October 1, 2015

Submitted via email to Notice.comments@irscounsel.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: Notice 2015-52 – Section 4980I – Excise Tax on High Cost Employer-Sponsored Health Coverage

Dear Sir or Madam:

We write on behalf of the American Benefits Council ("Council") to provide comment in connection with Notice 2015-52 ("Notice") regarding the 40 percent excise tax on high cost employer-sponsored health coverage under Internal Revenue Code ("Code") Section 4980I ("40 Percent Tax").

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to health and retirement plans that cover more than 100 million Americans.

The Council appreciates continued efforts by the Department of the Treasury and the Internal Revenue Service (collectively, the "Department") to involve the public in formulating guidance to implement the 40 Percent Tax.

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Introductory Comments:

The Affordable Care Act ("ACA") was intended to expand access to coverage while maintaining the employer-sponsored health insurance system. Unfortunately, the 40 Percent Tax threatens the long-term viability of that system. The 40 Percent Tax will very negatively impact American workers and their families, ultimately leaving them with fewer choices and higher out-of-pocket costs. The Council strongly urges the Department to implement the 40 Percent Tax in a manner that is least disruptive to the long-term viability of employer-sponsored health coverage.

For example, employers should not – and cannot – be put in the untenable position of having to choose between offering qualifying coverage under Code Section 4980H (the employer shared responsibility requirement) and eliminating coverage so as to not become subject to the 40 Percent Tax. It is crucial that the Department signal clearly, and as soon as possible, that in no event would solely offering the minimum coverage necessary to avoid an excise tax for purposes of Code Section 4980H result in an excise tax for purposes of Code Section 4980I.

As noted in our prior comments to the Department in connection with Notice 2015-16, although the Council does not believe that the administrative burdens and tremendous negative impact of the 40 Percent Tax can be fully alleviated by regulatory action, we urge the Department to make the 40 Percent Tax as workable as possible. We recommend that any final rule should, at minimum, incorporate the following concepts:

- Final rules should be easy for employers and other coverage providers to administer. Where appropriate, safe harbors should be used to reduce employers' administrative burden and to increase tax certainty and efficiency. Any such rules should reinforce the long-term viability of employer-sponsored health plans.
- Employers should not be penalized for ancillary programs that, in the long term, help to improve employees' health and reduce their overall health costs, including the use of innovative wellness arrangements and on-site clinics. At minimum, the 40 Percent Tax should not discourage employers from continuing to invest in, and develop, such health-focused programs for their employees.
- Employers will need information regarding the applicable dollar limits and valuation rules well in advance of 2018. This is not, however, just a one-year transition issue, but an issue that will play out year after year because of the time constraints faced by employers in designing plans and preparing enrollment materials and other employee communications.

Over 150 million Americans rely on the employer-sponsored system for receiving health care coverage. The following specific comments with regard to Notice 2015-52 are aimed at preserving this important source of health care coverage.

An employer with respect to a self-funded, single-employer plan should have the flexibility to determine if it is the "person that administers the plan benefits."

Code Section 4980I(c)(1) provides that each "coverage provider" must pay the 40 Percent Tax on its applicable share of the excess benefit with respect to an employee. Code Section 4980I(c)(2)(A) states that the health insurance issuer is liable for paying the share of the 40 Percent Tax attributable to health insurance coverage that it underwrites. With respect to health savings accounts ("HSAs") and Archer medical savings accounts ("MSAs"), Code Section 4980I(c)(2)(B) states that the "employer" is liable for paying the share of the 40 Percent Tax attributable to HSA and MSA contributions that are applicable employer-sponsored coverage. Code Section 4980I(c)(2)(C) states that the "person that administers the plan benefits" is liable for paying the share of the 40 Percent Tax attributable to "any other applicable employer-sponsored coverage," including self-funded coverage.

The statutory language of Code Section 4980I does not define "the person that administers the plan benefits," nor is that phrase defined elsewhere in the Code. Code Section 4980I(f)(6) does state that, "[the] term 'person that administers the plan benefits' shall include the plan sponsor if the plan sponsor administers benefits under the plan."

Under Notice 2015-52, it appears two different approaches are under consideration by the Department. The first approach (i.e., the "functionality" approach), as described in the Notice, looks to which entity is performing certain day-to-day functions with respect to the plan. Such functions could include, but are not limited to: receiving and processing claims for benefits; responding to inquiries; and providing a technology platform for benefits information. As acknowledged by the Department in the Notice, it should be anticipated under this approach that the plan's third party administrator ("TPA") would in most instances be performing many of these functions and, thus, could be the "person that administers the plan benefits" for purposes of Code Section 4980I(c)(2)(C).

Depending on the specific day-to-day functions encompassed by a proposed rule, it is quite possible that the employer plan sponsor could be responsible for engaging in one or more of these day-to-day functions solely, or could be responsible for engaging in certain aspects of one or more of these functions (such as responding to inquiries, depending on the nature of the inquiry).

The second approach described in the Notice (i.e., the "ultimate responsibility" approach) would assign liability to the entity that has ultimate authority regarding the administration of plan benefits – such as those relating to eligibility, claims, and contracts with service providers – even if that person is not routinely involved in the day-to-day administration of the plan.

The Council strongly recommends the second approach (i.e., the "ultimate

responsibility" approach) as it is less costly, less administratively burdensome, and seems less likely to result in confusion among parties as to which entity is the "person that administers the plan benefits." This is because parties will generally be able to look to the governing documents regarding the plan to determine which entity is the "person that administers the plan benefits," rather than having to look at who is *actually* engaging in activities with respect to the plan.

As mentioned, employers are required per the terms of Code Section 4980I(c)(4)(A) to calculate whether any 40 Percent Tax applies with respect to a given employee, and to provide notice of the share of such 40 Percent Tax to each responsible party, including the "person that administers the plan benefits" (with respect to coverage other than insured coverage, or coverage attributable to HSAs and Archer MSAs).

The Council expects that many employers may want to assume direct liability for the 40 Percent Tax with respect to self-funded coverage, as the "person that administers the plan benefits," because doing so is likely to reduce the administrative burdens, complexities and costs attributable to the 40 Percent Tax. Accordingly, regardless of the approach adopted by the Department as part of proposed rulemaking, it is important that employers be able to assume such direct liability via contract or via the governing plan documents in a clear and simple manner. Thus, for example, with respect to the "functionality" approach described above, the Council urges the Department to focus the determination on a function that is one typically or otherwise easily assumed by an employer (such as eligibility and/or enrollment). Therefore, if an employer seeks to be directly liable for any 40 Percent Tax with respect to its self-funded, single employer plan, it can do so by assuming the administrative obligation. Similarly, with respect to the second approach, the "ultimate responsibility" approach, the Council urges the Department to focus the determination on a responsibility that is often, or at least easily, assumed by an employer, such as establishment of the rules that determine which employees are eligible for benefits under the plan.

Regarding self-funded, multiple employer plans:

In addition to the above, the Council recommends the Department adopt a rule with respect to self-funded multiple employer plans[1] that would treat each participating employer as "the person that administers the plan benefits" for purposes of Code Section 4980I. We believe such approach is warranted given that the plan sponsors of these plans generally will not be in a position to bear the costs of the 40 Percent Tax with respect to their covered population. Additionally, they will not be in a position to evaluate the likelihood that the 40 Percent Tax is triggered with respect to a given

[1] For the purposes of this approach, a multiple employer plan would generally be any plan that is established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, with the exception of multiemployer plans as defined by Code Section 414(f) and ERISA Section 3(37).

covered individual, since they likely will lack any knowledge of what, if any, additional group health plan coverage may apply to the covered individual.

We note that the recommended rule generally reflects the approach previously adopted by the Department in applying other aspects of the ACA to multiple employer plans. (See, for example, the final Treasury Department regulations regarding Code Section 6055 at 79 FR 13228, and related Instructions for Form 1094-B/1095-B, p.2, which make the participating employer rather than the multiple employer plan sponsor or administrator liable for the tax reporting.) We also note that federal statutes and regulations have long-recognized how self-funded multiple employer plans generally differ in structure and operation from single employer plans, and thus require unique guidelines to operate effectively and efficiently. Thus, to avoid jeopardizing the ongoing viability of these important organizations, we urge the Department to adopt a rule with respect to self-funded multiple employer plans that would make each participating employer "the person that administers the plan benefits" for purposes of Code Section 4980I.[2]

Regarding multiemployer plans:

The Notice requests comments regarding the applicability of these approaches – the "functionality" or the "ultimate authority" approach – to collectively bargained multiemployer plans. For the following reasons, we recommend that IRS/Treasury adopt a rule that provides that the third party administrator or plan sponsor of a multiemployer plan (typically the Board of Trustees) is deemed the "person that administers the benefits" for purposes of Code Section 4980I under the "functionality" approach, and the plan sponsor of a multiemployer plan (again, typically the Board of Trustees) is deemed the "person that administers the benefits" for purposes of Code Section 4980I under the "ultimate authority" approach.

A multiemployer group health plan is a plan to which more than one employer contributes and which is maintained pursuant to collective bargaining agreements between the employers and a union or unions. Each participating employer in a multiemployer plan has bargained with a union to provide coverage to covered employees through the Funds, and has also agreed to contribute to the Funds for that coverage. Multiemployer health plans are typically subject to the Labor Management Relations Act of 1947, or Taft-Hartley Act, and therefore must be administered by a Board of Trustees jointly comprised of representatives of labor and management. *See* 29 USC § 186(c)(5). While some multiemployer health plans are self-administered, the vast

[2] Alternatively, MEPs and their participating employers could be allowed to agree per the terms of the participation agreements, or adoption agreements for the MEP that the participating employer will be responsible for the 40 Percent Tax. The key principle should be that there is a mechanism allowing participating employers to assume liability for the 40 Percent Tax, consistent with the approach under the "ultimate authority" approach for self-funded single employer plans.

majority may outsource aspects of the plan administration to third parties.

Very significantly, an employer's involvement with a multiemployer plan generally begins and ends with its contribution obligation to the plan. In this regard, the employer's sole responsibility under the terms of the collective bargaining agreement is to make a periodic monetary contribution to the plan on behalf of a bargained employee. Unlike with single employer plans, the employer has no control over the benefit design offered by the plan. Moreover, the plan, or its delegate, generally has full authority for all aspects of the plan – from benefit plan design, to eligibility and enrollment, as well as claims adjudication.

As a result of the manner in which these plans are structured and administered, employers that have agreed through collective bargaining to participate in multiemployer health plans have no meaningful control over the amount of coverage offered to their employees and retirees through these type of plans. Thus, employers that participate in multiemployer plans which provide benefits in excess of the Code Section 4980I thresholds would have little recourse to prevent those plans from triggering liability under the 40 Percent Tax.

In light of the foregoing, the Council recommends the adoption of a rule that would deem the multiemployer plan the "person that administers the plan benefits" for purposes of Code Section 4980I. Such a rule would create a significant incentive for the Board of Trustees to amend the plan (if necessary) to revise the benefits so ensure that there is no excess benefit with regard to the coverage. Otherwise employers could incur a 40 Percent Tax liability solely as a result of complying with their collective bargaining obligations, with no effective means to reduce or eliminate ongoing liability. Such a result seems contrary to the goals of the provision as well as the principles of tax equity and fairness.

Employers should be permitted to adopt any 12-month period as the taxable period so long as they apply the dollar thresholds applicable to the tax year in which such 12-month period begins.

Code Section 4980I(f)(8) generally provides that the "taxable period" "means the calendar year or such shorter period as the Secretary may prescribe." However, many plan sponsors may offer one or more non-calendar year plans. To assist these employers in complying with the 40 Percent Tax regime, the Council requests a proposed rule that would permit employers to determine 40 Percent Tax liability based upon any 12-month consecutive period. Such a rule would facilitate planning and compliance with respect to the 40 Percent Tax because employers with non-calendar year plans would not find themselves having to calculate 40 Percent Tax liability for a given taxable period using two different plan years' worth of data and cost valuations.

For employers with such non-calendar year plans who elect to use a non-calendar year taxable period, the employers should be permitted to use the Code Section 4980I(b)(3) annual limitations with respect to the tax year in which the selected taxable period begins for measuring *all 12 months of coverage*. Thus, if the employer selects a 12-month taxable period beginning June 1, 2019 (because its plans have a June 1 anniversary date), the employer would apply the 2018 dollar thresholds for measuring the value of coverage and determining any 40 Percent Tax liability for all 12-months of the taxable period (i.e., for June 1, 2019 through May 30, 2020). For the first year of the 40 Percent Tax, such employers would use the 2018 dollar thresholds for coverage from January 1, 2018 through the close of their selected taxable year beginning in 2018 (*i.e.*, using the above example, through the close of May 2019).

Alternatively, in calculating the 40 Percent Tax liability, employers could be permitted to apply the Code Section 4980I(b)(3) annual limitations applicable to each calendar month of the selected taxable period. Thus, for example, if an employer's selected taxable period ran from June 1, 2019 through May 30, 2020, it would apply the 2019 dollar limits to the seven months of the selected taxable period that occur in 2019 (i.e., June through December 2019) and the 2020 dollar limits that apply to the final five months of the taxable period that occur in 2020 (i.e., January through May 2020).

We believe such a rule, if implemented, would help reduce the administrative burdens of Code Section 4980I for those electing employers with non-calendar year plans.

Employers will need sufficient time to determine coverage cost, measure such coverage against the applicable dollar limits, notice responsible parties of any share of the 40 Percent Tax, and remit any 40 Percent Tax owed by the employer.

Employers will play a central role in administering the 40 Percent Tax regime for the IRS. This is because, pursuant to Code Section 4980I(c), the employer must determine the extent of any 40 Percent Tax with respect to an employee, provide notice to any responsible parties of their share of such 40 Percent Tax (*e.g.*, carriers with respect to insured coverage), and remit any 40 Percent Tax for which it is itself responsible (*e.g.*, with respect to HSA contributions, or if it is the "person that administers plan benefits" with respect to self-funded coverage).

The complex administration of 4980I is particularly daunting given that employers are already confronting a host of ACA-imposed tax reporting requirements that occur soon after the close of the taxable year – including Form W-2 reporting, as well as Code Section 6055 and 6056 reporting. Additionally, it should be expected that, to the extent any 40 Percent Tax is owed with respect to an individual employee, responsible parties may have questions regarding how the employer arrived at the resulting tax determination.

In light of the foregoing, it is imperative that the Department establish a reporting and payment timeline that recognizes the existing burdens imposed upon employers by the ACA and provides sufficient time following the close of the taxable period for the calculation, noticing and payment of any 40 Percent Tax liability, given the many parties involved.

Notice 2015-16 indicates the Department is contemplating several different methodologies for determining the cost of group health plan coverage. The Notice discusses the "past-cost" and "actuarial basis" methods, as set forth in Code Sections 4980B(f)(4)(B). Additionally, the Notice suggests employers may be permitted to look to "actual cost." Whereas the "past cost" and "actuarial basis" methods – or variants thereof – generally would allow the employer to determine cost prior to the start of the taxable period, use of an "actual cost" method would mean that employers would not know the actual costs of the plan until sometime after the close of the taxable period. Moreover, many plans utilize a run-out period, which is a period of time consecutive to the close of the plan year during which participants can submit claims for reimbursement that were incurred during the relevant plan year. For these plans, employers may not be able to determine actual cost until several months after the close of the plan year, since the related run-out period is typically many months, with some as long as 12 months.

Regardless of which of the above methods (or other method(s)) is made available for use by employers for purposes of Code Section 4980I, it is imperative that the Department provide sufficient time for employers to determine coverage cost, measure such coverage against the applicable dollar limits, notice responsible parties of any share of the 40 Percent Tax, and remit any 40 Percent Tax owed by the employer.

For example, with respect to cost methodologies that determine cost as of the start of the taxable year (*e.g.*, the "past cost" and "actuarial basis" methods), the following timeframe would seem to be appropriate for the administration of the 40 Percent Tax (assuming a calendar year taxable period applies to the employer):

- January 1st through July 1st – Employer calculates extent of 40 Percent Tax liability.

- July 1st– The date by which the employer must provide a preliminary notice to each coverage provider of such provider's share of the 40 Percent Tax liability.

- July 1st through September 15th – The period during which a coverage provider can reasonably request information and clarification from the employer regarding its calculation and determination of the 40 Percent Tax liability.

- October 1st – Employer files to-be-determined IRS tax form with the IRS noticing

40 Percent Tax liability and provides a copy of the same tax form to the relevant coverage provider.

- December 15th – Payments of 40 Percent Tax liability due to IRS by each coverage provider.

Please See Figure 1.1 for an graphic illustration of how such a timeline would work.

Where, however, the plan looks at actual cost incurred during the plan year, the Council urges the adoption of a timeline that takes account of the fact, as mentioned above, that many employer plans may utilize a run-out period following the close of the plan year that could be as long as 12 months in duration. For a graphic illustration of how such a timeline might be fashioned, please see Figure 1.2.

In addition to the above, the Council is very concerned about the potential effects of the 40 Percent Tax on employers if the IRS or a party assessed with tax liability seeks to contest a noticed tax liability. While employers recognize their statutorily-imposed role in helping to administer the 40 Percent Tax, it is ***imperative*** that employers not be burdened by, or otherwise drawn into, tax disputes with the IRS that are at the initiative of unrelated taxpayers. To this end, the Council is supportive of providing responsible parties with some limited period of time to answer reasonable questions with respect to an employer's calculation of the 40 Percent Tax liability (to the extent any). Employers should not find themselves having to participate in costly and time-consuming IRS investigations, audits and/or appeals involving other responsible parties. Accordingly, the Council recommends that as long as an employer performs its required actions in accordance with the dates set forth above, it shall be deemed to have satisfied its obligations in accordance with Code Section 4980I(c)(4) and will not be required to take any further actions in connection with disputes between the Department and coverage providers with regard to 40 Percent Tax liability.

Figure 1.1

Proposed Determination Period Timeline
for Calculation, Notice, Report and Payment of 40 Percent Tax

For Cost Determination Methods Where Cost is Known As of the First Day of the Taxable Period

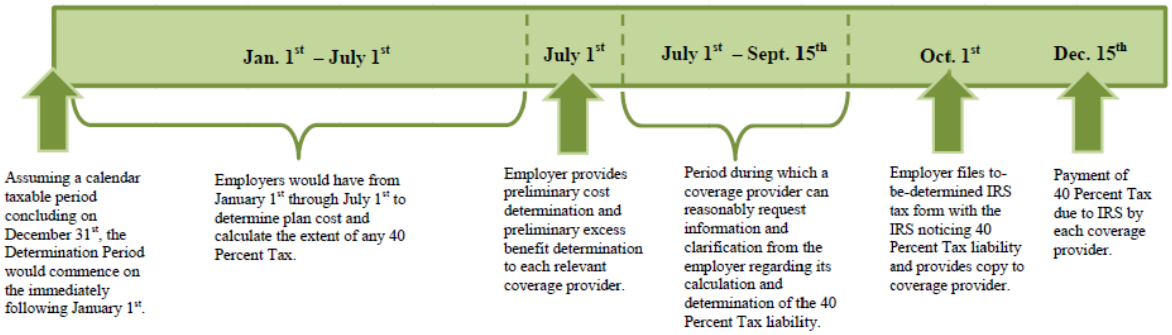
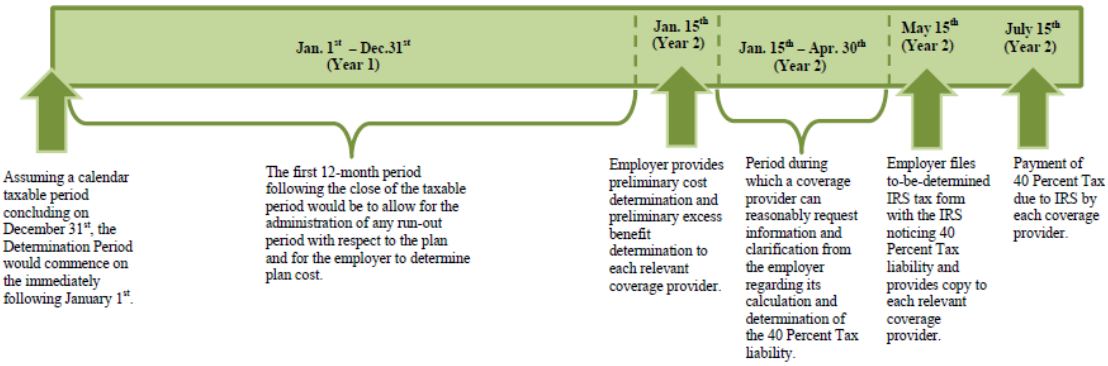


Figure 1.2

Proposed Determination Period Timeline
for Calculation, Notice, Report and Payment of 40 Percent Tax

For Cost Determination Methods Where Cost is Not Known until AFTER the First Day of the Taxable Period



Direct and indirect amounts attributable to the 40 Percent Tax should be excluded when valuing coverage for purposes of Code Section 4980I.

Notice 2015-52 indicates that when coverage providers pass through the cost of the 40 Percent Tax to employers, the amounts passed through that are attributable to the 40 percent Tax itself (referred to in the Notice as "Excise Tax Reimbursements") as well as some or all of the indirect income tax effects to the coverage provider (referred to in the Notice as "Income Tax Reimbursements"), may be excluded from the cost of applicable coverage.

The Council supports this approach and believes it is consistent with the express statutory language of Code Section 4980I(d)(2)(A), which states that in determining the of cost of coverage, "*any* portion of the cost of such coverage *which is attributable* to the tax imposed under this section shall *not* be taken into account" (emphasis added).

Moreover, the Council believes such an approach is supported by sound public policy. A contrary rule would penalize responsible parties, since a portion of the resulting 40 Percent Tax liability would not only be attributable to the nature of the coverage, but also the 40 Percent Tax itself. As such, this would seem to penalize responsible parties twice for the same Code Section 4980I excess benefit. Moreover, such a rule could result in reduced coverage for downstream enrollees since many employers might feel compelled to reduce coverage solely to account for the cost of the 40 Percent Tax when valuing coverage for purposes of Code Section 4980I.

Similarly, it is very important that the Income Tax Reimbursements also be excluded when determining coverage cost. As discussed in the Notice, it should be assumed for purposes of the proposed rulemaking that coverage providers will seek to not only pass through the direct 40 Percent Tax liability incurred, but also its indirect tax costs of such liability.

These indirect tax costs are comprised of two types of costs: (i) an amount equal to the lost deduction since the 40 Percent Tax is nondeductible, and (ii) an amount equal to the increased tax liability resulting from generally having to include any recouped amounts in gross income for purposes of determining federal income tax liability.

While it would be helpful for any Excise Tax Reimbursement to be excluded when determining the cost of coverage, as the following example demonstrates, the indirect tax effects to the coverage provider – and to the resulting cost of coverage – are quite material. Accordingly, it is imperative that these indirect costs also be excluded when determining the cost of coverage.

> **Example:** Issuer's insured group health plan coverage represents $450 of $1,050 of the employee's monthly coverage, or 43 percent of the total coverage. Because the total monthly coverage of $1,050 exceeds by $200 the applicable monthly threshold of $850, a 40 percent Tax liability is owed with respect to the $200 excess coverage. Given that the issuer's coverage represents 43 percent of the total cost of coverage, it would be liable for 43 percent of the amount of the 40 percent Tax owed, or $34.40 (i.e., 43 percent of $80).
>
> In addition to its direct $34.40 tax liability, issuer will have material indirect tax costs attributable to the 40 Percent Tax.
>
> First, because the issuer cannot deduct the cost of the $34.40, this results in a lost deduction and increased federal and state income tax liability. Assuming a

combined marginal federal and state income tax liability of 28 percent (i.e., 20% for federal income tax and 8% for state income tax purposes), this would result an indirect tax cost of $9.63.

Second, to the extent the issuer passes through its effective cost of $44.03 (i.e., the $34.40 direct tax liability and $9.63 cost attributable to the lost deduction), the issuer generally will need to include this entire amount (i.e., $44.03) in gross income when determining its federal income tax liability. Assuming its 28% marginal federal and state income tax rate, the issuer would owe an additional $12.33. The overall resulting cost attributable to the 40 Percent Tax liability is $56.36 (i.e., 70% of the original excess cost of $80).

As the above example indicates, the costs "attributable to" the 40 Percent Tax are numerous and can add up quite quickly. In our simple example above, one can see how the indirect costs of the tax are nearly as significant as the direct costs of the tax itself. Thus, it seems reasonable, if not necessary, to allow parties to exclude not only the Excise Tax Reimbursement but also any Income Tax Reimbursements when determining the cost of coverage for purposes of Code Section 4980I.

Comments were requested regarding whether, in determining the value of any Income Tax Reimbursements, 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). On this specific issue, the Council believes it would facilitate the administration of Code Section 4980I if coverage providers were permitted to utilize a standard rate, as provided by the IRS and Treasury in formal guidance, or their actual rate to the extent such rate is higher than the provided standard rate. The Council believes such a rule is needed to ensure that stakeholders have the ability to utilize actual rate information, at the coverage provider's election, if such rates would result in Indirect Tax Reimbursements greater than that which would result from the standard rate.

On a related note, the Council urges any proposed rule – whether it permits or requires the use of a standard or actual rate –take account not only of indirect tax effects under federal tax law, but also any effects of state and local tax law (including state and local federal income taxes). Taking account of federal tax effects is indeed helpful; however, stopping there would leave unaddressed the material tax effects that also occur as a result of state and local taxes. It should be expected that coverage providers will also seek to pass these indirect tax costs through to consumers. The Council thus believes it would be appropriate, if not necessary, to permit the exclusion of these additional state and local tax costs when determining the cost of coverage.

The Council is generally supportive of the contemplated approach for valuing medical savings accounts, but requests a rule that provides employers flexibility to adjust where utilization is less than 100% of annual contributions.

Notice 2015-52 sets forth a contemplated methodology for determining costs with respect to medical savings accounts. Specifically, under the contemplated approach, contributions to these account-based plans would be allocated on a pro-rata basis over the period to which the contribution relates (generally, the plan year), regardless of the timing of the contributions during the period. The Notice goes on to state:

> For example, if an employer contributes an amount to an HSA for an employee for a plan year, that contribution would be allocated ratably to each calendar month of the plan year. Similarly, if an employee elects to contribute to an FSA for a plan year, the employee's total contributions would be allocated ratably to each calendar month of the plan year, even though the entire amount contributed for the plan year would be available to reimburse qualified medical expenses on the first day of the plan year.

The Council supports the contemplated approach set forth in Notice 2015-52. As discussed above, Code Section 4980I is a complicated and burdensome provision for employers and we appreciate any efforts that can be undertaken by IRS and Treasury to help mitigate its effects.

The contemplated approach should be helpful to many employers because the cost of coverage for purposes of Code Section 4980I with respect to a medical savings account would be equal to the annual contributions made to such account. As such, employers would not need to look at the extent of any reimbursements. Moreover, because many plans provide for an administrative run-out period during which previously incurred claims may be submitted and reimbursed, the contemplated approach would eliminate any need to reconcile or otherwise "true-up" amounts after the close of the taxable period. Additionally, for plans that permit participants to rollover unused amounts from one plan year into the next plan year, the contemplated methodology would eliminate any need to track unused amounts from year-to-year for purposes of determining cost under Code Section 4980I. For these reasons, the Council believes the contemplated valuation approach would be useful to many employers, including many small employers.

Although the Council is supportive of the contemplated methodology, we are concerned that it may result in excessive cost determinations for plans where at least some participants customarily utilize less than 100% of the annual contributions. For example, this could be the case with certain types of HRAs and other arrangements that permit participants to rollover unused amounts into future plan years (*e.g.*, arrangements that let employees use existing amounts in retirement to pay out-of-pocket costs). Many plan designs have actually sought to foster less than 100%

utilization year-over-year as a means to encourage individuals to take ownership over their health care purchasing – with the idea that participants may make more considered purchasing decisions if any unused amounts remain available after the close of the plan year for use by the participant in future years. We think these designs should be encouraged by tax policy, including Code Section 4980I.

Accordingly, the Council requests a rule that would permit employers, at their election, to forego the contemplated methodology described in Notice 2015-52 and instead utilize a reasonable valuation methodology, in a consistent and uniform manner over a multi-year period, to determine the cost of overage with respect to the medical savings account at issue (*e.g.*, by determining the average plan-wide utilization over the course of the taxable period and applying 1/12 of such utilization to each calendar month for all similarly situated participants). Such a rule would ensure that employers are not discouraged from designing plans that foster increased employee engagement over health care purchasing behaviors.

Lastly, the Council urges the adoption of a rule that would exclude from valuation any amounts contributed to medical savings accounts prior to January 1, 2018. Many employers have established medical savings accounts for the benefit of their current or former employees (as well as spouses and dependents, depending on plan terms) and have made actual or notional contributions to these plans for many years. These amounts should be excluded from valuation for purposes of Code Section 4980I. In many instances, employees have planned for the future (for example, retirement) based on the expectation that these amounts would be fully available. To subject these amounts to valuation could result in some employers feeling compelled to curtail or reduce such contributed amounts in order to control potential 40 Percent Tax liability that could result, which would be unfair to individuals.

Clarification is needed regarding the contemplated valuation approach regarding FSA flex credits; the Council is supportive of rules that reduce administrative complexities of valuing such credits.

Code Section 4980I(d)(2)(B) states that in valuing health FSAs, the cost of coverage for purposes of the 40 percent Tax is equal to the sum of (i) the amount of any pre-tax contributions made by an employee 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.

With respect to (ii), it appears that any such "excess" would be limited employer "flex credits" within the meaning of Proposed Treasury Regulation §1.125-5(b)(1) which are generally defined as non-elective employer contributions to an employee's health FSA. Generally, in order for a health FSA to qualify as excepted benefits, these amounts

cannot exceed the lesser of $500 plus the amount of the participant's salary reduction election, or two times the employee's salary reduction contributions to the FSA.

Notice 2015-52 appears to set forth a contemplated valuation methodology with respect to employer flex credits. Specifically, Notice 2015-52 appears to provide that in determining the cost of coverage for purposes of Code sections 4980I(d)(2) and (d)(2)(B), an employer does not have to take into account employer "flex-credits" if the employee defers amounts to the cafeteria plan in excess of the Code Section 125(i) limit for FSAs and the amount elected by the employee for the FSA does not exceed the statutory limit of Code Section 125(i).[3] The Council supports this contemplated approach as it should make it easier for employers to administer the 40 Percent Tax. This is because, in order to determine an FSA's cost for purposes of the 40 Percent Tax, an employer will just need to add together (i) the amount of the employee's salary reduction contributions for the taxable period, and (ii) the amount of the employer flex-credits for the taxable period.

As noted, this contemplated methodology would appear to be limited to instances where the total contributions to the FSA for the calendar year do not exceed the Code Section 125(i) statutory limit (i.e., $2,550 for 2015, subject to annual indexing). Given that employer flex-credits made to HIPAA-excepted FSAs are so limited (as described above, i.e., equal to the lesser of (i) $500 and (ii) the amount of the employee's salary reduction contributions), the Council requests that the contemplated methodology apply to all employer flex-credits, regardless of amount, with respect to any FSAs that qualify as HIPAA-excepted within the meaning of Treas. Reg. §54.9831-1(c)(3)(v). Doing so should help reduce administrative burdens on employers and other coverage providers and otherwise facilitate compliance with Code Section 4980I.

The Council requests an age and gender adjustment that minimizes administrative burden on employers and is properly benchmarked on national workforce risk characteristics.

Code Section 4980I(b)(3)(C)(iii) provides for an express upwards adjustment to the dollar thresholds of Code Section 4980I(b)(3)if the age and gender characteristics of an employer's workforce result in materially increased plan costs related to those of the national workforce. More specifically, Code Section 4980I(b)(3)(C)(iii) provides that the dollar limit is increased by an amount equal to the excess of the premium cost of the

[3] Notably, some commentators have suggested that the contemplated methodology set forth in Notice 2015-52 regarding employer flex credits should be read to indicate that the IRS and Treasury are contemplating a rule whereby all employer flex credits would be disregarded entirely when determining the cost of FSA coverage for purposes of Code Sections 4980I. To the extent this reading is correct, the Council would certainly support any approaches that would except some or all contributions to medical savings accounts, including FSAs, HRAs, HSAs, and Archer MSAs from valuation. This is especially so because of the important value of these accounts in helping employees meet out of pocket medical costs that could otherwise go uncovered and subject individuals to financial stress.

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 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 seven-step test for applying the adjustment (which would be applied separately for self-only and other than self-only coverage).

The Council appreciates the considered approach of the Department in setting out in Notice 2015-52 a contemplated methodology with respect to the age and gender adjustment of Code Section 4980I(b)(3)(C)(iii). Generally, the Council is supportive of the contemplated methodology; however, we are concerned that the approach may be complicated to administer for many employers, regardless of size. This is because the contemplated approach would require employers to undertake a myriad of complex steps to determine whether any adjustment is available. Moreover, it would require employers to look at the age and gender characteristics of each employee and assign such employee to a given category for purposes of determining the extent of any adjustment. While we recognize the appeal of the contemplated approach from a tax equity perspective, from a tax administration perspective, this approach would be very difficult and costly to administer for employers. Accordingly, the Council requests that the IRS and Treasury consider a safe harbor approach that would permit employers to instead look at their employee workforce as a whole in determining what, if any, age and gender adjustment applies.

Additionally, the Council is concerned that the actual claims data with respect to the FEHBP Blue Cross/Blue Shield Standard Option may not be an accurate reflection of the national workforce because we understand the covered population may be relatively older and comprised of more females when compared to the national workforce.

In light of the foregoing, the Council recommends that the Department either (i) rely on national claims data (versus actual claims data from the FEHBP Standard Option), or (ii) first provide for an appropriate adjustment to the actual claims data from the FEHBP Standard Option to ensure that the benchmark comparison for purposes of the age and gender adjustment better reflects the age and gender characteristics of the national workforce.

Clarification is needed regarding how the controlled group rules apply for purposes of the 40 Percent tax; the Council urges adoption of a proposed rule that would limit the administrative burdens on affiliated employers.

Code Section 4980I(f)(9) 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.

Although the statute is clear that affiliated employers within the meaning of Code Section 414(b), (c), (m) and (o) "shall be treated as a single employer" under Code Section 4980I, what this exactly means is unclear. The Council believes the most reasonable reading of this language is that any such affiliated employers are jointly and severally liable for any 40 Percent Tax liability owed by a controlled group employer. We note that the IRS and Treasury recently construed very similar language in connection with the annual health insurer fee of ACA Section 9010 to be a rule imposing joint and several liability on controlled group members. *See* Treasury Regulation 26 CFR §57.7(e). Accordingly, we believe there is precedent for construing the language of Code Section 4980I(f)(9) in a similar fashion.

A broader reading of this language would require a controlled group member determining any 40 Percent Tax liability to take into account when not only its group health plan coverage with respect to a given employee (or former employee) for a given calendar month, but also that of any subject coverage in which the employee is enrolled for the same calendar month that is sponsored by an affiliated controlled group employer, such as a brother/sister or parent company. However, such a broad reading of Code Section 4980I(f)(9) would raise a host of additional questions and issues regarding administration of the 40 Percent Tax. For example, can or must any 40 Percent Tax liability be allocated among controlled group employers? Can one controlled group member choose to bear the entire 40 Percent Tax liability for the controlled group? Are there specific notice provisions that would need to devised under Code Section 4980I(f)(9)? How would the age and gender adjustment of Code Section 4980I(b)(3)(C)(iii) apply to the employers of an affiliated group? Additionally, for unrelated coverage providers (such as issuers) that could be liable for a share of 40 Percent Tax liability with respect to a controlled group member company employee, a broad reading of Code Section 4980I(f)(9) would result in increased complexities regarding planning and administration of the 40 Percent Tax, and could result in unintended tax liabilities for the provider.

In addition to the issues raised above, we also believe a broad reading of Code Section 4980I would be very difficult and costly to administer for employers that are members of larger controlled groups. This is because such employers may not have centralized benefit and payroll systems (given their independent corporate structures) and thus such member companies may not have full and complete information regarding whether a current or former employee is covered by other subject group health plan coverage sponsored by another controlled group member.

In light of the obvious administrative difficulties, and potential increased tax liabilities for unrelated coverage providers that would result from a broad reading of

Code Section 4980I(f)(9), we urge IRS and Treasury to follow the same approach it adopted with respect to ACA Section 9010 and to construe Code Section 4980I(f)(9) to provide solely for joint and several liability for controlled group employers.

The Council urges the adoption of a proposed rule that makes clear that no 40 percent tax liability applies with respect to A 60% "Minimum value" plan.

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 described in our prior comment letter with respect to IRS Notice 2015-16, the Council is very concerned that there will come a point in time when an employer will not be able to avoid an excise tax under both Code Section 4980I and the employer shared responsibility provisions of Code Section 4980H. The Council believes this dilemma is due in significant part to the inadequate indexing of the 4980I thresholds as well as the Department's decision to define "minimum value" for purposes of Code sections 36B and 4980H by reference to an external benchmark (rather than based upon a plan's own cost-sharing), and was not intended by Congress. Accordingly, the Council encourages the Department to implement a safe harbor whereby excise tax liability under Code Section 4980I would not be triggered merely for offering a plan with the minimum benefits required to avoid an excise tax under Code Section 4980H.

Code Section 4980H generally requires "applicable large employers" to offer certain levels of coverage or be potentially liable for two categories of assessable payments. The so-called "A-Penalty" under Code Section 4980H(a) may apply if the employer fails to offer its full-time employees (and their dependent children up to age 26) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan. The so-called "B-Penalty" may apply if the employer fails to offer minimum essential coverage that is affordable and provides minimum value as described in Code Section 36B.

Because current regulations dictate that a plan is required to determine whether it provides minimum value based on comparisons to a benchmark, practically speaking, all employers that are attempting to offer coverage in accordance with Code Section 4980H will eventually run afoul of the applicable dollar limits for purposes of Code Section 4980I. This result will occur because a plan cannot reduce its costs for purposes of Code Section 4980I without also negatively impacting its minimum value. This puts employers in an untenable situation, threatening the vital employer-sponsored health coverage of over 150 million Americans.

In light of the foregoing, the Council urges the Department to resolve this dilemma through the establishment of a safe harbor rule whereby tax liability under Code Section 4980I would not be triggered merely for offering a plan with the minimum value required to avoid an excise tax under Code Section 4980H.

The Council urges the Department to use its statutory authority under Code Section 4980I to provide for a geographic adjustment; such an adjustment is needed to ensure that all Americans are treated fairly for purposes of the 40 Percent Tax.

The Council remains very concerned that if employers are not permitted to adjust upwards the annual limitations to take account of regional differences in health care costs, that employers and employees in such higher-cost areas will be unduly harmed by the 40 Percent Tax.

It is uncontroverted that the cost of health care can vary significantly from one part of our country another; even sometimes from one part of a state to another part of the same state. To the extent that the Department proposes a cost determination methodology that looks at a plan's actual or expected health care costs (rather than, for example, the plans actuarial value or "AV" rating), it is imperative that the Department also allow employers to increase the applicable annual limitations when measuring the cost of coverage, to reflect regional differences in the cost of health care.

The absence of such a geographic adjustment would unfairly penalize employers operating in higher-cost areas, as well as their employees. This is because employers in higher-cost areas would be required to pay (directly or indirectly) more 40 Percent Tax than employers offering the same coverage to employees in lower-cost areas. To the extent these employers sought to reduce or eliminate their 40 Percent Tax liability by reducing the extent of coverage, this would then disadvantage their employees relative to employees in lower-cost areas. This is because these employees would be forced to forego health care coverage enjoyed by employees in lower-cost areas. Either of these results seems wholly contrary to sound tax as well as public policy.

We note that the statutory language of Code Section 4980I provides the Department with ample authority to provide the requested geographic adjustment. More specifically, Code Section 4980I(d)(2)(A) states that "[t]he cost of applicable employer-sponsored coverage shall be determined under rules ***similar to***" COBRA (emphasis added). The legislative history to the federal statute that created COBRA clearly indicates Congress' intention that COBRA rules account for regional differences in health care costs. Specifically, Conference Report No. 453 states that, in determining the applicable premium that will apply for COBRA purposes, the plan should look to the similarly situated individual. "In 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. The Report 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***." H. Conf. Rep. No. 453, 99th Cong., 2nd Sess. 565-566 (emphasis added).

The above language indicates that when Congress enacted COBRA, it clearly intended for regional differences in health care costs to be taken into account by the Department. Given the language of Code Section 4980I(d)(2)(A), and its specific cross-reference to COBRA, it seems clear to the Council that the Department has more than ample statutory authority to provide for the requested geographic adjustment to the annual limitations. As mentioned above, the provision of such an adjustment is not only supported by the statute, but is compelled for policy reasons as well as the notion of simple fairness.

* * *

Thank you for considering these comments submitted in response to the Notice. If you have any questions or would like to discuss these comments further, please contact us at (202) 289-6700.

Sincerely,

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