Notice 2015-52

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Room 5203
Internal Revenue Service
P.O. Box 7604
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Washington, DC 20044

Towers Watson Comments on Notice 2015-52 Regarding the ACA High-Cost Plan Excise Tax

Introduction

We are writing on behalf of our firm, Towers Watson, to submit comments in response to your request in Notice 2015-52 to help frame upcoming guidance and identify potential approaches and issues relevant to the "excise tax on high cost employer-sponsored health coverage" under §4980I of the Internal Revenue Code, as added by the Patient Protection and Affordable Care Act (ACA). Our comments are set forth below.

Towers Watson is a leading global professional services company that helps organizations improve performance through effective people, risk and financial management. With 16,000 associates around the world, we offer consulting, technology and solutions in the areas of benefits, talent management, rewards, and risk and capital management. Towers Watson's Health and Group Benefits business sector assists employers in optimizing both global and local benefit program performance and gaining maximum value from the annual expenditure for medical, dental and risk (life, accident and disability) programs. We work with many of the country's largest employers on their health care benefits.

Our comments are intended to promote the following objectives and principles:

- Solicit guidance on a comprehensive range of issues and scenarios in effect for large employers so that they can prepare properly for assessing the impact of this tax, and taking mitigating steps as necessary, well in advance of the 2018 effective date
- Support plan sponsor flexibility and reasonable ease of administration, given the wide array of complex plan arrangements in effect for large self-insured employers
- Develop appropriate definitions of "applicable employer-sponsored coverage" (hereinafter referred to as "applicable coverage"), within the constraints of regulatory authority, and ensure alignment of cost determination approaches with reasonable, well-established and effective plan pricing arrangements in effect for large employers across the US

Since in this comment letter we make several references to our comments provided on Notice 2015-16, also attached is our earlier comment submission for your convenience.

Preamble: Comments on Timing Considerations

Large employers devote significant resources to the annual benefit planning process, following a timeline of interrelated resource-intensive activities that often begin more than one year before the start of a plan year. This planning cycle will be impacted very substantially by the advent of the §4980I excise tax in 2018. We anticipate that a large majority of employers will seek to make changes to their health care benefit program to avoid a §4980I obligation. Accordingly, it will be critical for employers to understand the full implications of their risk under this tax early enough in the planning cycle to be able to undertake appropriate analysis and remedial action to ensure that their plan costs do not trigger the excise tax while also ensuring that their plans continue to meet business, HR and competitive objectives.
Given the nature of the large employer benefit planning process, we believe that it will be imperative for employers to know all relevant parameters of the excise tax as early in the planning process as possible. We believe that future guidance should confirm the following:

- All costs for applicable coverage will be determined on a prospective basis, as is current practice for employer budget development as well as what is required for COBRA rate development
- The following parameters should be published, in final form when possible, prior to the end of the first quarter of the year prior to the applicable tax year (e.g., no later than March 31, 2017 for the 2018 tax year)
    - Tax thresholds
    - Age and gender adjustment tables; in addition, such tables should change as infrequently as possible in order to provide greater predictability for employers
    - The age and gender adjustment "snapshot" date should be determined by the employer as any date in the year prior to the applicable tax year, subject to a consistency rule
    - Maximum contributions to health flexible spending accounts (FSAs) and health savings accounts (HSAs), as these amounts will influence how employers will structure limits under these accounts for enrollment purposes (we understand that there may be statutory limitations on the timing for release of these parameters)

We cannot overstate the importance of timely release of relevant tax parameters in order to avoid imposing substantial hardship on large employers during their benefit planning process.

Comments on Section III. Persons Liable for the § 4980I Excise Tax

A. Coverage Provider and B. Person That Administers Plan Benefits

Self-Insured Group Health Plans

Notice 2015-52 sets forth two possible approaches for defining "the person that administers plan benefits" as the coverage provider for self-insured group health plans. Under one approach, the person that administers plan benefits would be the person responsible for performing day-to-day functions that constitute the administration of plan benefits; under the second approach, the person that administers plan benefits would be the person with ultimate authority or responsibility under the plan with respect to the administration of plan benefits, regardless of whether that person routinely exercises that authority or responsibility.

We believe that, at a minimum, employers should be given the flexibility to select "the person that administers plan benefits" using either of these two approaches. If future guidance specifies only one approach, we strongly recommend adopting the second approach under which the "the person that administers plan benefits" will be the person with the ultimate authority or responsibility under the plan with respect to the administration of plan benefits, which in most cases will be the employer. It is very uncommon for large employers to use only one third-party administrator for all health benefits includible in the definition of applicable coverage. In addition, for most large employers with self-insured group health plans, the third-party administrators are not involved in developing projected costs for potential use in the §4980I cost determination. For such employers with a range of self-insured group health plans, only the

employer will have all of the information necessary to compute any excise tax obligation across aggregated benefits defined as applicable coverage. This approach promotes both ease of identifying the "the person that administers plan benefits" as well as administration of the activities relating to excise tax calculation, reporting and payment.

Insured or Mix of Insured and Self-Insured Group Health Plans

For employers offering either only insured group health plans or a range of group health plans including both insured and self-insured arrangements, we recommend allowing the employer to choose to act as the coverage provider for all applicable coverages in order to streamline the excise tax calculation and administration process. We understand that the statute defines the health insurance issuer as the coverage provider for insured coverage; we inquire as to the possibility of allowing an insurer to delegate the coverage provider responsibility to an employer when mutually agreeable, subject to appropriate contractual requirements.

Few large employers offer only insured group health plans. Many large employers, however, offer a mix of plans with different funding arrangements (e.g., a self-insured national plan along with regional insured HMO options); in this case, an employer choosing to act as coverage provider for all plans can more easily manage the assessment process needed to either avoid the excise tax (which we believe most employers intend to do) or to pay the excise tax if avoidance is unsuccessful. Regardless, the employer remains the only party with access to all of the information required to properly assess excise tax implications across all of its applicable coverages. In addition, this avoids the need for the employer and the insurer to deal with the administration and potential costs of insurer pass-through and income tax reimbursement of the excise tax obligation.

Multiemployer Plans

For multiemployer plans offering self-insured coverage, we advise a similar approach under which the board of trustees of the fund could either select one of the two approaches outlined or – if only one approach is specified – define the "the person that administers plan benefits" as the board of trustees of the fund. As we do not work extensively with multiemployer plans, we will defer to other commenters (including those representing multiemployer plans) in providing additional input on this issue.

Comments on Section IV. Employer Aggregation

With respect to the employer aggregation rules under §4980I, we believe that employers who are members of a controlled group of corporations under §414 should be given the flexibility to determine which entity or entities within the controlled group should be required to identify:

- The applicable coverage taken into account for purposes of determining any excise tax liability,
- The employees who should be taken into account for purposes of any adjustments to the excise tax thresholds,
- The entity within the controlled group responsible for calculating and paying the excise tax, and
- The entity within the controlled group liable for any penalty for failing to pay the excise tax.

The employer aggregation approach set forth in the statute can present many practical challenges to large employers with complex organizational structures. For example, an employer's controlled group could have one ultimate parent company (such as a holding company), however, it may include several subsidiaries or operating entities (e.g., for different business units within the controlled group) with each operating entity having its own set of employee benefit plans as well as different administrators and human resource departments. In such cases, treating the combined organization as a single employer and the parent company as the "employer" for purposes of §4980I could present several challenges since the parent company may not employ *any* individuals (or may not control the day-to-day operations of the entities in the controlled group) and would likely not have the details of the benefit offerings for each applicable subsidiary or business unit.

We believe the IRS should give employers the flexibility to select which entity or entities within its controlled group should be considered to be the employer for purposes of §4980I, provided that the total excise tax liability for the entire controlled group is calculated and remitted to the IRS in a timely manner. For example, an employer may decide to allocate excise tax responsibilities among "applicable large employer members", which have been identified for purposes of complying with the ACA employer shared responsibility mandate. For other employers, it may be preferable to consolidate the excise tax-related responsibilities at the parent organization level of the controlled group. These and other similar approaches should be permissible as long as a determination has been made as to whether any excise tax liability is owed with respect to all employees and retirees with applicable employer-sponsored coverage within the controlled group.

Comments on Section V. Cost of Applicable Coverage

A. Taxable Period

We have no comments on this subsection.

B. Determination Period

Self-Insured Group Health Plans

In our comments provided in response to Notice 2015-16, we outlined the process by which many large employers develop plan costs for health care benefits on a prospective basis (in advance of the start of the plan year). Rates for continuation coverage under §4980B (COBRA) are also universally set on a prospective basis. Accordingly, employers will know in advance of the plan year (and will certainly need to know in advance for management of the excise tax starting in 2018) whether any package of benefit elections defined as applicable coverage will exceed the thresholds under §4980I. This will include projected costs for the underlying medical and prescription drug benefit plans as well as the level of allowable account funding for HSAs, FSAs and HRAs that prevent total costs for applicable coverage from exceeding the excise tax thresholds. In this case, for employers facing an excise tax obligation, the calculation of actual excise tax due, if any, will largely be a function of final enrollment for each month of the year for each individual with an aggregated cost of applicable coverage that exceeds the applicable thresholds. More specifically, all applicable costs will be known in advance while final enrollment by individual by month will not be known until year end. Accordingly, there would be no need to assess any claims submitted during a run-out period.

This year-end tax determination process is simplified if, as outlined earlier, the employer is designated as the coverage provider for self-insured group health plans (and, at employer discretion, for insured group health plans as well). In addition, we anticipate that many employers will take steps to reduce the cost of applicable coverage in advance of the plan year (for example, by increasing member cost sharing, such as deductibles, copays and coinsurance, at the point of service) to a level so that the value or cost of the coverage is no higher than the §4980I thresholds, thus avoiding any excise tax obligation under §4980I. In addition, with respect to benefits such as FSAs and HSAs, we expect that most employers facing a potential §4980I excise tax obligation will act in advance of the plan year to limit employee pre-tax salary reduction elections to amounts that when aggregated across other applicable coverage elections do not exceed the applicable excise tax thresholds. We anticipate that many employers will ultimately eliminate the use of those accounts altogether when needed to avoid an excise tax obligation.

Insured Group Health Plans

We support conceptually the reduction of applicable coverage cost for insured group health plans with a participating (or "experience-rating") arrangement under which a premium refund or dividend may be payable in the event that plan year experience is more favorable than anticipated in premium rates. We also note that, in some cases, insured group health plans may also include an up-front premium discount coupled with a right to collect an additional premium in the event that plan experience is less favorable

than anticipated in premium rates. As we do not work extensively with participating insured plans, we will defer to other commenters (including those representing health insurance issuers) in providing input on these issues from an administrative perspective.

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

Self-Insured Group Health Plans

Pursuant to the statutory language in §4980I, any excise tax obligation is excludible from the cost of applicable coverage subject to the excise tax. As outlined earlier, we strongly recommend that employers with self-insured group health plans be allowed to act as the coverage provider (i.e., the person that administers the plan benefits). Assuming employers are allowed to act as the coverage provider, the issues relating to excise tax reimbursement and the income tax reimbursement from a non-employer coverage provider to the employer will not apply.

Insured Group Health Plans

We recommend that employers be allowed to act as the coverage provider, if they so choose, for their insured group health plans. In this case, there would be no pass-through of excise tax cost or associated income tax reimbursement for taxable health insurance issuers. All tax implications relating to non-deductibility of the §4980I excise tax would be borne solely by the employer, with no involvement by contracted health insurance issuers.

In cases where an issuer acts as the coverage provider for insured group plans, we request that future guidance specify that any income tax reimbursement applied by a health insurance issuer (as the coverage provider and a taxable entity) be excluded from the cost of applicable coverage for determination of any excise tax obligation. It is hard to imagine a statutory intent to subject employers to the excise tax on an income tax reimbursement levied by a taxable health insurance issuer subject to this tax as a coverage provider. Administrative challenges should not drive a regulatory policy that would raise the cost of this already-onerous tax.

We will defer to other commenters (including those representing health insurance issuers) to provide input on practical approaches supporting the administration of income tax reimbursement (including the separate billing of excise tax amounts and any associated income tax reimbursement).

D. Income Tax Reimbursement Formula

This section would not apply to employers with insured or self-insured group health plans if, as we requested earlier, such employers will be allowed to act as the coverage provider. Accordingly, we will defer to other commenters (including those representing health insurance issuers) on the issues relating to calculation of income tax reimbursement applicable to taxable health insurance issuers acting as coverage providers.

E. Allocation of Contributions to HSAs, Archer MSAs, FSAs, HRAs

HSAs and FSAs

We strongly support the approach under consideration to pro rate contributions to HSAs and FSAs over the period to which the contribution relates (generally the plan year), regardless of the actual timing of contributions during the period. This supports equity and ease of administration. As noted earlier, we anticipate that most employers who offer these accounts will limit employee pre-tax salary reduction contributions on a prospective basis (i.e., before the start of the plan year, during annual enrollment) to ensure that such account elections do not cause the aggregate cost of applicable coverage to exceed the thresholds under §4980I. It is likely that employers will ultimately eliminate such accounts altogether

once contributions, when combined with the cost of other categories of applicable coverage, would cause those employers to become subject to the excise tax under §4980I.
See our accompanying comments in response to Notice 2015-16 for an articulation of reasons why we believe employee pre-tax contributions to an HSA should be excludible from the definition of applicable coverage.

HRAs

We also support the pro ration approach for HRAs, with the additional comment that we believe the cost of applicable coverage for an HRA should be determined with respect to projected claim payments under the account rather than nominal employer contributions. Since HRAs are subject to rollover and forfeiture provisions, nominal account credits over time will always exceed actual plan costs. In our comments to Notice 2015-16, we expand further on the process we recommend for determining cost for HRAs.

F. Cost of Applicable Coverage under FSAs with Employer Flex Credits

We ask that the IRS clearly delineate whether the reference in Notice 2015-52 to "flex credits" would include employer contributions from all sources (e.g., wellness credits).

G. Inclusion in Applicable Coverage of Self-Insured Coverage Includible in Income under §105(h)

We have no comments on this subsection.

Comments on Section VI. Age and Gender Adjustment to the Dollar Limit

Background

The age and gender adjustment factor is intended to increase the excise tax thresholds when the age and gender composition of an employer's workforce indicates that the employer's health plan costs will likely be higher than the national average due purely to age and gender demographics. The composition of the national workforce may be based on data from the Current Population Survey while cost data may be derived from the FEHBP BCBS standard option.

Our comments address areas of concern on whether the proposed approach will meet the statutory objective of this adjustment. We offer comments on possible alternatives that might fulfill this adjustment's intent while reducing the administrative burden on employers.

Determination by Benefit Package

We also ask that future guidance specify the basis for applying age and gender adjustments under the "benefit package" concept introduced in Notice 2015-16. Our comments in response to Notice 2015-16 provide substantial input on the process by which employers develop cost projections for self-insured plans. This includes the cost projection process when multiple options are offered to a common population under which a "single risk pool" rating approach is typically employed for determination of costs for budgeting and COBRA rate purposes. We ask the IRS to clarify that employers will be allowed to develop and apply an age and gender adjustment separately for each benefit package that includes one or more unique plans offered to a common population.

Threshold Adjustments for Early Retirees

The statute provides for higher excise tax thresholds specifically for early retirees. Please confirm the age and gender adjustments are applicable to early retirees and, if so, please provide further guidance on coordination of the age and gender adjustments when an employer's covered population includes early retirees in addition to active employees.

A. Determination of Age and Gender Distribution

The National Workforce

The notice contemplates using data from the Current Population Survey (CPS) as published by the Bureau of Labor Statistics (BLS) to represent the national workforce. The proposed Table A-8a falls short of the objective as it groups together all workers over age 55. The impact of age is most pronounced for older workers so it will be critical for the national workforce distribution to include employees by five-year age bracket beyond age 55. We also request consideration of whether use of one-year age brackets would be preferable to use of five-year age brackets in terms of developing workforce adjustments on a basis of greater refinement and credibility.

Inconsistency of Cost Basis and Workforce Composition

National workforce distributions sort employees by age and gender. The adjustment methodology contemplates directly linking cost levels with demographic factors to determine if thresholds can be raised for a given employer's workforce. There are two areas in particular where we believe that the proposed approach skews the linkage between cost levels and age and gender factors which could lead to inappropriate results.

FEHBP plan blends retiree costs with active employee costs

FEHBP plans provide coverage to active employees as well as early retirees, retirees with Medicare and disabled individuals, some of whom have qualified for Medicare. We believe that it is inappropriate to include retiree and other inactive employee claims in the development of cost factors that are applied to a workforce distribution composed solely of active employees. Claim patterns for retirees and disabled individuals differ significantly from claim patterns for active employees, even within the same age bracket. Claims for individuals on Medicare are further distorted by the presence of Medicare as a primary payer and the differing levels of Medicare coordination of benefits that may apply. If future guidance specifies use of the FEHBP claim data set, please confirm that data to be used in developing age and gender adjustment tables will exclude claims on retired and inactive individuals.

Impact of dependents

Workforce figures do not distinguish between workers who provide health coverage for family members, workers who cover themselves only, and those who do not elect health insurance. Cost data from the FEHBP will include claims for *enrolled* employees and family members. We do not believe it is appropriate to apply a national workforce distribution based solely on employment to cost factors that include only those who enroll for coverage and that are derived separately for employees with self-only (SO) coverage and employees with other-than-self-only (OTSO) coverage.

A Recommended Alternative Approach

As an alternative to the methodology outlined in Notice 2015-52, we strongly recommend developing a single multiplicative adjustment factor based on the overall workforce distribution of the employer relative to the national workforce. That factor would then be multiplied by the standard SO and OTSO tax thresholds to determine adjusted thresholds. This approach is easier to determine and administer, and is consistent with a multiplicative adjustment contemplated in the statute for changes in cost trend.

Timing Considerations

As outlined in our preamble comment on timing considerations, we believe it is imperative for employers to be able to determine potential age and gender threshold adjustments early in the year prior to the applicable tax year in order to fit within the employer's benefit planning cycle. We recommend that future guidance specify that employers can select as their age and gender snapshot date any day in the year

prior to the applicable tax year, subject to a consistency rule. For example, in preparing for the 2018 tax year, employers could determine their age and gender adjustment using a workforce snapshot date of March 31, 2017 so that any projected excise tax risk can be factored appropriately into benefit planning. Given that large employer workforces tend to exhibit relatively stable age and gender composition, greater flexibility on an age and gender measurement date will facilitate employer planning while not introducing meaningful variation in the resulting adjustment.

We also request that future guidance outline requirements and conditions under which an employer may revise both its thresholds and projected costs for applicable coverage during a calendar year if there are significant changes in its workforce composition. This could occur, for example, following a significant acquisition or divestiture that materially impacts workforce age and gender composition.

B. Development of Age and Gender Adjustment Tables

Limitations of FEHBP Standard Plan Data

Notice 2015-52 requests comments on whether age and gender adjustments should use claim data from the FEHBP standard option or another national claim data set reflecting plans with design similar to the FEHBP standard option. We recommend using a source other than FEHBP for the following reasons:

- FEHBP claim data includes retirees and other inactive employees; results are not representative of national averages unless claims for inactive employees can be removed
- The FEHBP standard option is a choice among a range of options, thus introducing a potential level of adverse risk selection within the FEHBP experience that could distort its validity
- A larger database could provide higher credibility and more consistent adjustment results over time, thus improving predictability for employers

Composition of Claim Data Used to Determine Age and Gender Adjustments

The statute refers to age and gender adjustments based on a comparison of premium costs under the FEHBP compared to a calculation of premium costs based on the employer's workforce. Notice 2015-52 then specifies use of FEHBP "claims expenses" in the development of adjustment tables. We have two comments on the meaning of terms including premiums and claim costs:

- First, premiums for insured coverage include a number of components beyond claims paid under the plan, including insurer administration costs, risk charges, state and federal taxes, reserve charges and profit load. We believe that such additional costs should not be included in the calculation of age and gender adjustment factors since such inclusion would distort the intended cost relativities by underlying claim experience.
- Second, the term "claims expense" appears to reference actual claim payments made under the plan after applying member cost sharing features such as deductibles and copays. We believe that the appropriate basis for developing age and gender adjustment factors is "allowable charges" before the application of deductibles and copays, etc. In this way, the true underlying morbidity ratio of each age and gender cohort is not distorted by the inclusion of plan payment provisions which do not apply uniformly across a claim probability distribution.

Individual and Small Group Market Age Factors

Notice 2015-52 solicited comments on whether the age and gender adjustment should take into account the age rating scale in effect for individual and small group market coverage as required under the ACA starting in 2014. *We strongly discourage this approach.* Age rating within the individual and small group market artificially limits rates for older individuals to no more than three times the rates for the youngest adults, thus creating an "intergenerational subsidy". Actual claim experience by age within employer

group health plans will normally show a steeper ratio of costs by older employees compared to younger employees. Use of a three-to-one age limitation would likely produce unreasonably low threshold adjustments relative to actual group plan claim distribution.

Comments on Section VII. Notice and Payment

A. Notice of Calculation of Applicable Share of Excess Benefit

The Notice indicates that the employer will be required to calculate the amount of excess benefit subject to the tax, including the applicable share by each coverage provider, and to notify the Secretary and each coverage provider of the amount so determined for each coverage provider. Notification will be required at the time and in the manner to be specified by the Secretary. We request that future guidance address the following:

- What form this notification may take and what information will be required for inclusion with the notification
- Whether a model notice will be issued
- Whether some form of actuarial attestation will need to accompany the notification to confirm for self-insured coverage that cost determination for applicable coverage has been performed in accordance with regulatory guidance
- Confirmation that if the employer acts as the coverage provider for self-insured coverage, and potentially for insured coverage, then this notification to the coverage provider would not be required
- For employers determining that their plans do not exceed the applicable thresholds, and therefore owe no tax under §4980I, confirmation that no notification would be required

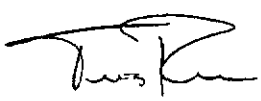
B. Payment of the §4980I Excise Tax

The Notice indicates that Form 720, Quarterly Excise Tax Return, may be designated as the appropriate method for payment of the tax, with a particular quarter identified for this purpose. We request that future guidance provide more detail on the timing, form and content of this approach so that employers have more clarity on the required notification and payment process. In order to maximize the time available for determining and paying the excise tax, it would be advantageous for either the third or the fourth quarter after the end of the applicable calendar year to be designated as the applicable quarter for paying the excise tax.

Closing

Thank you for inviting comments on Notice 2015-52. We look forward to the release of future regulatory and sub-regulatory guidance on this issue of immense importance to our clients as they continue to evaluate their health care benefit offerings in light of this substantial new tax.

Very truly yours,



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