plan to calculate the adjustment will best reflect the actual cost of coverage.

Mercer also believes the same demographic adjustment factor should apply for employees enrolled in self-only coverage and "other than self-only coverage". To reflect the cost of dependent coverage, a separate adjustment should apply, determined from the age/gender of employees enrolled in the "other than self-only" tier. This approach avoids the need to obtain dependent age/gender data and is consistent with the method employers typically use to calculate COBRA rates. Rather than develop COBRA rates based on the different demographics of enrollees in each coverage tier, employers typically apply standard tiering factors that reflect the expected cost of dependent coverage in light of the employee population. If employers will determine the cost of coverage for the excise tax by applying existing COBRA methods, Mercer's recommended approach is most consistent with how the cost of COBRA coverage by tier is developed.

Appendix II sets out a Mercer recommended methodology using the seven step framework included in Notice 2015-52.

3. The CPS data, including Table A-8a, in its current form are not sufficient to support Notice 2015-52's proposed approach to age and gender adjustment. Other data sources can either be developed or used for this purpose.

The IRS/Treasury proposed use of CPS national all-employee workforce data (including Table A-8a) will not provide the information needed to develop benchmarks for age and gender adjustment. Here are some of Mercer's concerns about this data source:

- Table A-8a does not include five year bands in the crucial span between ages 25 and 54. Instead, the table just reflects three 10 year age bands.
- Table A-8a does not go to age 75+, but instead has an upper group for ages 55+.
- CPS Table 3 does not include both the five year bands and the groupings for up to age 75 and for ages 75+.
- The CPS tables contain data on employees, and provide no information for employers that need to develop a different demographic factor for covered retirees.

In addition, existing CPS data is not adequate to use if age/gender adjustments are based on the demographics of actual enrollees – the approach Mercer recommends – rather than the entire workforce. While an employer generally can determine the age/gender distribution of enrolled employees, similar national workforce data is not part of the CPS national workforce data. None of the CPS data appears to have health coverage as a dimension; instead just all-employee workforce data is available. For the excise tax's age/gender adjustments, breakdowns of national workforce data by both health coverage enrollment and health coverage tier are needed.

There are a few alternatives to obtaining the data. If this information is captured by the Bureau of Labor Statistics (BLS) in the CPS, BLS can create a new table that reflects both

the age/gender and health care coverage election status of the national workforce. Even if this information is not captured currently in the CPS, BLS could create a table that reflects age and gender and marital status such that there is a proxy available for the split of self and other than self-only coverage.

Another option is to have an independent professional organization, such as the American Academy of Actuaries, generate such a distribution table based on employer data it can obtain.

4. Provide means for employers to determine the age and gender adjustment factors in advance of the plan year.

Section VI.A of Notice 2015-52 proposes using the first day of the plan year as a snapshot date to determine the composition of the employee population. From a technical perspective, the age and gender adjustments should be based on the population used to develop applicable premium rates.

The proposed use of the first day of the plan year as a snap shot date presents technical and practical challenges. A plan sponsor cannot predict the exact demographics of the covered population at a future point in time. Therefore, a plan sponsor will not know the applicable adjusted cost thresholds for the following year at the time benefits and rates are determined for the upcoming year. As a practical matter, the tax can't serve its intended purpose of discouraging the use of high cost plans if employers don't know the adjusted cost threshold before finalizing their benefit designs for the coming year. Therefore, the age/gender adjustment should be calculated at the time the plan sponsor is determining the benefits that will be offered in the coming year.

In addition, Notice 2015-16 proposed that a self-funded plan could determine its coverage costs for the 4980I excise tax using the past cost and actuarial basis methods specified in COBRA, which requires calculating the applicable COBRA premium before the start of the determination period. For consistency, the same population should be used to determine a plan's cost and its age/gender adjustment factor under 4980I.

In light of these issues, Mercer's recommends that employers have the flexibility to determine their population distribution based on a time of their choosing at or preceding the development of the COBRA applicable premium. For example, an employer might set the census snapshot date as the first date of the preceding plan year. This date is commonly within the time period of the claims experience used to develop the rates. Or, an employer could take the census at the midpoint of the experience period or use an average of demographics throughout that period.

To illustrate the practical implications, consider a plan that has an average age of 45, warranting a demographic adjustment to the cost threshold from \$10,200 to \$11,500, and an expected plan cost of \$11,000, so no expected excise tax. If there is a new group of younger employees added to the plan, dropping the average age to 40, the adjustment could be eliminated if measured based on the actual ages during the plan year. With no opportunity to change fully insured premiums or COBRA rates already in effect, the plan would trigger an excise tax, even though its actual costs would fall below the threshold. Applying the same dataset and timeframe to determine both a plan's cost and its age/gender adjustment would simplify this process and better align the two calculations.

5. Use experience from a broader set of coverage options in the FEHBP to develop age and gender adjustment tables.

Notice 2015-52 proposes using claims experience from the Standard option to develop the age and gender adjustment tables for calculating the demographic adjustment factor. Use of the claims experience for the Standard option would not reflect the true expected cost differences associated with the demographic differences. Due to employee selection, the claims experience under one individual medical plan that is offered in conjunction with other options is expected to exhibit skewed costs relative to age and gender that are not reflective of the true cost differences attributable to age/gender mix. The vast majority of the eligible FEHBP population is enrolled in either the Standard or Basic plan options, with the Basic plan having a less generous design and lower employee contributions. When multiple plan options are offered to a population at varying contribution amounts, significant selection is expected, with higher cost members disproportionately electing the more generous (and more expensive) plan option. As a result, FEHBP members enrolled

in the Standard option are expected to be more costly on average than those enrolling in the Basic option (before reflecting the impact of plan design difference) since those employees with greater health care needs are most likely to pay more for richer coverage. This selection may skew both the enrollment by age and the cost relative to age within the Standard option.

Mercer recommends using more comprehensive experience (not impacted by selection issues) to develop the age/gender adjustment tables. An alternative, more appropriate, approach would be to include the experience in a broader set of FEHBP options (such as all FEHBP options that the U.S. Office of Personnel Management describes as “Fee-for-Service”) when developing the age and gender adjustment tables. This approach would ensure that the demographic factors developed reflect the true cost differences by age/gender. The group ratios developed using this comprehensive experience would then be multiplied by the most recent annual premium cost of the FEHBP standard option, consistent with the language in 4980I and Notice 2015-52.

6. Using the age rating scales that are adopted in regulations for the individual and small group market would not accurately reflect the expected age-related cost differences for employers’ health plans under Section 4980I.

Notice 2015-52 requests comments on whether the age and gender adjustment factors developed for 4980I purposes should reflect the regulations adopted for the age-rating scale used in the individual and small group markets. Because the regulations on the age rating scales used for these markets impose “artificial” constraints on the demographic factors (e.g., restrict the cost differential between the youngest and oldest members), the associated age rating scales are not reflective of the true cost impact expected from demographic differences in employers’ health plans. Section 4980I appears to require that the demographic factor reflect employers expected cost differences, which the regulations in the individual and small group market do not reflect.

B. The excise tax regulations should include approaches that simplify administration, calculation, and payment of the excise tax.

Mercer urges that IRS and Treasury permit simplified and streamlined approaches to several administrative issues. These issues include determining who pays the excise tax for self-insured coverage, who is considered a single employer for implementing key excise tax provisions, how contributions to HSA, FSA and HRAs are allocated over a coverage period, and how employers can prevent double counting amounts carried over to the next year when determining the cost of FSA coverage.

1. Determining who pays the tax for self-insured coverage

Section 4980I uses the term “coverage provider” to describe the specific entities that are liable for the excise tax. For insured coverage the coverage provider is the health insurance issuer, and for HSA and Archer medical savings account (MSA) contributions that are applicable employer sponsored coverage, the employer is the coverage provider. Outside of these two categories, the entity that must pay the tax is the “person that administers the plan benefits.”

Section 4980I does not define this phrase, but says that it would include a “plan sponsor” (as that term is defined under ERISA) if the plan sponsor “administers benefits under the plan.” With the lack of specifics, the IRS and Treasury seek comments on two alternative approaches that would identify “the person that administers plan benefits” liable for excise tax purposes as either:

- The person or entity responsible for performing the day-to-day functions that constitute the administration of plan benefits, or
- The person or entity that has the “ultimate authority or responsibility under the plan or arrangement” concerning the administration of plan benefits, including final decisions on administrative matters. This entity would be liable regardless of whether the entity routinely exercises that authority or responsibility.

Mercer supports an approach that gives employers the flexibility to decide who is in the best position to pay the tax, including the ability of an employer to pay the entire excise tax for all of its self-insured arrangements. Mercer urges the IRS to clarify that the plan sponsor alone could pay the excise tax for its self-funded arrangements since the plan sponsor has ultimate responsibility, at least under ERISA, for all plan administration functions. Specifically, a plan sponsor could still pay the entire tax liability even where it has contracted to give final decision making authority for other plan administration functions to a third party. For instance, it is not unusual for an employer with a self-insured option (or options) that has final decision making authority on plan administration functions such as plan eligibility and/or has the ability to terminate service provider contracts to delegate the final authority for claims determination or any other plan administration functions to a third party. Regardless of who performs or is responsible for plan administration, the employer as plan sponsor under ERISA still has the responsibility to monitor the performance of all parties performing these functions and the ultimate authority to terminate their service.

Giving employers the option to pay all excise taxes for self-insured arrangements is the best approach for a variety of reasons including the following:

- It aligns with other Section 4980I provisions, and simplifies administration of excise tax payments.
- It allows employers to avoid the “tax-on-the-tax.”
- It is consistent with policy objectives.

Aligns with other 4980I provisions; simplifies tax payment and administration

Section 4980I already clearly assigns to the employer the task of calculating the amount of any tax for each coverage provider and notifying each one of their respective excise tax amount. The statute also looks to the ERISA definition of “plan sponsor”, which is always the employer for a single employer arrangement. Allowing the plan sponsor that has ultimate authority for at least some plan administration functions to pay the excise tax makes the same entity that calculates the tax responsible for paying it. This eliminates the

unnecessary step of having an employer notify each third party vendor of any excise tax amount. This also aligns with section 4890I(e) which places the penalty for underpayment of the tax only on the employer/plan sponsor. Third party vendors, regardless of their level of authority or responsibility or whether their work involves the day-to-day administration of the plan, have no accountability to IRS under the statute for the accuracy of the payment. Requiring them to pay the tax does not appear to serve any legal or administrative purpose.

In addition, both of the IRS/Treasury proposed approaches could result in multiple coverage providers having to make a payment for the same group health plan. Under the first approach, those performing the day-to-day functions contemplated by IRS/Treasury could include a long list of entities that contract with a plan sponsor to provide a variety of services. Examples include those administering claims for benefits for medical and/or mental health coverage, pharmacy benefit managers, case management vendors, administrators for flexible spending accounts and health reimbursement arrangements, wellness program vendors etc. An employer could have more than one self-insured plan option each with different third party administrators performing these functions. In addition, the entities performing these services for any one plan option could change from year to year. While identifiable, these entities will be cumbersome to track for excise tax payment purposes. This will complicate the administration of the tax not only for employers, but for the IRS.

If the second approach proposed in Notice 2016-52 requires that third party administrators with final decision-making authority pay the tax, then this approach has the same potential for administrative complexity as the first approach, with multiple parties having to pay the tax.

It allows employers to avoid the “tax-on-the-tax”

Permitting employers to pay the entire tax not only alleviates the administrative complexity of the process, but it also eases the financial burden on employers by allowing them to avoid the “tax-on-the-tax” issues IRS outlines in the Notice 2015-52. Section V.C. of the notice, acknowledges that when the coverage provider liable for excise tax payment is not the employer, that coverage provider will likely pass through all or part of their portion of

the excise tax to the employer. Since the excise tax is not deductible, an employer's reimbursement of the amount passed through to the employer creates additional taxable income to the coverage provider that the employer will also have to reimburse. This effectively results in an additional financial burden on employer above and beyond the amount of the excise tax.

Employers can completely avoid this additional financial responsibility if they pay the excise tax directly for all third parties involved in the plan administration of all self-insured coverage. Mercer appreciates that the IRS and Treasury are considering excluding from the cost of coverage for the excise tax both the excise tax reimbursement and income tax reimbursement. Even the IRS and Treasury acknowledge, however, that the possible approaches they outline for excluding these amounts could present administrative challenges and, at a minimum, would require that any excluded amounts be separately billed in order to be excluded. These procedural hoops are not necessary if plan sponsors can pay the tax for their self-insured arrangements.

It is consistent with policy objectives

Giving employers the flexibility to pay the entire tax appears to better accomplish the goals of Congress under 4980I. The plan sponsor of a single employer plan usually has control over plan design across all types of group health benefits and group health benefits options. As a result, the sponsor is best positioned to make changes to the program with the goal of reducing medical cost trend while assessing the impact of changes on plan participants and beneficiaries.

Some third party vendors may have the discretion to make decisions on plan design and program policy in specific areas. However, this discretion does not necessarily mean a vendor has the incentive or ability to promote cost effective plan strategies that focus on the unique characteristics of specific employer populations. The plan sponsor is usually the most appropriate entity to oversee these objectives.

Mercer also recommends that Treasury and IRS consider allowing plan sponsors to serve as the coverage provider for fully-insured health coverage. Many large employers that sponsor self-insured coverage also have fully-insured options at some or all of their

locations nationwide. Providing a framework where the plan sponsor can take on the coverage provider role for a health insurance issuer streamlines the calculation and payment process for the excise tax.

2. Employer aggregation

Section 4980I provides generally that all employers within a controlled group under sections 414(b), (c), (m), or (o) of the Code are treated as a single employer for excise tax purposes. Treasury and IRS have asked for comments on the practical challenges if employers are required to aggregate controlled group members for various purposes under the excise tax.

Mercer urges the Treasury and IRS to allow permissive disaggregation of a controlled group into separate employers for purposes of the excise tax. Employers have already expended significant resources to comply with the ACA's employer shared responsibility and reporting requirements and to provide affordable, minimum value coverage under the employer shared responsibility rules. Employers have to disaggregate their controlled group into separate members, assign full-time employees to each specific employer, and, in many cases, track employee hours on a member-by-member basis within the controlled group. For many employers, this has required changes to health plan design and eligibility rules and development of new systems to obtain data from multiple vendors and sources. Additional changes may – and most likely will -- be necessary for employers to avoid paying the excise tax under Section 4890I.

We understand that the IRS will want to ensure that employers do not attempt to avoid the excise tax by offering multiple plans sponsored by different members of the controlled group. However, requiring employers to aggregate control group members in all situations will add to the complexity of the tax, especially if each controlled group member is separately responsible for the excise tax. Of course in some situations administering the tax on a controlled group basis makes more sense in light of the employer's structure or administration. Mercer asks for flexibility---any disaggregation should be permissive and not mandatory.

Allowing permissive disaggregation is more consistent with approaches being considered by the IRS and Treasury for the cost of coverage calculation and the age and gender adjustment. Notice 2015-16 discusses how to determine the cost of coverage based on the coverage in which the individual is enrolled. Consistent with this approach, the age and gender adjustment should be based on the same groups of enrolled employees used to determine the plan's cost. Since neither of those calculations is likely to be determined at the controlled group level, some form of employer disaggregation usually will be warranted to make implementation of the excise tax workable.

As an example, consider a scenario where each of three operating companies within the same parent entity sponsors its own group health plan, with age and gender compositions that differ for each plan. In this situation, the cost of coverage and the age and gender adjustment would differ if calculated for each of the three operating entities rather than on an aggregated controlled-group basis. Allowing disaggregation in this example would enable separate determinations of the cost of coverage and the age/gender adjustment for each entity.

Permissive disaggregation for calculating, reporting and paying the excise tax would also ease the burden on employers' human resources, benefits, and finance staff. Allowing employers the flexibility to assign the responsibility for each of these tasks based on the employers' own structure will give the employer the opportunity to plan ahead and allocate resources based on capacity or expertise. For simplicity, the entity calculating any excess benefit should be responsible for reporting and paying any excise tax owed.

3. Allocation of contributions to HSAs, FSAs and HRAs

Mercer supports the proposal in Notice 2015-52 to allocate HSA, FSA, and HRA contributions on a pro-rata basis over a contribution period (usually a plan year) when determining the cost of applicable coverage. This simple and practical approach will help employers that have more than two payroll periods in a month or that fund HRAs in the first month of the year so that the entire account is available on the first day of the plan year.

4. Use of FSA safe harbors

The IRS states in Notice 2015-52 that the cost of applicable health FSA coverage for a plan year would be the greater of the amount of an employee's salary reduction or the total reimbursements under the FSA. A proposed safe harbor would help to avoid the double counting associated with FSA amounts that are carried over from one year to the next and resolve some issues with the treatment of flex credits. As discussed below, however, Mercer recommends further simplifying the valuation of applicable FSA coverage to use only the annual FSA amount elected, whether contributed by salary reduction or flex credits. While we agree that the amount of the salary reduction must be limited to \$2500 as indexed, the \$2500 limit does not apply to flex credits contributed by an employer.

The proposed requirement to tally actual FSA reimbursements would leave employers unable to determine the cost of applicable coverage until after the end of the taxable year. Employers need the ability to determine the cost of coverage – including health FSA coverage – in advance of the calendar year for which the tax is owed. Sponsors have to make decisions about plan structure, contribution limits, and any other changes to avoid the tax for high-cost coverage well in advance of the plan year. If events (like claim reimbursement amounts) taking place during the plan year are required to be known before determining the cost of coverage, employers will not have the opportunity to avoid high costs – the very intent of the law.

In addition, use of actual FSA reimbursements (rather than salary reduction elections) in the determination of applicable cost of coverage would require many employers to develop a much more rigorous process of collecting claims data on each individual. In contrast, data on FSA contributions (regardless of source) are generally available to employers (and at a much earlier date). The monthly determination period if combined with uneven monthly reimbursement amounts would further complicate using actual reimbursements to determine the applicable cost, particularly for employees enrolled for a partial year.

C. Regulations should include an actuarial value safe harbor to align the excise tax under 4980I and employer shared responsibility assessments under 4980H.

Treasury and IRS have requested comments on how to address the potential for employers that offer affordable, minimum value coverage meeting 4980H requirements to face paying the excise tax under 4980I. Congress could not have intended imposing an excise tax on employers that are simply providing the minimum value coverage necessary to avoid paying assessments under the employer shared responsibility requirements. An employer should not face the excise tax simply because its minimum value plan has high cost -- like enrollees with expensive medical needs, geography or industry -- unrelated to excessively generous benefits.

Mercer's May comment letter suggested a safe harbor that would exempt an employer-sponsored plan from the excise tax if the actuarially-determined cost of the coverage does not exceed the cost of a nationally available plan, such as the FEHBP.

Another alternative approach to align 4980H and 4980I would offer an excise tax safe harbor to plans that have coverage costs exceeding the 4980I threshold but an actuarial value not exceeding a specified limit. In other words, the excise tax would not apply to any plan that either has coverage costs below the 4980I thresholds or an actuarial value at or below a certain percentage. Mercer suggests setting the actuarial value (AV) safe harbor at 90% -- the AV of the richest plan (platinum) available on the public exchanges. This would ensure employers can offer plans that not only meet 4980H requirements but also provide benefits as rich as a public exchange plan without risking an excise tax.

In contemplating an AV safe harbor, Mercer asks the IRS and Treasury consider the numerous factors that influence plan cost in addition to the richness of the benefits offered. These factors include morbidity (overall health status of the employees and their dependents), geography, family size, and industry among others. While 4980I calls for an age/gender adjustment, this only partially addresses the relative health or sickness of a population, and no adjustments are made for the other referenced factors. These factors would have only a minimal impact on the AV calculated for a plan, which therefore serves as a more pure measurement of the richness of the benefits being offered.

Page 19
October 1, 2015
CC:PA:LPD:PR (Notice 2015-52)
Internal Revenue Service

In Appendix III Mercer provides additional data and details to illustrate the benefits of an AV safe harbor. We hope this data will be useful to Treasury and IRS in further analyzing this issue. In our view, the actuarial value safe harbor (with a safe harbor percentage of 90%) used as a secondary test for those plans that exceed the cost thresholds would be sufficient to allow plans to meet the 4980H requirements as to minimum value, while also meeting the 4980I excise tax requirements.

Mercer welcomes the opportunity to have further discussions, including in person meetings, with the IRS and Treasury on this safe harbor, and approaches to calculating actuarial value in light of the ACA's essential health benefit rules and differences between the existing AV and MV calculators.

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Page 20
October 1, 2015
CC:PA:LPD:PR (Notice 2015-52)
Internal Revenue Service

If you have any questions or need further information, please contact Kaye Pestaina at 202 263-3949 or kaye.pestaina@mercer.com or Cheryl Risley Hughes at 202 263-3918 or cheryl.hughes@mercer.com or, for actuarial questions, Molly Loftus at 860 550-8257 or molly.loftus@mercer.com. We thank Treasury and IRS for the opportunity to respond to the request for comments in Notice 2015-52.

Sincerely,



James McNary
Senior Partner, North America Health and Benefits Business Leader



Molly Loftus, FSA, MAAA
Partner, Chief US Healthcare Actuary



Tracy Watts
Senior Partner, US Health Care Reform Leader

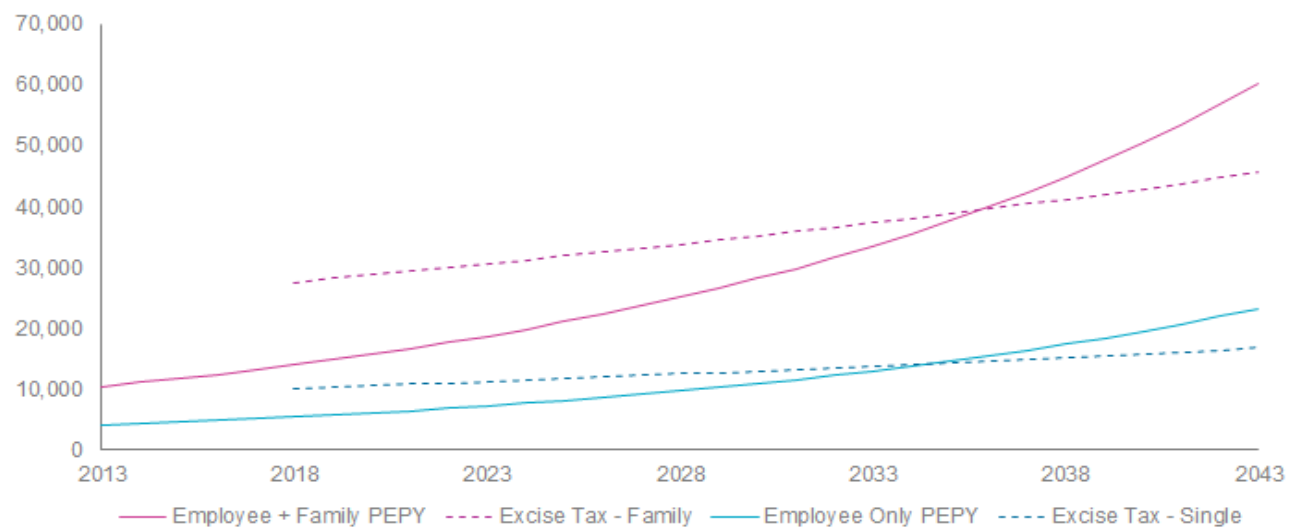
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Mark Iwry
Kevin Knopf
Karen Levin
Stephen Tackney

Appendix I: When will a 60% AV plan hit the threshold?

Table 1:

WHEN WILL A 60% PLAN HIT THE THRESHOLD?

AVERAGE PPO PLAN – 60% PLAN VALUE



ESTIMATES BASED ON DATA FROM MERCER'S NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS 2013; PREMIUM TRENDED AT 6%, TAX THRESHOLD TRENDED AT 3% FOR 2019; 2% THEREAFTER.

Appendix II: Mercer's recommended demographic adjustment methodology
(using the seven step framework in Notice 2015-52, section VI.B.)

As noted previously Mercer recommends using claims experience from a broader set of coverage options in the FEHBP to develop the age and gender adjustment tables (rather than using claims experience specific to the standard option, as proposed in Notice 2015-52). For the purpose of the methodology and examples below, the FEHBP claims experience used to develop the tables is referred to as the "experience pool."

Part 1: Calculating the demographic adjustment calculation for self-only tier:

For this methodology, the demographic adjustment for the self-only tier will consider the age/gender characteristics of all employees of the employer who are enrolled in medical coverage). The development of the group ratios as described in Notice 2015-52 that are used to calculate the demographic adjustment for the self-only coverage tier will reflect the costs of all covered employees (and will exclude the costs of their covered dependents).

- **Step 1 - Determine average cost for FEHBP coverage:** Claims experience for all employees in the experience pool will be aggregated and will then be divided by the total number of covered employees in the experience pool. Claims expenses incurred by covered dependents will be excluded from this calculation. Section B of Table 2 below provides an example of this calculation (average cost per employee is \$6000).
- **Step 2 – Determine average cost for each age and gender group:** To determine the average cost of each age and gender group, all employees in the experience pool will be grouped by their age/gender bucket. For each age/gender group, the average cost will be determined by dividing the total claims incurred by employees in that age/gender group by the number of covered employees in that age/gender group. Costs for covered dependents will be excluded from this calculation. Section A of Table 2 below illustrates the calculation of the average cost for a male group age 30 to 34 (\$3500 average cost per employee).
- **Step 3 – Determine group ratios:** The group ratio is each age/gender group average cost as determined in step 2 divided by the FEHBP average cost as determined in Step 1. Section C of Table 2 below shows the calculation of group ratios for the male 30 to 34 group (employee group ratios is 0.583).

- **Step 4 – Determine group premium cost:** The group premium cost is determined by taking each group ratio and multiplying it by the most recent annual premium cost of the FEHBP standard option. Table 3 below shows this calculation for all group ratios. For example, the group premium cost for male 30 to 34 year old employees is calculated as \$5110, based on an assumed premium of \$8,760 for the self-only coverage tier of the FEHBP Standard option.
- **Step 5 – Determine national premium cost:** The national premium cost will be determined by multiplying each group premium cost by the fraction of employees in the national workforce who are in that group. The national premium cost will then be calculated by adding together the product of each of these calculations. Using the illustrative data provided in Table 4, 6.7% of the national workforce is assumed to be comprised of 30 to 34 year old males. Therefore, in the calculation of the national premium cost, the group premium cost of \$5,110 for 30-34 year old males will be multiplied by 6.7%. This calculation will be replicated for all age/gender groups, and the results for each group will be added together to develop the national premium cost.
- **Step 6 – Determine employer’s premium cost:** The employer’s premium cost will be determined by multiplying each group premium cost by the fraction of its employees who are in that group (inclusive of employees, enrolled in self-only coverage, and employees enrolled in other than self-only coverage). The employer premium cost is calculated by adding together the product of each of these calculations. Using the illustrative data provided in Table 4, 4.1% of employees of the employer are assumed to be comprised of 30 to 34 year old males. Therefore, in the calculation of the national premium cost, the group premium cost of \$5,110 for 30-34 year old males will be multiplied by 4.1%. This calculation will be replicated for all age/gender groups, and the results for each group will be added together to develop the national premium cost.
- **Step 7 – Determine adjustment:** If the employer per employee premium cost (step 6) is higher than the national workforce per employee premium cost (step 5), the differential will be added to the self-only coverage tier dollar limit. See examples below.

Part 2: Calculating the demographic adjustment for *other than self-only tier*:

In order to appropriately reflect the cost impact of the dependents covered under the plan, the demographic adjustment factor for the other than self-only coverage tier should reflect the demographics of both the employee population and the expected costs associated with their

covered dependents. In order to calculate this adjustment, Mercer recommends developing a table of group premium costs (as outlined in Notice 2015-52) that reflects the costs of dependents covered under each employee age/gender group (excluding the costs of the associated employee). The adjustment applied to the other than self-only tier would then reflect both the group ratios developed for the employee population (as described in Part 1 above) and the group ratios developed for the dependent population, as described further below. Group ratios that reflect the costs of covered dependents will be developed by grouping all dependents in the experience pool into age and gender buckets based on the demographics of the corresponding employee.

- **Step 1 - Determine average cost for FEHBP coverage:** Claims experience for all covered dependents in the experience pool will be aggregated and divided by the total number of covered employees in the experience pool. Claims expenses incurred by employees will be excluded from this calculation. Section B of Table 2 below has an example of the development of this calculation (average per employee cost of dependents is \$9600).
- **Step 2 – Determine average cost for each age and gender group:** To determine the average cost of each age and gender group, all dependents in the experience pool will be grouped into the age/gender bucket associated with the corresponding employee. For each age/gender group, the average cost will be determined by dividing the total claims incurred by dependents who are in that age/gender group (determined by the demographics of the corresponding employee) by the number of employees in that age/gender group who are covering dependents. Section A of Table 2 below shows the average per employee cost of dependents covered by 30 to 34 year old males (\$8800).
- **Step 3 - Determine group ratios** The group ratio is each age/gender group average cost as determined in step 2 divided by the FEHBP average cost as determined in step 1. Section C of Table 2 below shows the calculation of the dependent factor for the male 30-34 year old group ratio as .917.
- **Step 4 - Determine group premium cost:** The group premium cost for dependents is determined by taking each group ratio and multiplying it by the most recent annual dependent premium cost of the FEHBP standard option. The dependent premium cost of the FEHBP Standard option is calculated by subtracting the self-only premium from the

other than self only premium. Table 3 below shows this calculation for all group ratios. For example, the group premium cost for dependents of 30 to 34 year old male employees is \$10120, based on an assumed dependent premium of \$11, 040 for the FEHBP Standard option.

- **Step 5 - Determine national premium cost:** The national premium cost for dependents will be determined by multiplying each group premium cost by the fraction of employees in the national workforce who are in that group. The national premium cost will then be calculated by adding together the product of each of these calculations. Using the illustrative data provided in Table 4, 6.7% of the national workforce is assumed to be comprised of 30 to 34 year old males. Therefore, in the calculation of the national premium cost, the group premium cost of \$10,120 for dependents covered by 30-34 year old males will be multiplied by 6.7%. This calculation will be replicated for all age/gender groups, and the results for each group will be added together to develop the national premium cost. If national workforce data is available that is split between employees enrolled in self-only coverage versus other than self-only coverage, Mercer recommends using the distribution specific to those employees enrolled in other than self-only coverage for this calculation.
- **Step 6: Determine employer's premium cost:** The employer's premium cost will be determined by multiplying each group premium cost by the fraction of its employees who are enrolled in the other than self-only coverage tier who are in that group. The employer premium cost will then be calculated as the product of each of these calculations. Using the illustrative data provided in Table 4, 3.7% of employees of the employer are enrolled in other than self-only coverage are assumed to be comprised of 30 to 34 year old males. Therefore, in the calculation of the national premium cost, the group premium cost of \$10,120 for dependents covered by 30-34 year old males will be multiplied by 3.7%. This calculation will be replicated for all age/gender groups, and the results for each group will be added together to develop the national premium cost.
- **Step 7: Determine adjustment:** To calculate the demographic adjustment for the family tier, the national workforce premium cost for dependents will be added to the national workforce premium cost for employees to determine the national workforce premium cost for other than self-only coverage. This total will be compared to the employer premium cost for other than self-only coverage, calculated as the sum of the employer premium cost for dependents and the employer premium cost for employees. If the employer premium cost

Page 26
October 1, 2015
CC:PA:LPD:PR (Notice 2015-52)
Internal Revenue Service

for other than self-only coverage is higher than the national workforce premium cost for other than self-only coverage, the differential will be added to the other than self-only coverage tier dollar limit when determining any excess benefit for the employer. See examples below.

Page 27
 October 1, 2015
 CC:PA:LPD:PR (Notice 2015-52)
 Internal Revenue Service

Tables 2 – 4 below illustrate the methodology described above.

Table 2: Group Ratio Development Illustration: Male 30-34 Year Old Group

A) Development of 30-34 year old male group ratios	
Number of covered 30-34 year old male employees (000s) (A)	200
Annual claims cost for male 30-34 year old employees (000s) (B)	\$700,000
Average cost for male 30-34 year old employee group (C = B/A)	\$3,500
Number of 30-34 year old male employees covering dependents (000s) (D)	120
Annual claims cost for dependents covered by male 30-34 year old employees (000s) (E)	\$1,056,000
Average per employee cost of dependents covered by male 30-34 year old employees (F = E/D)	\$8,800
B) Development of FEHBP average cost	
Number of covered employees - all ages and genders (000s) (G)	3,000
Annual claims cost for all employees - all ages and genders (000s) (H)	\$18,000,000
Average cost per employee (I = H/G)	\$6,000
Number of employees covering dependents - all ages and genders (000s) (J)	2,000
Annual claims cost for dependents - all ages and genders (000s) (K)	\$19,200,000
Average per employee cost of dependents covered (L = K/J)	\$9,600
C) Calculation of group ratios	
Male 30-34 year old group ratio - Employee Factor (M = C/I)	0.583
Male 30-34 year old group ratio - Dependent Factor (N = F/L)	0.917

Note: All experience data in Table 2 reflects FEHBP experience, as outlined in Notice 2015-52

Table 3: Group Premium Development Illustration

	Employees				Dependents			
	Group Ratios		Group Premium Cost (Group ratio x \$8760)		Group Ratios		Group Premium Cost (Group ratio x \$11,040)	
	Male	Female	Male	Female	Male	Female	Male	Female
<20	0.426	0.483	\$3,732	\$4,231	0.333	0.368	\$3,676	\$4,063
20-24	0.405	0.438	\$3,548	\$3,837	0.562	0.349	\$6,204	\$3,853
25-29	0.450	0.605	\$3,942	\$5,300	0.792	0.497	\$8,744	\$5,487
30-34	0.583	0.685	\$5,110	\$6,001	0.917	0.689	\$10,120	\$7,607
35-39	0.613	0.804	\$5,370	\$7,043	1.248	0.775	\$13,778	\$8,556
40-44	0.704	0.956	\$6,167	\$8,375	1.304	0.864	\$14,396	\$9,539
45-49	0.943	1.167	\$8,261	\$10,223	1.325	0.964	\$14,628	\$10,643
50-54	1.106	1.306	\$9,689	\$11,441	1.332	1.022	\$14,705	\$11,283
55-59	1.256	1.457	\$11,003	\$12,763	1.302	1.176	\$14,374	\$12,983
60-64	1.954	1.853	\$17,117	\$16,232	1.337	1.432	\$14,760	\$15,809
65-69	2.543	2.432	\$22,277	\$21,304	1.465	1.698	\$16,174	\$18,746
70+	3.215	3.015	\$28,163	\$26,411	1.663	1.772	\$18,360	\$19,563

Group ratios shown in Table 3 for Employees and Dependents are developed as shown in Table 2

FEHBP Standard option self-only premium (most recent year) (A): \$8,760

FEHBP Standard option other than self-only premium (most recent year) (B): \$19,800

FEHBP Standard option dependent premium (most recent year) (C = B-A): \$11,040

Group premium cost for Employees calculated by multiplying \$8,760 by corresponding Group Ratio

Group premium cost for Dependents calculated by multiplying \$11,040 by corresponding Group Ratio

Page 29
 October 1, 2015
 CC:PA:LPD:PR (Notice 2015-52)
 Internal Revenue Service

Table 4: National and Employer Enrollment Distribution

	Enrollment Distribution – Employee Factor				Enrollment Distribution – Dependent Factor			
	National Workforce ¹		Employer ²		National Workforce ³		Employer ⁴	
	Male	Female	Male	Female	Male	Female	Male	Female
<20	1.5%	1.6%	0.0%	0.0%	1.5%	1.6%	0.0%	0.0%
20-24	4.9%	4.6%	0.9%	0.5%	4.9%	4.6%	0.3%	0.2%
25-29	5.8%	5.0%	3.1%	1.9%	5.8%	5.0%	2.5%	1.7%
30-34	6.7%	5.0%	4.1%	2.4%	6.7%	5.0%	3.7%	2.2%
35-39	5.4%	4.6%	4.0%	2.3%	5.4%	4.6%	3.8%	2.1%
40-44	5.6%	4.9%	5.1%	2.9%	5.6%	4.9%	5.4%	3.2%
45-49	5.7%	5.1%	8.6%	4.6%	5.7%	5.1%	8.9%	4.9%
50-54	6.0%	5.4%	15.6%	7.4%	6.0%	5.4%	15.9%	7.4%
55-59	5.2%	4.8%	14.0%	6.8%	5.2%	4.8%	14.3%	7.1%
60-64	3.6%	3.2%	7.3%	3.5%	3.6%	3.2%	7.6%	3.8%
65-69	1.7%	1.4%	2.7%	1.1%	1.7%	1.4%	2.7%	1.1%
70+	1.3%	1.0%	1.0%	0.2%	1.3%	1.0%	1.0%	0.2%

¹ Reflects all employees in the national workforce (limited to those with medical coverage if this breakout is available).

² Reflects all employees of the employer who are enrolled in medical coverage.

³ Reflects all employees in the national workforce (limited to those enrolled in other than self-only medical coverage if this breakout is available; data in Table 4 assumes this breakout is not available, so national workforce distribution used for the dependent factor equals the national workforce distribution used for the employee factor).

⁴ Reflects only those employees of the employer enrolled in other than self-only medical coverage.

Examples: Using Table 3 and Table 4 to calculate employer's demographic adjustment

Self Only Tier:

National Premium Cost – Employee (A) = \$8,799; Calculated by taking the product of the distribution of the National Workforce (see footnote (1) above) and the corresponding Employee Group Premium Cost shown in Table 3, and adding together each component

Employer Premium Cost – Employee (B) = \$10,497; Calculated by taking the product of the distribution of all employees of the Employer (see footnote (2) above) and the corresponding Employee Group Premium Cost shown in Table 3, and adding together each component

Adjustment to Self-Only Tier ($C = B - A$; if $A \geq B$, $C = 0$) = \$1,698

Other than self only tier:

National Premium Cost – Dependent (D) = \$11,100; Calculated by taking the product of the distribution of the National Workforce (see footnote (1) above) and the corresponding Dependent Group Premium Cost shown in Table 3, and adding together each component

Employer Premium Cost – Dependent (E) = \$13,228; Calculated by taking the product of the distribution of all employees of the Employer who are enrolled in other than self-only medical coverage (see footnote (3) above) and the corresponding Employee Group Premium Cost shown in Table 3, and adding together each component

National Premium Cost - Other than Self-Only Tier ($F = A + D$) = \$19,899

Employer Premium Cost - Other than Self-Only Tier ($G = B + E$) = \$23,724

Adjustment to Other than Self-Only Tier ($H = G - F$; if $F \geq G$, $H = 0$) = \$3,825

Appendix III: Actuarial Value Safe Harbor – Key Findings

- Introduction of an AV safe harbor would provide reasonable protection for employers who are likely to pay the excise tax in 2018, but who do not offer excessively rich benefits.
- Based on Mercer's 2014 National Survey of Employer-Sponsored Health Plans, Mercer projects that 36% of employers would pay the excise tax in 2018 on at least one plan offering based on their current plan designs. Mercer projected whether each plan is expected to incur an excise tax based on the current premium rates trended forward at 6% per year. Mercer did not include any other costs in this projection, such as health FSA contributions or employee pretax HSA contributions.
- Within this cohort of employers with costs that are projected to exceed the excise tax thresholds:
 - 48% have an AV $\leq$ 85% for their richest plan offering
 - 67% have an AV $\leq$ 89% for their richest plan offering
 - 78% have an AV $\leq$ 90% for their richest plan offering
- As the chart above indicates, many of the employers who anticipate paying the excise tax are offering plans at an AV of 90% or lower, no richer than the platinum plans offered on the public exchanges.
- An AV safe harbor would also protect employers who do not offer excessively rich benefits, but have employees in a high-cost geography. A comparison of costs across the country demonstrates that even after adjustment for differences in the overall morbidity (i.e. health status) of a population, there is still significant variation in medical cost. Without an AV safe harbor, an employer could offer the same benefit plans in 2 different parts of the country and be found to be high cost in one part, but not the other. See Table 5 below for an example of cost variability by geography.

Table 5: Data Points - Geographic Cost Variability

Comparison of Cost by Area after Adjustment for Population Health Status

Geographic Area	Total Spend PMPY (Per Member Per Year) Med & Rx	Relative Health Index	Adjusted Total Spend PMPY Med & Rx
Mobile, AL	\$ 5,583	128	\$ 3,718
Camden, NJ	\$ 5,555	89	\$ 5,320
San Francisco-San Mateo-Redwood City, CA	\$ 5,526	70	\$ 6,716
New York-White Plains-Wayne, NY-NJ	\$ 5,340	81	\$ 5,600
Cleveland-Elyria-Mentor, OH	\$ 4,359	93	\$ 3,976
Washington-Arlington-Alexandria, DC-VA-MD-WV	\$ 3,937	78	\$ 4,281
Memphis, TN-MS-AR	\$ 3,886	85	\$ 3,886
National Avg Health Index		85	

In comparing costs by geographic area, an adjustment must be made to account for differences in the relative health status of the populations in those areas. For example, the expected cost of a group of 25 year olds, each of whom are physically active and nonsmokers, would be very different than that of a group of 60 year olds with multiple chronic diseases. An age/gender adjustment factor will adjust for some but not all of the differences in health status.

In the table above, the Adjusted Total Spend PMPY backs out the impact in each area of their relative health status. So for instance, Mobile Alabama is a very high cost area at \$5,583 per member per year, and in fact is the highest cost area of the 7 areas shown. However the health index in Mobile is 128, much higher than the national average of 85. Adjusting for the impact of the poor health status in Mobile brings the PMPY down to \$3718, or the lowest cost of all the areas shown on an adjusted basis.

As demonstrated by this table, geographic variation in cost persists even after adjustment for the relative health of the population in each area. Employers in metropolitan markets will be more likely to trigger excise tax than employers in rural markets, even where they are offering identical benefits. For example, an employer in San Francisco is more likely to pay a 2018 excise tax than an employer in Mobile Alabama due solely to the high variation in their local costs. Addition of an AV safe harbor would result in a more equitable treatment of employers across different geographies.

Actuarial Value Calculation Methodology

- If an AV safe harbor were to be implemented, Mercer supports use of a standard calculator, but more study is needed on whether the HHS MV calculator can be used. Potential additional options to consider would be the AV calculator, historical actuarial value, or an actuarial value determination as performed by an appropriately qualified actuary.
- Mercer recommends that the AV test include employer-funded HRAs and HSAs but exclude pre-tax employee HSA contributions.
- Other AV methodology issues to be considered include:
 - Whether certain benefits (such as non-essential benefits like adult dental, standalone vision, and out-of-network benefits) will be included.
 - Whether certain benefits must be included even if not covered by the health plan (e.g., skinny plan with hospitalization/physician services and preventive care only).
 - Mercer's May comment letter to IRS recommends exclusion of a broad set of onsite clinic services from the plan cost calculation – including immunizations, primary care, chronic care mgmt. These would also need to be excluded from any AV calculation. If included in AV, challenges in calculating "cost" would need to be addressed.