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Submitted Electronically via Email: Notice.comments@irs.counsel.treas.gov

CC:PA:LPD:PR (Notice
2015-16) Room 5203 Internal
Revenue Service P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

***RE: Section 4980I – Excise Tax on High Cost Employer-Sponsored Health Coverage
(Notice 2015-52)***

To Whom It May Concern:

The U.S. Chamber of Commerce (the “Chamber”) submits these comments in response to Notice 2015-52 (“Notice.”) The Notice was released by the Department of the Treasury (“Treasury”) and the Internal Revenue Service (“IRS”) (collectively, the “Department”), and describes potential approaches with regard to a number of issues under §4980I of the Internal Revenue Code, as added by §9001 of the Patient Protection and Affordable Care Act and amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the “Affordable Care Act” or “ACA”).¹ According to the Notice, one or more of the approaches discussed within could be incorporated in future proposed regulations.

The Chamber is the world’s largest business federation, representing the interests of more than three million businesses and organizations of every size, sector and region, with substantial membership in all 50 states. More than 96 percent of the Chamber’s members are small businesses with 100 or fewer employees – 70 percent of which have 10 or fewer employees. Therefore, we are particularly cognizant of the problems of smaller businesses. Yet, virtually all of the nation’s largest companies are also active members, so we have insight into issues facing the business community at large. Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide spectrum of employers in different industries and locations. Each major classification of American business – manufacturing, retailing, services, construction, wholesaling, and finance – is represented. These comments have been developed with the input of our member companies with an interest in improving the health care system.

¹ The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (2010).

OVERVIEW

The Chamber appreciates the careful and collaborative process the Treasury and IRS has adopted regarding the implementation of Code section 4980I, and the opportunity to comment on this second Notice.

We urge Treasury and the IRS to recognize the very important role the current employer-sponsored health care system plays in providing vital health coverage to millions of American workers and their families. In this regard, employers have worked hard, and continue to work hard, to design coverage options for their employees that provide important health coverage, and ensure that their employees are protected against unreimbursed medical expenses that could result in financial distress for employees and their families. In particular, employers have embraced arrangements that couple comprehensive medical coverage with health savings accounts (“HSAs”), flexible spending arrangements (“FSAs”) and/or health reimbursement arrangements (“HRAs”) that provide employees with additional resources to pay for qualified medical expenses while also encouraging them to be value-conscious consumers of health care. Accordingly, we urge Treasury and IRS to continue to consider how they can use their administrative authority, within the confines presented by the statutory language, to ensure that American workers are not placed in dangerous financial positions by reason Code section 4980I.

As discussed in greater detail below, employers will play a central role regarding the calculation, and noticing of any Code Section 4980I excise tax liability. Given the broad application of the tax to employers of all types (including public, private, non-profits and tax-exempts) as well as of all sizes (since there is no small employer exception), we urge Treasury and IRS to promulgate rules that will minimize the burdens and costs on employers in this regard.

We understand the challenges that the Administration faces given some of the statutory language in this provision as added by the ACA’s §9001, but urge the regulators to strongly consider and evaluate the inconsistencies in terminology within this provision, as well as the inconsistencies in overall ACA policy that may result without additional flexibility and safe harbor rules.

LIABLE ENTITY

As discussed in Notice 2015-52, employers will play a very central role in administering the excise tax. Per Code section 4980I(c)(4)(A), an employer will be required to (i) determine the cost of any applicable employer-sponsored coverage, (ii) compare the cost of such coverage against the applicable annual limitation, and (iii) notice any excess benefit within the meaning of Code section 4980I(b) to each responsible coverage provider, for any and all of its employees as applicable.

Quite significantly, Code section 4980I applies to all employers, including public and private employers, as well as non-profit and tax-exempt employers, and also applies to employers of all sizes (i.e., there is no small employer exception). Thus, it is very important that any proposed rule take into account of this fact and provide employers of all types and sizes with sufficient time to

perform their obligations as required by Code section 4980I.

Employers are already struggling under the weight of new and additional ACA-imposed requirements, including many that require employer action at or near the close of a given taxable year (e.g., Form W-2 tax reporting and Code sections 6055 and 6056 reporting.) Additionally, many employers sponsor plans with plan years ending at or near calendar year end. Many of these employers also have to address other tasks at year's end related to plan administration, including participant open enrollment and disenrollment as well the provision of numerous ERISA-required disclosures, including Summary Plan Descriptions ("SPDs") or Summaries of Material Modification ("SMMs") and the Summary of Benefits and Coverage ("SBC").

Significantly, the statute does not prescribe any specific time periods for the calculation, notice, and/or payment of the excise tax. Thus, Treasury and the IRS have significant discretion in setting forth the timeline that will apply to the administration and payment of the excise tax. We urge Treasury and IRS to use this discretion to promulgate rules that will not add to the burdens that employers already face in fulfilling their ACA and ERISA obligations.

As suggested in the Notice, many plans may not know their actual cost of "coverage" until sometime after the close of the taxable period. For example, an insured plan may utilize features like premium rate credits (paid or accrued), or a premium stabilization reserve ("PSR") to reduce premium volatility for employers and plan participants. The use of these premium rate credits or PSRs would also serve a very useful purpose in a manner consistent with the intent of Code section 4980I, in that they would to limit the dollars spent by employers and employees toward health care coverage. Therefore, continued use of these credits or PSRs should not be discouraged by the Code section 4980I rules promulgated by Treasury and IRS.

Additionally, almost all self-funded plans provide for an administrative run-out period during which participants can submit claims incurred during the plan year following the close of the plan year. These run-out periods are essential to the administration of self-funded plans because of the realities of medical billing (which may result in expenses for reimbursement being submitted to the plan many days, if not months, following the date the services was provided). While many plans may limit the run-out period to 4-6 months, we have members who provide for a run-out period of up to 12 months to ensure that their employees have sufficient time to reimburse claims incurred during the plan year.

In light of the foregoing, we urge Treasury and IRS to fashion a determination period that fully takes account of a plan's run-out period. For example, the rules regarding the determination period could provide that employers are not required to begin calculating any excess benefit until some period of time has elapsed following the close of the employer plan's run-out period. Alternatively, the rules could recognize that most run-out periods are 12 months or less and therefore, all employers – regardless of their specific run-out period – are not required to calculate the cost of the applicable employer-sponsored coverage until the close of the 12-month period following the close of the respective plan year. This will help facilitate accurate cost determinations with respect to the subject coverage and should help provide employers with adequate time to perform the respective cost determination.

Following the employer's determination of the cost of coverage, Treasury and IRS should also provide employers with sufficient time to compare the cost of the coverage against the annual limitation applicable to the employee (to determine the extent of any excess benefit), as well as sufficient time thereafter for employers to provide notice to the responsible coverage provider (such as an insurer with respect to insured coverage) of their share of any excess benefit.

Lastly, the Chamber is concerned that employers not be drawn into tax disputes between the IRS and unaffiliated coverage providers. If employers are required by law to respond to document or information requests by the IRS or coverage providers in connection with such tax disputes, significant costs and burdens would result at no benefit to employers. To protect against this result, we recommend that Treasury and the IRS consider a rule that would assign employers no further obligations under Code section 4980I, including with respect to any downstream tax controversy involving unrelated parties, so long as they provide in writing to the coverage provider(s) the methodology used by the employer in determining the extent of any excess benefit and make themselves available for some period of time following notice to the coverage provider of any excess benefit to provide information and documentation in response to reasonable requests by the coverage provider.

DETERMINING THE COST OF COVERAGE

The Chamber supports the adoption of a safe harbor rule that would allow employers, at their discretion, to adopt a look-back method in determining the cost of a plan's coverage for purposes of Code section 4980I(d)(2).

Under the contemplated approach, an employer would be permitted to look to the cost of coverage in a prior year for purposes of determining any excess benefit with respect to the taxable period. Thus, for example, if an employer has a calendar year plan, in determining the cost of coverage for the taxable period comprised of the 2018 year, the employer would be permitted to look to the cost of coverage with respect to a prior plan year. Given our comments above regarding the common use of run-out periods by self-funded plans (as well as the use of certain premium-stabilizing features with respect to insured plans), the Chamber recommends that employers be permitted to look as far back as two prior plan years. This will ensure that employers have sufficient time to account for claims that come in after the close of the plan year. It should also facilitate compliance with Code section 4980I by providing employers with sufficient time to carry out their obligations with respect to Code section 4980I, including in determining the cost of coverage and the extent of any excess benefit, and in noticing coverage providers of their share of any resulting excess benefit.

Concededly, allowing employers to look to a prior plan year in valuing the cost of the coverage could result in lower cost valuations, assuming year-over-year inflation. To control for this result, we encourage Treasury and IRS to utilize the indexing methodology that applies by statute to the "past cost" COBRA valuation methodology. Specifically, Code section 4980B(f)(4)(B)(ii) provides the COBRA applicable premium is equal to "(I) the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period... adjusted by (II) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current

Business) for the 12-month period ending on the last day of the sixth month of such preceding determination period.” Accordingly, this index factor could be used by employers under our proposed methodology to account for the passage of time from the close of the plan year until the start of the taxable period.

We think this valuation rule, if established as a safe harbor rule, would be utilized many employers. This is because, using this methodology, employers will be able to be confident that their cost valuations are correct, and that such valuations account for all applicable claims, including those submitted during a run-out period. Moreover, such a rule should alleviate some of the burdens placed on employers by reason of Code section 4980I by eliminating the need for them to engage in rushed and potentially incomplete valuations that could result in incorrect cost determinations.

We note that the statute appears on its face to provide Treasury and IRS with the needed authority to implement an elective look-back approach as proposed herein. Specifically, Code section 4980I(d)(2)(A) states that rules “similar to” the COBRA valuation rules of Code section 4980B(f)(4) are to be used in determining the cost of applicable employer-sponsored coverage. For the reasons noted above, we think sound policy argues in favor of Treasury and the IRS using this authority to adopt the recommended safe harbor rule.

THE VALUE OF HSAs, FSAs, HRAs, & MSAs

Notice 2015-52 sets forth, and requests comments regarding, a contemplated methodology for determining the cost of coverage with respect to medical savings accounts, including HSAs, FSA, HRAs, and Archer MSAs. Specifically, the Notice contemplates a rule whereby the monthly cost of coverage would be equal to one-twelfth of the annual contributions to the respective medical savings account (including employer contributions or employee contributions via salary reduction, as applicable).

The Chamber is supportive of the contemplated valuation methodology, as it should ease the administrative burdens on employers and facilitate compliance with the administration, calculation, and payment of the tax. The contemplated methodology would allow employers to focus solely on the extent of annual contributions to an employee’s medical savings account and would not require employers to engage in the administratively complex task of looking at account utilization by the employee. This should speed cost determinations and result in more accurate and timely determinations.

Notwithstanding our general support of the methodology, we are concerned that the methodology may overstate the “cost” of medical savings accounts in instances where it can be expected, or is actually the case, that the utilization of the medical savings account is materially less than 100% of the annual contributions. For example, certain plan designs intentionally seek to encourage less than 100% utilization in an effort to foster an increased sense of awareness by employees of their health care utilization. These plan designs serve a helpful purpose and should be encouraged by the rules under Code section 4980I. Thus, the Chamber urges Treasury and IRS to fashion a rule that would permit employers, at their election, to determine the cost of an employee’s medical savings account based upon actual or expected utilization, so long as the methodology is

used consistently across taxable periods and is otherwise consistent with generally accepted accounting techniques. Moreover, to assist employers in determining cost under this optional method, the Chamber recommends that the rule permit employers to determine cost based upon medical savings account utilization either by the respective employee, or across the plan as a whole.

EMPLOYER “FLEX CREDITS” TO FSAS

Code section 4980I(d)(2)(B) provides that the cost of applicable coverage under an FSA, is equal to the sum of (i) the amount of any contributions made under a salary reduction election, plus (ii) the cost of applicable coverage under the generally applicable rules for determining the cost of applicable coverage with respect to any reimbursement under the arrangement in excess of the contributions made under the salary reduction agreement.

Notice 2015-52 suggests that if the employee defers amounts to the cafeteria plan that exceed the Code section 125(i) limit for FSAs, and the amount elected by the employee for the FSA was less than or equal to the maximum amount permitted by Code section 125(i), the FSA would be treated as funded solely by salary reduction. The Chamber endorses this approach as it will ease the burden of Code section 4980I administration and give employees more flexibility with regard to their cafeteria plan elections. The Chamber also encourages the IRS and Treasury to extend this approach to any HIPAA-excepted FSAs within the meaning of Treas. Reg.

§54.9831-1(c)(3)(v) and provide that employer flex-credits to such FSAs would not be taken into account in determining the cost of applicable coverage. This is appropriate given that employer flex-credits to such FSAs are limited to the lesser of (i) \$500 and (ii) the amount of the employee’s salary reduction contributions.

SMALL EMPLOYER CONSIDERATIONS

As noted above, there is no specific statutory exception from the excise tax for small employers. As a result, it appears small employers, like large employers, will be subject to the excise tax. It is imperative, therefore, that small employers be presented with rules for purposes of Code section 4980I that they can in fact administer and comply with.

There are a host of unique issues with respect to the small group insurance market that we urge the Department to take into account as it continues to work on promulgating rules to implement Code section 4980I. For your information, we set forth several of these issues below. As discussed, if left unaccounted for, it is likely, if not certain, that many small employers will find themselves subject to unintended and unwanted excise tax liabilities.

First, to the extent the Department’s eventual rules utilize COBRA rates for purposes of the cost determination required by Code section 4980I(d)(2), the Department should keep in mind that small employers generally are provided with one of the following types of rating quotes from insurers. The first type is a “composite” rating, which is essentially the average premium that will be charged across the covered group. The second type is an “employee rating” whereby the employer is quoted a premium for each employee that will be covered under the arrangement. The employee rating is based upon each employee’s specific characteristics, as permitted under the

ACA's rating rules; this includes age, tobacco use, and the employee's geographic location. Some states only permit insurers to provide an "employee rating" versus a "composite" rating. Thus, for example, a non-smoking 56 year-old employee living in New York City, New York might have a premium of \$12,000, whereas a non-smoking 24 year-old living in suburban New Jersey might have a premium of \$4,500.

Quite notably, existing federal regulations strongly encourage issuers in the small group market to price their coverage for employers using "employee" versus "composite" rating, and encourage small employers to effectively pass these employee rated premiums on to each employee (i.e., thus the 56 year-old employee would pay \$12,000 for coverage and the 24 year-old premium would pay \$4,500). (See Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, Department of Health and Human Services, Final rule, 78 Fed. Reg. 13,406 (February 27, 2013). To the extent that small group employers pass these rates through as encouraged by federal policy, then generally these rates will reflect the COBRA premiums for each employee, respectively.

Therefore, to the extent the Department requires employers to determine cost of coverage for purposes of Code section 4980I(d)(2) by relying on these COBRA rates, then employers that use employee rating should still be permitted to determine cost of coverage for the same purpose when using a composite COBRA rate.

Second, as our short example above demonstrates, many small employers receive premium quotes based upon the age and geography of a given employee, as well as whether the employee is enrolled in self-only or other family coverage. As a result, small employers with identical age populations often face markedly different premium costs. Similarly, employers with same age populations, but located in different geographic areas within a state (or if in different states) could face wildly different premium costs as well. As a result, one small employer in a state could trigger the 40 percent excise tax while another small employer purchasing *the same product with the same age composition in the same state* would not trigger this tax because that employer is in a lower cost area of the state. To ensure increased parity across small employers, and to ensure that federal policy does not create unwanted incentives (i.e., federal policies that discourage the hiring and retention of older employees), we urge the Department to permit small group policies to be adjusted to level-out any premium differences as a result of adverse age or geographic characteristics of a small employer's workforce, or based on family size and coverage level election.

Third, the Chamber urges the Department to consider the even greater need among small employers for predictable business costs, particularly given the realities of how small employers purchase and pay for small group coverage. Like all employers, small employers generally budget costs on an annual basis; however, unlike larger employers, small employers may have relatively less access to capital or lending to help them meet unexpected expenses that may arise. Accordingly, small employers tend to be very sensitive to volatility in expense rates over the year (or across years).

In an effort to control the costs of health care coverage, many small employers now offer (or may soon offer) high-deductible health plans, coupled with HSAs or FSAs. Unlike larger employers

that may have in-house or outside benefits and tax counsel to assist them in setting up guideposts regarding the use of such medical savings accounts by their employees, so that their employees' use of these accounts will not trigger an excise tax, small employers typically lack access to such counsel. As a result, to the extent that amounts are contributed to HSAs or FSAs by employees with pre-tax dollars, small employers may find themselves in the very unfortunate position of incurring an excise tax liability, notwithstanding their best efforts.

With small group coverage, even the hiring or loss of one or two employees can severely adversely affect the ability of an employer to stay below the excise tax thresholds of Code section 4980I. For example, using our example from above, the 24 year-old employee could leave employment with the small employer during a policy year (for example, to go back to school for tax accounting). This would have the effect of materially increasing the small employer's composite rating, and as a result also increasing the small employer's plan costs for the policy year at issue. Given this uncertainty, a small employer could purchase an insurance policy with an initial quote that does not trigger the excise tax, only to find the tax is triggered later that policy year as a result of events that are beyond its control.

As mentioned, small group employers often lack access to skilled tax and benefit professionals who can assist them in navigating an ever-more complex regulatory landscape. Given the central role played by employers in the administration of this excise tax, it is imperative that the Department take into account this reality when fashioning rules with respect to Code section 4980I. From a policy perspective, we should all work to avoid creating rules that: will place undue burdens or costs on small employers; could cause small employers to practically or financially be unable to comply with the rules; might discourage continued plan sponsorship by employers, or; could leave downstream stakeholders in untenable or disadvantageous positions (such as the downstream insurer that is not noticed timely (or ever) by the small employer regarding its share of the excise tax with respect to the excess benefit).

In light of the foregoing, we urge the adoption of safe harbor rules that will provide needed predictability for small employers – to ensure that they do not inadvertently find themselves subject to costly and unwanted – and certainly unplanned for – excise tax liabilities. To that end, we recommend the following:

- Based upon existing guidance holding that HSAs generally are not treated as group health plans, the Department should **not** include the cost of employer and employee pre-tax contributions (as applicable) to HSAs and FSAs when determining the extent of any excess benefit.
- IRS should allow for adjustments based on age, geography, and family size to assure that all small employers are treated equitably under the excise tax provision. Such adjustments would also provide for the needed predictability particularly imperative in the small group market.

- Insurers should be allowed to use a cost “snapshot” when the quote is issued to provide predictability and tax certainty for insurers and employers alike (so that unintended downstream events that could inadvertently trigger a tax liability can be disregarded).
- Insurers should be permitted to incorporate a “40 percent excise tax surcharge” at the time that would reflect the final applicable cost of coverage for that small employer and would not be subject to changes mid-year.
- At a minimum, the IRS should provide a 3-year period, beginning with the 2018 tax year, during which (1) the excise tax would not result solely because of the extent of any HRAs FSA, and HSA coverage, and (2) adjustments for age, family size, and geography would be permitted in determining the cost of the small group insurance.

As an alternative to the above, we note that the IRS could ease the administrative challenges associated with the excise tax provisions, as well as improve predictability, by establishing a safe harbor based upon a plan’s actuarial value (“AV”) rating. Under this approach, a plan would not trigger an excise tax unless its AV rating exceeded a certain threshold.

Given the very important role that small businesses play in the American economy, it is crucial that the Department consider the potential adverse effects of the tax on small business and its employees. We urge the Department to carefully consider the comments set forth above.

LIABILITY FOR SELF-FUNDED PLANS

Notice 2015-52 requests comments regarding which party should be the “person that administers the plan benefits” for purposes of Code section 4980I(f)(6). As discussed below, the Chamber believes that employers should have the discretion to identify themselves as the “person that administers the plan benefits.” Alternatively, the Chamber advocates a rule that would make the employer the “person that administers the plan benefits” in all events.

Code section 4980I(c)(2)(C) provides with respect to self-funded coverage (other than HSAs) that the “person that administers the plan benefits” is liable for any resulting share of the determined excess benefit. Notably, Code section 4980I(f)(6) acknowledges that employers may in fact be “the person that administers the plan benefits.” (Specifically, Code section 4980I(f)(6) states that, “The term ‘person that administers the plan benefits’ shall include the plan sponsor if the plan sponsor administers benefits under the plan.”)

The Chamber strongly urges Treasury and the IRS to fashion rules that would allow employers to effectively opt into being the “person that administers the plan benefits.” This could be achieved by implementing a rule that allows employers to assume such status by contract (or assign such status to a third-party administrator (“TPA”) by contract). Alternatively, as discussed below, this could be achieved with respect to the contemplated “functionality” approach set forth in the Notice – by identifying a relevant function that could easily be assumed by employers when entering into an administrative services agreement (“ASA”) with the TPA. With respect to the “ultimate authority” approach set forth in the Notice, this also could be achieved by focusing on

an ultimate authority that typically rests with employers as plan sponsors (rather than an authority that often rests with the TPA) or could be easily adopted by employers in their plan sponsor role.

With respect to the two contemplated approaches set forth in Notice 2015-52, the first approach – the functionality approach – appears to determine one’s status as the “person that administers the plan benefits” based upon which party – the employer or TPA – is *actually* engaging in certain functions or activities with respect to the plan. The possible functions or activities, as identified in the Notice, include receiving and processing claims for benefits, responding to inquiries, or providing a technology platform for benefits information. As the Notice observes, one of the difficulties with this approach is the possibility of confusion regarding which entity is liable for the tax as the “person that administers the plan benefits,” since it is quite possible that both parties may be engaged in aspects of the relevant functions. For example, with respect to receiving and processing claims for benefits, it is possible that the TPA is by reason of the administrative service agreement, or practice, responsible for processing claims for benefits, but the employer is responsible for receiving those claims. Accordingly, to the extent that the IRS and Treasury adopt this approach, we urge the Department to fashion a rule that focuses on a narrow set of functions to reduce the potential for confusion.

Additionally, as noted above, we urge Treasury and IRS to focus on a function or activity that is either typically performed by employers with respect to their plans, or could be easily assumed by the employer with limited burden. This should help facilitate administration of the excise tax because it will allow those employers that seek to be directly liable for the share of any excess benefit attributable to the self-funded coverage, to make themselves the “person that administers the plan benefits” for purposes of Code section 4980I(c)(2)(C).

The second contemplated approach set forth in Notice 2015-52 – the “ultimate authority” approach – appears to assign liability as the “person that administers the plan benefits” to the party which has ultimate authority with respect to certain aspects of plan administration, regardless of whether such authority is actually exercised by the party. Per the Notice, this could include eligibility determinations, claims administration, and entering into or terminating arrangements with service providers.

Similar to our comments regarding the “functionality” approach, we think it is important that any resulting rule eliminate the possibility for confusion between the employer and the TPA as to which party is the “person that administers the plan benefits” and thus liable for any share of the excess benefit attributable to the self-funded coverage. Accordingly, we recommend that this approach, if adopted, focus on a very narrow set of administrative matters– perhaps as few as one – in determining which party is the “person that administers the plan benefits.” Additionally, for the same reasons above, we urge Treasury and the IRS, if this approach is adopted as part of proposed rule, to focus on an authority that could be assumed by employers via plan document or ASA with limited burden and expenses.

EXCLUDE AMOUNTS ATTRIBUTABLE TO THE TAX FROM THE COST OF COVERAGE

Code section 4980I(d)(2)(A) states that “any portion of the cost of coverage which is attributable

to the tax imposed under this section shall not be taken into account” when determining the cost of the coverage (emphasis added). Per this language, it appears clear that Congress intended for “any” portion of the cost of the coverage attributable to the excise tax to be excluded when determining the cost of coverage for purposes of Code section 4980I.

The Chamber agrees with the acknowledgment in Notice 2015-52 that the costs eligible for exclusion should not be limited to the direct cost of the tax itself (referred to in the Notice as “Excise Tax Reimbursements”), but may also properly include indirect costs, including what the Department terms “Income Tax Reimbursements.” We urge the Department to reflect such understanding in any proposed rule and, accordingly, permit employers to exclude not only the portion of the cost of coverage attributable to the direct tax cost to the coverage provider, but also any related indirect costs borne by the coverage provider.

We note that a contrary rule would result in incorrect cost determinations because a portion of the cost of coverage would then be attributable to the excise tax, which would be in obvious conflict with Congress’ intentions as evidenced by the statutory language of Code section 4980I(d)(2)(A). Moreover, a contrary rule could inappropriately result in decreased coverage for enrollees. This is because employers might feel compelled to reduce the value of the coverage to reflect the fact that a portion of coverage provider’s costs with respect to the excise tax cannot be properly excluded under a contrary rule when valuing the coverage.

As acknowledged in the Notice, parties responsible for paying a share of any excess benefit will not be able to deduct the cost of the actual tax itself because the tax is nondeductible by reason of Code section 4980I(f)(10). Accordingly, the effective cost of the excise tax to the coverage provider is thus increased (since its taxable income cannot be reduced by reason of a business deduction attributable to the excise tax payment to the IRS).

Additionally, it should be presumed that all coverage providers will seek to recoup any direct or indirect costs they incur with respect to the excise tax. The Notice makes clear that any recouped amounts generally will need to be taken into gross income by the coverage provider for purposes of federal income taxes. As a result, the effective value of any actual amounts recouped by the coverage provider is reduced by the extent of the coverage provider’s marginal federal tax rates.

We note that the Notice is unclear as to whether, in determining the extent of any Income Tax Reimbursements, a party may take into account not only the indirect costs to the coverage provider *by reason of federal income taxes*, but also those attributable to state and local (such as city or municipal) income taxes and state premium taxes. It is essential that the Indirect Tax Reimbursements include not only indirect costs attributable to federal income taxes, but the same with respect to state and local taxes. This is because the state and local tax effects on the cost of coverage are likely to be consequential and, in accordance, with the statutory language of Code section 4980I(d)(2)(A), cannot be ignored.

Notice 2015-52 requests comments regarding whether coverage providers should be permitted to use their actual marginal tax rates, or whether all parties should be required to use a standard rate (i.e., a uniform rate across all coverage providers) when determining the extent of any Income Tax Reimbursements. As mentioned above, Code section 4980I applies to all employers

regardless of size or type. Accordingly, it is important that any rules be easy to administer by all employers regardless of size. On the other hand, some employers may be interested in assuming greater administrative burden or cost, at their election, to result in a more accurate cost calculation for purposes of Code section 4980I. Thus, the Chamber supports a rule that would provide a default rule for use by employers that is based upon a standard rate – however, for the reasons noted above, one that reflects not only average federal tax liabilities, but also state and local tax liabilities, but allow employers at their election, if supported by the coverage provider, to determine any Income Tax Reimbursements using the coverage provider’s actual marginal rates. We believe such an approach reflects sound public policy by providing for an administrable default rule, while allowing employers and their coverage providers the option to collaborate to use actual marginal rates.

GUARD AGAINST DOUBLE LIABILITY

The Chamber is very concerned about the potential for employers to find themselves in the unenviable (and unfair) position of having to decide between paying an excise tax by reason of Code section 4980I, or alternatively paying an excise tax by reason of Code section 4980H.

Notice 2015-52 requests comments regarding the interaction between Code section 4980I, regarding the 40 Percent Tax, and the employer shared responsibility provisions of Code section 4980H, including how the provisions can be coordinated “consistent with the statutory requirements” and in a way that is administrable for the employer and the IRS.

As noted by other stakeholders, there is concern that this current dilemma was created in large part by the Department’s interpretation of “minimum value” for purposes of Code section 36B and 4980H. More specifically, Code section 36B defines “minimum value” based upon whether the plan’s share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs. Code section 36B(c)(2)(C)(ii). In this regard, the statutory language quite clearly signals that minimum value is to be determined based upon the percentage of any covered expense that is borne by the plan versus the participant. Notwithstanding the language of Code section 36B, Treasury adopted a “minimum value” standard that looks not at the plan’s cost-sharing structure itself, but compares a plan’s cost-sharing provisions to those of an external composite benchmark plan. Moreover, to the extent a plan benefit is excluded from coverage (for example, in an effort to keep the plan from exceeding the thresholds of Code section 4980I and to keep the plan from triggering an excise tax under Code section 4980H), this has the effect of reducing the plan’s minimum value percentage (*e.g.*, from 60% to 59%).

Congress could not have intended to place employers in the position of having to trigger an excise tax under one of these Code provisions solely because of an employer’s efforts to avoid an excise tax under the other provision. Nonetheless, for the reasons noted above, this is the position in which employers now find themselves.

Additionally, the Department, along with the Departments of Health and Human Services (“HHS”) and Labor (“DOL”) (collectively, the “Departments”) recently imposed a new requirement on all plans beginning with the 2016 plan year, which requires the use of an

embedded individual maximum out-of-pocket limit of \$6,850 for persons enrolled in other than self-only coverage. This administrative “clarification” not only contradicts the statutory language itself, but it was done in complete disregard for the procedural requirements mandated by the Administrative Procedure Act. Beyond the legal and procedural fouls of this clarification, the end result is detrimental for employers and employees alike. This “clarification” will only serve to increase premiums which will not only make coverage less accessible and affordable but will increase artificially the value of the plan and trip the excise tax thresholds sooner. This is another instance of how plan costs will increase as a result of agency interpretations that reach far beyond the four corners of the statute itself. It is also yet another example of how employers are confronting conflicting policy directives under the ACA, and another example of how employers are being placed in difficult, if not untenable, positions as a result of the Department’s interpretations.

In light of the foregoing, we urge Treasury and the IRS to adopt a rule that would provide that an employer does not trigger a Code section 4980I excise tax solely because it seeks to offer coverage necessary to avoid penalties under the employer shared responsibility provisions of Code section 4980H. It is the Chamber’s belief that such a rule would be “consistent with the statutory requirements” of Code sections 4980H and 4980I and for the reasons noted above, should be provided.

PRE-TAX CONTRIBUTIONS TO AN HSA

As mentioned in our introductory comments, we urge the Department to use its administrative authority, to the extent possible, to ensure that American workers, and their families, are not subjected to financial distress by reason of Code section 4980I. To that end, we reiterate our prior request that contributions made to an HSA by an employee via salary reduction (“HSA”) be excluded when determining cost of coverage. Such a rule, we believe, is supported not only by the statutory language, but also by sound public policy.

As discussed in our prior comment letter with respect to Notice 2015-16, Code section 4980I includes inconsistent language regarding the treatment of HSA contributions in valuing the cost of coverage. More specifically, Code section 4980I(d)(2)(C) states that, “In the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of employer contributions under the arrangement” (emphasis added). This is in contrast to other references in the statute to “employee” contributions. (For example, Code section 4980I(d)(2)(B), with respect to health FSAs refers to “employer contributions under any salary reduction arrangement.”) Accordingly, we believe the Department has sufficient flexibility to construe the excise tax provisions of Code section 4980I to apply only to non-elective employer contributions to employees’ HSAs (and, thus, to exclude pre-tax employee contributions to HSAs via salary reduction).

We believe such a rule is also supported, if not required, on public policy grounds. As the Department is certainly aware, there are several ways an employee can have contributions made to their HSA. First, an employer can make non-elective employer contributions to the employee’s HSA (i.e., the employee cannot elect to receive these amounts as wages or in some

other benefit form). Second, an employee can make contributions to their HSA via salary reduction through their employer's Code section 125 cafeteria plan. Third, an employee can make after-tax contributions to their HSA and, by reason of Code section 223, can then take an "above-the-line" deduction on the Form 1040 (which has the practical effect of treating the contributions as if they were pre-tax contributions for purposes of federal income tax).

Statements contained in Notice 2015-16 suggest the Department is poised to promulgate a rule that would subject the first two categories of HSA contributions (i.e., employer non-elective contributions and pre-tax employee contributions via salary reduction) to the excise tax provisions of Code section 4980I. The Chamber strongly opposes the adoption of such a rule. Subjecting the first two categories of contributions to the excise tax – including, specifically employee pre-tax contributions – will place many lower wage and lower income individuals in a relatively worse tax position compared to their higher-paid counterparts. This is because these individuals tend to rely on the first two categories of contributions to fund their HSAs. To the extent these contributions cease being made available to the employee (which would seem to be a logical byproduct of such a Departmental rule), these individuals may now lack sufficient HSA funds to help them pay for incurred out-of-pocket medical costs. As a result, these individuals, and their families could face financial distress. In contrast to this category of workers, higher-paid individuals will remain able to make after-tax contributions to their HSAs, and to effectively convert these contributions to pre-tax contributions for federal income tax purposes by merely claiming the "above-the-line" deduction on their Form 1040.

For the above reasons, we urge the Department to use its administrative authority to exclude pre-tax HSA employee contributions via salary reduction from the scope of the Code section 4980I excise tax.

THE APPLICATION OF THE CONTROLLED GROUP RULES

Notice 2015-52 references the language of Code section 4980I(f)(9), which states that all employers treated as a single employer under subsections (b), (c), (m) and (o) of Code section 414 "shall be treated as a single employer" for purposes of Code section 4980I.

This language raises many complex questions. For example, is the provision merely intended to make all controlled group members jointly and severally liable for another member company's excise tax liability? Or alternatively, is the provision intended to do more – for example, to require employers within a controlled group to aggregate coverage with respect to a given employee when determining the extent of any excess benefit?

The Chamber believes the language should most reasonably be read to only impose joint and several liability on controlled members. Thus, if one member of the controlled group incurs an excise tax liability and fails to pay the tax as required by Code section 4980I, the IRS can seek to recover the tax (plus applicable penalties and interest) from one or more of the controlled group members.

The Chamber is concerned that a more expansive reading of Code section 4980I(f)(9) by the Department could result in additional costs and burdens for employers with respect to the administration of the tax. Most specifically, the Chamber is concerned that a broader reading could cause each employer within a controlled group to have to take into account not only its own group coverage with respect to an employee, but also any other coverage in which the employee is enrolled that is sponsored by another member company. Such a rule would be very difficult for many employers to comply with given that many member companies may have distinct benefit and payroll systems. Additionally, such a rule would materially increase the complexities, costs and burdens of administering the tax for companies that are part of a larger controlled group.

For the above stated reasons, we urge the Department to clarify that Code section 4980I(f)(9) is only to be construed as imposing joint and several liability on controlled group members.

AGE AND GENDER ADJUSTMENTS

Code section 4980I provides for an upward adjustment to the annual limitation to the extent the age and gender characteristics of the employee's workforce differ from that of the national workforce. More specifically, Code section 4980I(b)(3)(C)(iii) provides that the annual limitation with respect to an employee is increased by an amount equal to (1) the excess of the premium cost of the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefit Plan (FEHBP standard option) if priced for the age and gender characteristics of all employees of an individual's employer (the employer's premium cost), over (2) the premium cost for providing this coverage if priced for the age and gender characteristics of the national workforce (the national premium cost).

Notice 2015-52 sets forth a contemplated methodology for use by an employer in applying the age and gender adjustment provisions of Code section 4980I(b)(3)(C)(iii). The Chamber very much appreciates the efforts of the IRS and Treasury in setting forth a contemplated methodology. While the Chamber is generally supportive of the contemplated methodology, it is concerned that the methodology may be difficult for some employers to administer, especially smaller-sized employers, given the multi-step process contemplated in the Notice. Accordingly, to ensure that employers of all types and sizes can avail themselves of the adjustment, the Chamber urges the Department to adopt a methodology that allows employers, where possible, to refer to easy-to-read and understand reference tables (for example, with respect to steps 4 and 5 of the contemplated methodology).

Additionally, the Chamber is concerned that utilizing the actual claims data with respect to the FEHBP standard option could provide employers with a less than full adjustment value since we understand the population covered by the FEHB standard population may not reflect the age and gender characteristics of the national workforce (and may, in fact, encompass a relatively greater percentage of women and older individuals). Accordingly, the Chamber urges the Department to utilize claims data that most appropriately reflects the actual age and gender characteristics of the national workforce.

GEOGRAPHIC ADJUSTMENTS TO THE ANNUAL LIMITATIONS

We are concerned that the Notice did not include any contemplated methodology for use in adjusting the annual limitations or plan cost based upon geographic differences. It is imperative that employers be permitted to take into account the differences in the health care costs across different geographic areas when valuing their coverage for purposes of the excise tax. Health care costs vary widely across the country. Absent a geographic adjustment, employers in higher-cost areas (*e.g.*, insert) will face increased excise tax liability. And to the extent these employers seek to minimize tax liability through corresponding reductions in coverage, their employees in these areas will be forced to forego essential coverage otherwise enjoyed by employees in lower-cost areas.

The Chamber believes that sound public policy, as well tax equity, require the Department's adoption of a rule that would permit employers to apply an upward adjustment to the annual limitations to account for geographic differences in the cost of health care. Otherwise, employers and employees in higher cost areas will likely find themselves deeply disadvantaged with respect to Code section 4980I.

We understand that the Department may be concerned that it lacks authority to promulgate rules allowing employers an upward adjustment based upon increased health care costs solely as a result of geography (*e.g.*, versus as a result of cost-sharing or utilization). The Chamber directs the Department to the language of Code section 4980I(d)(2)(A), which states that rules "similar to" COBRA shall apply when determining the cost of coverage with respect to the excise tax. We note that the legislative history to COBRA itself clearly authorizes the Secretary of Treasury to promulgate rules with respect to COBRA that allow an employer to take into account geographic disparities in health costs.

More specifically, the legislative history to COBRA '85 discusses the "applicable premium" that may be used for COBRA purposes. Specifically, it states that "[i]n general, similarly situated individuals are those individuals defined by the plan (consistent with Treasury regulations) to be similarly situated and with respect to which no qualifying event has occurred." .” H. Conf. Rep. No. 453, 99th Cong., 2nd Sess. 565-566 (emphasis added). It goes on to state that, “[t]he Secretary of Treasury is to define similarly situated individuals by taking into account the plan under which the coverage is provided (*e.g.*, high or low option), the type of coverage (single or family coverage) and, if appropriate, regional differences in health costs.” See *Id.* Given this clear pronouncement in the legislative history to COBRA '85, as well as the language of Code section 4980I(d)(2)(A), we are confident that the Department has sufficient statutory authority – and certainly sufficient reasons as enumerated above – to provide for a geographic adjustment for purposes of Code section 4980I.

ECONOMIC REGULATORY ANALYSIS

When the Department issues proposed or final regulations regarding the excise tax, it must comply with compliance with Executive Orders 12866 and 13563 and include a required regulatory economic analysis addressing the costs and benefits of the regulation. Regardless of

whether the Department estimates that the annual compliance cost will exceed or be less than \$100 million, the Department will be obligated to publish its analysis and demonstrate the basis of its conclusion. In the past, the Department has dismissed this regulatory analysis obligation by claiming that the cost is under \$100 million. We remind the Department that the \$100 million annual cost threshold applies only to the obligation to submit its analysis to OMB/OIRA for pre-publication review. The threshold does not relieve the Department of the obligation under the Executive Orders to conduct a regulatory economic impact analysis.

As a part of the required regulatory economic impact analysis:

- The Department must compare the costs and benefits of alternative regulatory approaches considered. In particular, the Department should examine and present the cost differentials arising from alternative definitions of applicable coverage.
- The Department should recognize in its cost analysis that recordkeeping, reporting and administrative costs may be imposed on individuals and companies that do not pay the excise tax. All potentially affected employers will incur costs to determine and document their tax liability status, even if the liability is none.
- Lack of discretion does not excuse the agency from analyzing costs. Even if the agency believes that a compliance cost is required by the underlying statute, the agency should identify and include the cost in its regulatory economic analysis. Congress and the public depend on the agency's compliance cost analysis to identify cost issues that may need to be considered for legislative mitigation.
- In particular, the agency should carefully consider the initial compliance costs of modifying information systems and procedures to facilitate recordkeeping and reporting requirements of the regulation, and consider alternative implementation schedules to mitigate the costs of systems transitions.

CONCLUSION

We urge Treasury and the IRS to continue to work carefully, pragmatically and cooperatively with the numerous stakeholders to minimize burdens placed on employers and to provide flexibility as employers work to comply with the law. We look forward to continuing to work together in the future.

Sincerely,



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