

Section 4980I — Excise Tax on High Cost Employer-Sponsored Health Coverage

Notice 2015-52

I. PURPOSE AND OVERVIEW

This notice is intended to continue the process of developing regulatory guidance regarding the excise tax on high cost employer-sponsored health coverage under § 4980I of the Internal Revenue Code (Code). Section 4980I, which was added to the Code by the Affordable Care Act,¹ applies to taxable years beginning after December 31, 2017. Under this provision, if the aggregate cost of applicable employer-sponsored coverage (applicable coverage) provided to an employee exceeds a statutory dollar limit (dollar limit), which is adjusted annually, the excess benefit is subject to a 40 percent excise tax.

On February 23, 2015, the Department of the Treasury (Treasury) and the Internal Revenue Service (IRS) issued Notice 2015-16, 2015-10 IRB 732, which describes potential approaches regarding a number of issues under § 4980I that may be incorporated into future regulations. Notice 2015-16 addresses issues primarily relating to (1) the definition of applicable coverage, (2) the determination of the cost of applicable coverage, and (3) the application of the dollar limit to the cost of applicable coverage to determine any excess benefit subject to the excise tax. Treasury and IRS invited comments on the issues addressed in that notice and on any other issues under § 4980I.

This notice is intended to supplement Notice 2015-16 by addressing additional issues under § 4980I, including the identification of the taxpayers who may be liable for the excise tax, employer aggregation, the allocation of the tax among the applicable taxpayers, and the payment of the applicable tax. This notice also addresses further issues regarding the cost of applicable coverage that were not addressed in Notice 2015-16. Treasury and IRS invite comments on these issues and any other issues under § 4980I. After considering the comments on both notices, Treasury and IRS intend to issue proposed regulations under § 4980I. The proposed regulations will provide further opportunity for comment, including an opportunity to comment on the issues addressed in the preceding notices.

¹ The “Affordable Care Act” refers to the Patient Protection and Affordable Care Act (enacted March 23, 2010, Pub. L. No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (enacted March 30, 2010, Pub. L. No. 111-152), and as further amended by the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (enacted April 15, 2011, Pub. L. No. 112-10).

This notice includes the following sections:

- Section I: PURPOSE AND OVERVIEW
- Section II: BACKGROUND
- Section III: PERSONS LIABLE FOR THE § 4980I EXCISE TAX
- Section IV: EMPLOYER AGGREGATION
- Section V: COST OF APPLICABLE COVERAGE
- Section VI: AGE AND GENDER ADJUSTMENT TO THE DOLLAR LIMIT
- Section VII: NOTICE AND PAYMENT
- Section VIII: REQUEST FOR COMMENTS
- Section IX: RELIANCE
- Section X: DRAFTING INFORMATION

II. BACKGROUND

Section 4980I(a) imposes a 40 percent excise tax on any “excess benefit” provided to an employee, and § 4980I(b) provides that an excess benefit is the excess, if any, of the aggregate cost of applicable coverage of the employee for the month over the applicable dollar limit for the employee for the month.²

Section 4980I(c)(1) provides that each coverage provider must pay the excise tax on its applicable share of the excess benefit with respect to an employee for any taxable period.

Section 4980I(c)(2) defines the “coverage provider” as (A) the health insurance issuer, in the case of applicable coverage under a group health plan that provides health insurance coverage, (B) the employer, in the case of applicable coverage under an arrangement in which the employer makes contributions described in § 106(b) or (d) (health savings accounts (HSAs) and Archer medical savings accounts (Archer MSAs)), and (C) the person that administers the plan benefits, in the case of any other applicable coverage. Section 4980I(f)(6) provides that the term “person that administers the plan benefits” includes the plan sponsor if the plan sponsor administers benefits under the plan. Section 4980I(f)(7) provides that the term “plan sponsor” has the meaning given such term in § 3(16)(B) of the Employee Retirement Income Security Act of 1974 (ERISA).

² See sections III and IV of Notice 2015-16 for background on the provisions of § 4980I related to the definition of applicable coverage and the calculation of the excess benefit (including the calculation of the aggregate cost of the applicable coverage and determination of the applicable dollar limit).

Section 49801(c)(3) defines a coverage provider's applicable share of an excess benefit for any taxable period as the amount which bears the same ratio to the amount of such excess benefit as (A) the cost of applicable coverage provided by the provider to the employee during that period, bears to (B) the aggregate cost of all applicable coverage provided to the employee by all coverage providers during that period.

Section 49801(c)(4)(A) provides that each employer must calculate for each taxable period the amount of the excess benefit subject to the excise tax and the applicable share of such excess benefit for each coverage provider. Section 49801(c)(4)(A) further provides that each employer must notify, at such time and in such manner as the Secretary may prescribe, the Secretary and each coverage provider of the amount so determined for the provider.

Section 49801(c)(4)(B) provides a special rule for multiemployer plans under which the plan sponsor of the multiemployer plan (as defined in § 414(f)) is responsible for making the calculations and for providing the notice.

Section 49801(f)(8) provides that the term "taxable period" means the calendar year or such shorter period as the Secretary may prescribe. Section 49801(f)(8) further provides that the Secretary may prescribe different taxable periods for employers of varying sizes.

Section 49801(f)(9) provides that all employers treated as a single employer under subsection (b), (c), (m), or (o) of § 414 are treated as a single employer.

Section 49801(f)(10) provides a cross-reference to § 275(a)(6) for the denial of a deduction for the tax imposed by § 49801. Section 275(a)(6) provides that no deduction is allowed for the taxes imposed by chapters 41, 42, 43, 44, 45, 46 and 54 of the Code. Section 49801 is located in chapter 43 of the Code, and therefore no deduction is allowed for the payment of tax under § 49801.

III. PERSONS LIABLE FOR THE § 49801 EXCISE TAX

A. Coverage Provider

Section 49801(c)(1) provides that the coverage provider is liable for any applicable excise tax. The identity of the coverage provider depends on the type of coverage provided. Under the statute, in the case of applicable coverage provided under an insured group health plan, the coverage provider is the health insurance issuer. With respect to coverage under an HSA or an Archer MSA, the coverage provider is the employer. For all other applicable coverage, the coverage provider is "the person that administers the plan benefits."

B. Person That Administers the Plan Benefits

Section 49801 does not define the term "person that administers the plan benefits." Section 49801(f)(6) provides that the term "person that administers the plan benefits" includes the plan sponsor if the plan sponsor administers benefits under the

plan, which indicates that the plan sponsor of a self-insured arrangement may be, but is not always, the person that administers benefits under the plan. The term, “person that administers the plan benefits,” is not used elsewhere in the Code, nor is it used elsewhere in the Affordable Care Act or in ERISA or the Public Health Service Act, both of which were amended by the Affordable Care Act. Because the term “person that administers the plan benefits” is not used in other statutory contexts, Treasury and IRS are considering two alternative approaches to determining the identity of the person that administers the plan benefits.³ Under either approach, it is anticipated that the person that administers the plan benefits will generally be an entity, rather than an individual, but for purposes of the discussion below, the relevant entity or individual is referred to as a “person.”

Under one approach, the person that administers the plan benefits would be the person responsible for performing the day-to-day functions that constitute the administration of plan benefits, such as receiving and processing claims for benefits, responding to inquiries, or providing a technology platform for benefits information. Treasury and IRS anticipate that this person generally would be a third-party administrator for benefits that are self-insured, except in the rare circumstance in which the employer or plan sponsor performs these functions, or owns the person that performs these functions. Comments are requested on the types of administrative functions that should be considered under this approach when determining the person that administers the plan benefits. Comments are also requested on whether the person that administers the plan benefits could be easily identified in most instances under this approach, or whether the identity of the person that administers the plan benefits would often be unclear because, for example, multiple parties (such as a pharmacy benefit administrator and a medical claims benefit administrator) perform the relevant functions with respect to a benefit package for which a single cost of applicable coverage will be determined as discussed in section IV.C of Notice 2015-16 (concerning potential approaches for determining the cost of applicable coverage). In addition, Treasury and IRS request comments on any other concerns this approach would raise.

Under the second approach that Treasury and IRS are considering, the person that administers the plan benefits would be the person that has the ultimate authority or responsibility under the plan or arrangement with respect to the administration of the plan benefits (including final decisions on administrative matters), regardless of whether that person routinely exercises that authority or responsibility. For purposes of this second approach, the relevant types of administrative matters over which the person

³ The Department of Health and Human Services (HHS) recently issued regulations defining a category of self-administered, self-insured plans for purposes of applicability of the fee, imposed by § 1341 of the Affordable Care Act, which funds the Transitional Reinsurance Program. The definition in these HHS regulations focuses on the party directly responsible for claims administration and plan enrollment. See *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Final Rule*, 79 Fed. Reg. 13744, 13772-75 (March 11, 2014). Section 4980I of the Code and § 1341 of the Affordable Care Act are provisions with no common statutory language. Accordingly, it is not anticipated that the definition of the person that administers the plan benefits for § 4980I purposes will align with the definition for self-insured self-administered plans in the HHS regulations.

that administers plan benefits would have ultimate authority or responsibility could include eligibility determinations, claims administration, and arrangements with service providers (including the authority to terminate service provider contracts). Treasury and IRS anticipate that the person with such ultimate administrative authority or responsibility under the plan or arrangement would be identifiable based on the terms of the plan documents and often would not be the person that performs the day-to-day routine administrative functions under the plan. Comments are requested on whether the person that administers the plan benefits would be easy to identify under this second approach in most circumstances or whether multiple parties have ultimate authority or responsibility for the different relevant administrative matters with respect to the same benefit package, and whether in most instances this approach would identify an appropriate person as the person that administers the plan benefits. Comments are requested on any other issues this approach would raise.

Comments are invited on the application of these approaches to collectively bargained multiemployer health plans.

IV. EMPLOYER AGGREGATION

Section 4980I(f)(9) provides generally that, for purposes of § 4980I, all employers treated as a single employer under subsections (b), (c), (m), or (o) of § 414 are treated as a single employer. Treasury and IRS invite comments on the practical challenges presented by the application of those aggregation rules to § 4980I. In particular, Treasury and IRS request comments on the application of these employer aggregation rules to the: (1) identification of the applicable coverage taken into account as made available by an employer (§ 4980I(d)(1)(A)); (2) identification of the employees taken into account for the age and gender adjustment (§ 4980I(b)(3)(C)(iii)), and the adjustment for employees in high risk professions or who repair and install electrical or telecommunications lines (§ 4980I(b)(3)(C)(iv)); (3) identification of the taxpayer responsible for calculating and reporting the excess benefit (§ 4980I(c)(4)(A)); and (4) identification of the employer liable for any penalty for failure to properly calculate the tax imposed under § 4980I (§ 4980I(e)(1)(B)).

V. COST OF APPLICABLE COVERAGE

A. Taxable Period

Taxable period is defined under § 4980I(f)(8) to mean the calendar year or such shorter period as the Secretary may prescribe. The section provides that the Secretary may have different taxable periods for employers of varying sizes. Treasury and IRS anticipate that the taxable period will be the calendar year for all taxpayers.

B. Determination Period

To calculate the amount of any excise tax that a coverage provider may owe under § 4980I for a taxable period, an employer must determine the extent, if any, to which the cost of applicable coverage provided to an employee during any month of the taxable period exceeds the dollar limit. The employer then must notify both IRS and the

coverage provider of the amount of the excess benefit, and the tax must be paid by the coverage provider. Accordingly, Treasury and IRS anticipate that employers will be required to determine the cost of applicable coverage provided during a taxable year sufficiently soon after the end of that taxable year to enable coverage providers to pay any applicable tax in a reasonably timely manner.

Section 49801(d)(2)(A) provides that the cost of applicable coverage is to be determined using rules “similar to the rules of section 4980B(f)(4)” regarding the determination of the COBRA applicable premium. Section IV.C of Notice 2015-16 invited comments on potential approaches to determining the cost of applicable coverage. Treasury and IRS now invite further comments on any issues raised by the anticipated need to determine the cost of applicable coverage for a taxable period reasonably soon after the end of that taxable period.

Treasury and IRS anticipate that the potential timing issues are likely to be different for insured plans and self-insured plans, and will also be different for HSAs, Archer MSAs, health flexible spending arrangements (FSAs),⁴ and health reimbursement arrangements (HRAs). In the case of self-insured plans, for example, if the cost of applicable coverage is determined based on a period ending at or before the beginning of the applicable calendar year, then the necessary information should be available to the employer relatively soon after the applicable calendar year ends to permit it to calculate any excess benefit for each employee and allocate any excess benefit among coverage providers. In contrast, if the cost of applicable coverage is determined based on a period ending during or at the end of the applicable calendar year, the cost may be determinable only after the end of both the applicable calendar year and a subsequent run-out period during which employees may submit claims for reimbursement. In that case, an employer will need additional time to compute the cost of applicable coverage before it can calculate any excess benefit for each employee and allocate any excess benefit among coverage providers.

In addition, experience-rated arrangements may provide for payments to be made to or from an insurance company after the end of a coverage period that relate to the coverage provided during that coverage period. In other instances, the equivalent of those types of payments may be made through a premium discount for the next coverage period. Comments are requested on how those payments or discounts may be reflected in the cost of applicable coverage, including comments on any administrative issues that might arise if, for purposes of determining the cost of applicable coverage, the payments or discounts are attributed back to the original period of coverage (for which the taxable year might have ended) rather than accounted for during the period of coverage in which the amounts are paid or the discount applied. In addition, comments are requested on how employers are addressing these payments or discounts currently for purposes of determining COBRA applicable premiums. Taking into account the potential approaches to the determination of the cost of

⁴ All references in this notice to flexible spending arrangements refer only to health flexible spending arrangements.

applicable coverage outlined in Notice 2015-16, as well as other issues with timing implications, Treasury and IRS request comments on the processes expected to be involved in calculating and allocating any excess benefit and the time period necessary to complete these processes.

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

As discussed in section III of this notice, the excise tax will be paid by the health insurance issuer for insured coverage and by the “person that administers the plan benefits” (which may, in some instances, be the employer) in the case of self-insured coverage. It is expected that, if a person other than the employer is the coverage provider liable for the excise tax, that person may pass through all or part of the amount of the excise tax to the employer in some instances. If the coverage provider does pass through the excise tax and receives reimbursement for the tax (the excise tax reimbursement), the excise tax reimbursement will be additional taxable income to the coverage provider. Because § 4980I(f)(10) provides that the excise tax is not deductible, the coverage provider will experience an increase in taxable income (that is not offset by a deduction) by reason of the receipt of the excise tax reimbursement. As a result, it is anticipated that the amount the coverage provider passes through to the employer may include not only the excise tax reimbursement, but also an amount to account for the additional income tax the coverage provider will incur (the income tax reimbursement).

In determining the cost of applicable coverage subject to the excise tax, § 4980I(d)(2)(A) provides that “any portion of the cost of such coverage which is attributable to the tax imposed under this section shall not be taken into account.” This indicates that the excise tax reimbursement should be excluded from the cost of applicable coverage, and it is anticipated that future regulations will reflect this interpretation.

Treasury and IRS are also considering whether some or all of the income tax reimbursement could be excluded from the cost of applicable coverage. However, Treasury and IRS are concerned that a methodology for excluding an income tax reimbursement may not be administrable, given the potential variability of tax rates and other factors among different coverage providers and potential difficulties in determining and excluding the reimbursement amount. Nonetheless, comments are requested on administrable methods for exclusion of the income tax reimbursement.

Because it may not be feasible to exclude amounts that are not separately billed, Treasury and IRS anticipate that coverage providers would be permitted to exclude the amount of any excise tax reimbursement or income tax reimbursement only if it is separately billed and identified as attributable to the cost of the excise tax. Separately billed amounts in excess of the excise tax reimbursement or the income tax reimbursement (as determined in the manner discussed in section V.D below) could not be excluded from the cost of applicable coverage (and, therefore, would be treated as part of the cost of applicable coverage). Comments are requested on any practical

issues or legal barriers to passing through any or all of these amounts or to separately identifying these amounts, such as federal rating rules or state insurance law.

Coverage providers generally will not know the amount of any excise tax due with respect to applicable coverage provided for a taxable period (discussed in section V.A above) until after the end of the taxable period. As a result, Treasury and IRS expect that, as a practical matter, the coverage provider generally will be unable to bill for the excise tax reimbursement or the income tax reimbursement until the excise tax is paid by the coverage provider. However, comments are requested on whether there are alternative approaches that might allow for earlier billing of the amount but that would not give rise to undue administrative complexity or difficulty.

D. Income Tax Reimbursement Formula

If Treasury and IRS conclude that an income tax reimbursement can be excluded from the cost of coverage, it is anticipated that the amount of the income tax reimbursement would be determined using a formula commonly used to calculate “tax gross-ups.” As mentioned previously, a coverage provider that passes the excise tax through to another party will have additional taxable income as a result of receipt of the excise tax reimbursement. If a coverage provider then also passes through the amount of the income tax due on the excise tax reimbursement, the reimbursement of that additional amount will further increase the taxable income of the coverage provider, and the coverage provider will owe additional income tax due to that reimbursement as well. The formula would take these additional taxes into account in determining the amount of the income tax reimbursement. Under the formula, the amount of the income tax reimbursement that would be excludable from the cost of applicable coverage would be:

$$\text{Income Tax Reimbursement} = \frac{[\text{amount of tax}]}{(1 - [\text{marginal tax rate}])} - [\text{amount of tax}]$$

In this formula, the “amount of tax” is the excise tax rate multiplied by the initial excess benefit calculated without regard to any portion of the cost of applicable coverage that the coverage provider identifies as arising from an excise tax reimbursement or an income tax reimbursement. For example, if the cost of applicable coverage without regard to the tax is \$2,500 in excess of the dollar limit, a coverage provider would owe \$1,000 as a § 4980I excise tax (\$2,500 times the 40 percent rate). If the coverage provider’s marginal tax rate is 20 percent,⁵ the formula would divide \$1,000 (the amount of the excise tax) by .8 (1-0.2), which equals \$1,250; and then subtract \$1,000 (the amount of the excise tax), which equals \$250 (\$1,250 - \$1,000).

⁵ If the coverage provider were not subject to income tax on the excise tax reimbursement (for example, because it is a tax-exempt organization described in § 501(c) that is not subject to unrelated business income tax on the reimbursement under § 511), its marginal tax rate on the reimbursement would be zero, producing an income tax reimbursement amount of zero under the formula.

Accordingly, the income tax reimbursement on an excise tax of \$1,000 paid by a coverage provider with a marginal tax rate of 20 percent would be \$250.

If it is determined that an income tax reimbursement can be excluded from the cost of applicable coverage, Treasury and IRS are considering two possible approaches for applying the formula described above. The first approach would use the coverage provider's actual marginal tax rate in the formula. This approach could provide greater flexibility to taxpayers, but also could create administrative difficulties for IRS, coverage providers, and employers due to the extended time needed to determine a taxpayer's marginal tax rate for any year, changes in a coverage provider's marginal tax rate from year to year (including potential retroactive changes due to amended returns, audits, or other circumstances), and the fact that a coverage provider's marginal tax rate is generally determined for its fiscal year, which may not be the same as the calendar year taxable period for which the cost of applicable coverage is determined. This approach could also create an additional administrative burden in cases in which multiple coverage providers are liable for tax for coverage offered by a given employer. Comments are requested on whether there are workable solutions to these administrative challenges that would permit Treasury and IRS to implement such an approach.

The second approach would prescribe, for purposes of applying the income tax reimbursement formula in a manner that is administrable, a standard marginal tax rate⁶ based on typical marginal tax rates applicable to different types of health insurance issuers. It is anticipated that the prescribed rates would reflect an approximately representative marginal rate that would be less than the statutory maximum rate. The prescribed rate for an insurer would be used in the income tax reimbursement formula rather than the coverage provider's actual marginal tax rate. While more administrable, this approach may not permit some taxpayers to exclude from the cost of applicable coverage the total income tax reimbursement, but would permit other taxpayers to exclude from the cost of applicable coverage more than the total income tax reimbursement. Comments are requested on how these standard marginal tax rates might be determined, how many such rates might apply (for example, one for each of two or three categories of insurers) and for what types of insurers, and how this approach would affect particular segments of taxpayers.

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

Applicable coverage under § 4980I(d)(1)(A) is "coverage under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106)." Applicable coverage includes coverage under certain HSAs, Archer MSAs, FSAs, or HRAs.

⁶ If an approach using a standard marginal tax rate were adopted, the standard marginal tax rate would not be available to coverage providers that are not subject to income tax on the excise tax reimbursement.

Section 49801(a) imposes an excise tax equal to 40 percent of the excess benefit if an employee is covered under any applicable coverage of an employer at any time during a taxable period and there is any excess benefit with respect to the coverage. Under § 49801(b)(1), an excess benefit means, with respect to any applicable coverage made available by an employer to an employee during any taxable period, the sum of the excess amounts determined for months during the taxable period. Under § 49801(b)(2), the excess amount determined for any month is the excess (if any) of (A) the aggregate cost of the applicable coverage of the employee for the month over (B) an amount equal to 1/12 of the dollar limit for the calendar year in which the month occurs.

Section 49801(d)(2)(D) provides that if the cost of applicable coverage is determined on other than a monthly basis, the cost is allocated to months in a taxable period on such basis as the Secretary may prescribe.

Treasury and IRS are considering an approach under which contributions to 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. Treasury and IRS anticipate that this allocation rule would apply to HSAs, Archer MSAs, FSAs, and HRAs that are applicable coverage. 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, regardless of when the employer actually contributes the amount to the HSA. 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. Comments are requested on this approach as well as alternative approaches.

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

Section 49801(d)(2)(B) provides that in the case of applicable coverage consisting of coverage under an FSA, the cost of applicable coverage 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. Thus, the cost of applicable coverage of an FSA for any plan year would be the greater of the amount of an employee's salary reduction or the total reimbursements under the FSA.

Under this general rule, in determining the portion of the cost of applicable coverage attributable to non-elective flex credits contributed to an FSA by an employer (either in combination with employee salary reduction contributions or without), the cost of the non-elective flex credit would be the amount that is actually reimbursed in excess of the employee's salary reduction election for that plan year. For example, if an

employee elects to make a salary reduction contribution to an FSA in the amount of \$1,000 for a plan year and the employer makes a non-elective flex credit in the amount of \$500 available to the employee under the FSA for that plan year, but the employee only has \$1,200 in medical expenses reimbursed under the FSA for that plan year, the cost of applicable coverage for the FSA for the plan year would be \$1,200 (comprised of the \$1,000 salary reduction plus the additional \$200 in reimbursements attributable to the non-elective flex credit provided by the employer) rather than the full \$1,500 elected or available for the FSA for the plan year.

Under this rule, the cost of applicable coverage of the FSA would not be known until some point in time after the end of the taxable year. With respect to amounts carried over to a subsequent year, this rule would take such amounts into account in a later year if the reimbursements in the subsequent year exceeded the amount of employee salary reduction in the subsequent year.

To avoid the double counting associated with taking salary deferral amounts that are carried over from one year to another year into account in determining the cost of coverage in both the year of contribution and the subsequent year, which would be the result under the general rule outlined above, Treasury and IRS are considering providing a safe harbor. Under this safe harbor, the cost of applicable coverage for the plan year would be the amount of an employee's salary reduction without regard to carry-over amounts. Unused amounts that are carried forward would be taken into account when initially funded by salary reduction but would be disregarded when used to reimburse expenses in a later year. For example, if an employee elected to reduce his salary by \$1,200 to contribute to an FSA in a given year, the FSA's cost of applicable coverage in that year would be \$1,200 even if some or all of the \$1,200 was not used to reimburse expenses in that year. Accordingly, if that same employee carried over \$500 of unused funds that were used to reimburse expenses in the second year, and elected no new salary reduction for the second year, the FSA's cost of applicable coverage in the second year would be \$0.

The possible safe harbor described above would be limited to cases in which non-elective flex credits are not available for use in the FSA. To address situations in which non-elective flex credits are available under a cafeteria plan that includes an FSA, Treasury and IRS are considering a variation on the safe harbor that would allow an FSA with non-elective flex credits to be valued under the safe harbor described in the preceding paragraph in certain situations.

Under some cafeteria plan arrangements, an employee may elect to defer amounts to the cafeteria plan that exceed the § 125(i) limit for FSAs (for 2015, \$2,550), and the employer may offer additional non-elective flex credits. These amounts may be allocated to pay for various benefits available under the cafeteria plan, such as reimbursements under an FSA, dependent care assistance, and health insurance. The possible variation on the safe harbor would provide that an FSA could be treated as funded solely by salary reduction if the amount elected by the employee for the FSA were less than or equal to the maximum amount permitted by § 125(i). For example, if an employee with a \$1,000 non-elective flex credit available reduces salary by an

additional \$5,000 under a cafeteria plan and allocates \$2,550 to the FSA, the FSA would be treated as funded solely by salary reduction. As a result, the cost of applicable coverage would be \$2,550. Under the safe harbor proposal, the salary reduction taken into account would be counted only in the year an amount was elected for the FSA and, therefore, would be disregarded in later years if amounts were carried over. Comments are requested on the allocation of FSA amounts between non-elective flex credits and salary reduction when the total election for the FSA exceeds the maximum salary reduction amount permitted by § 125(i).

Treasury and IRS request comments concerning whether these potential approaches are administrable. In addition, comments are requested generally on the potential safe harbors described above and on any other issues arising from the valuation of FSAs.

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

Section 49801(d)(1)(A) defines applicable coverage to include coverage under any group health plan made available to the employee by an employer that is excludable from the employee's gross income under § 106 (or would be so excludable if it were employer-sponsored coverage).

Section 106 excludes employer-provided coverage under an accident or health plan from an employee's gross income. For an employee who then receives reimbursement for medical expenses of the employee or his family under an employer-provided accident or health plan, § 105 further excludes those reimbursement amounts from the employee's income. In the case of reimbursements paid to a highly-compensated individual under a self-insured plan that discriminates in favor of highly compensated individuals, however, § 105(h) provides that the exclusion does not apply to the extent that the amounts constitute an "excess reimbursement." The amount of the excess reimbursement is included in the gross income of the highly compensated individuals.

Section 6051(a)(14) requires employers to report on the Form W-2, Wage and Tax Statement (Form W-2), the aggregate cost of applicable coverage as defined in § 49801(d)(1). Notice 2012-9, 2012-4 IRB 315, currently permits employers to reduce the amount reported on the Form W-2 by any excess reimbursement included in gross income by application of § 105(h).

Although excess reimbursements currently can be excluded from the cost reported on the Form W-2, Treasury and IRS do not believe such amounts reduce the cost of applicable coverage subject to tax under § 49801. It is the coverage (excludable from income under § 106), and not the resulting benefit (excludable from income under § 105), that is applicable coverage under § 49801, and it is the cost of that coverage that is compared to the dollar limit to determine the amount of any excise tax under § 49801. Inclusion of excess reimbursements in an employee's income does not reduce the cost of applicable coverage subject to tax under § 49801. Treasury and IRS anticipate that

Notice 2012-9 will be modified in the future to make excess reimbursements subject to reporting under § 6051(a)(14) and that the forms and instructions will be modified to reflect this change. Taxpayers should continue to follow Notice 2012-9 until modification of that notice is issued.

VI. AGE AND GENDER ADJUSTMENT TO THE DOLLAR LIMIT

Section 49801(b)(3) provides two baseline per-employee dollar limits for 2018 (\$10,200 for self-only coverage and \$27,500 for other than self-only coverage) but also provides that various adjustments, discussed in section V.C of Notice 2015-16, will apply to increase these amounts. As stated in Notice 2015-16, Treasury and IRS intend to include rules regarding these adjustments in proposed regulations and have invited comments on the application and adjustment of the dollar limits.

One of these adjustments, set forth at § 49801(b)(3)(C)(iii), provides for an increase in the dollar limits based on the age and gender characteristics of all employees of an employer. In accordance with the statute, no downward adjustments can occur (that is, the statute does not provide for any decrease in the dollar limits based on age and gender). Specifically, the adjustment increases the dollar limit by an amount equal to the excess of the premium cost of the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits 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). Section 49801(b)(3)(C)(iii)(II)(aa) provides that the adjustment is based on "the type of coverage provided such individual in such taxable period." In other words, the age and gender adjustment is determined separately for self-only coverage and other than self-only coverage.

While rating based on age and gender in the individual and small group market is subject to certain restrictions under the Affordable Care Act, the actual cost of applicable coverage generally differs based on age and gender. On average, older individuals have higher health costs than younger individuals, and, on average, younger women have higher health costs than younger men. Consequently, some employers may have higher health costs than other employers under identical benefit plans due to the age and gender characteristics of their workforce. In determining the effect that the age and gender characteristics of a workforce have on premium rates, it is not sufficient to simply compare the average age and gender of an employer's workforce to the average age and gender of the national workforce. Rather, the premium rate depends on the distribution of men and women in different age groups.

A. Determination of Age and Gender Distribution

To compare the employer's premium cost with the national premium cost, it will be necessary to establish the age and gender characteristics of the national workforce. To determine the age and gender distribution of the national workforce, Treasury and IRS are considering using the Current Population Survey as summarized in Table A-8a,

Employed Persons and Employment-Population Ratios by Age and Sex, Seasonally Adjusted (Table A-8a), published annually by the Department of Labor Bureau of Labor Statistics. This publication provides the number of individuals participating in the labor force by five-year age-bands (up to age 75 and over) and the ratio of male to female workers in each age-band. Treasury and IRS request comments on whether Table A-8a and the Current Population Survey more generally is an appropriate source of data for the age and gender characteristics of the national workforce for purposes of § 4980I and whether other sources of data for the age and gender characteristics of the national workforce should be considered.

To determine the age and gender characteristics of a particular employer's population, Treasury and IRS are considering a requirement that an employer use the first day of the plan year as a snapshot date for determining the composition of its employee population. In other words, an employer would be required to determine the age and gender of each employee as of the first day of the plan year and that distribution of age and gender characteristics would apply for purposes of the age and gender adjustment. Comments are requested on the administrability of this approach, whether it is likely to result in a representative age and gender distribution, and whether employers should be permitted to choose a different date other than the first day of the plan year to determine the age and gender characteristics of its employees. If employers were permitted to choose a different date, it is anticipated that the employer would not be permitted to vary the date from one taxable year to the next. To the extent that commenters recommend that employers be permitted to use a date other than the first day of the plan year, Treasury and IRS ask that the commenters address why permitting the use of a different date will result in a more accurate representation of the age and gender characteristics of an employer's workforce, whether flexibility in determining the snapshot date is susceptible to abuse, and any administrability issues associated with requiring a specific date or permitting flexibility in the choice of date.

B. Development of Age and Gender Adjustment Tables

Treasury and IRS anticipate that IRS will formulate and publish adjustment tables to facilitate and simplify the calculation of the age and gender adjustment. The following approach is being considered for the development of these tables and the calculation of the age and gender adjustment. All adjustments and calculations would be determined separately for self-only coverage and for other than self-only coverage.

1. Determination of average cost for FEHPB coverage. The average cost of applicable coverage under the FEHBP (FEHBP average cost) would be determined by aggregating all claims expenses of the FEHBP standard option and dividing the total by the number of coverage units. Each employee policyholder would be a coverage unit.

2. Determination of average cost for each age and gender group. Claims expense data would be sorted into groups, separating the population into male and female coverage units and further separating each gender population into multi-year age-bands. For example, the dollar amount of claims for all male individuals between the ages of 30 and 34 would be added together. The dollar amount of claims for each

group would then be divided by the number of coverage units in that age and gender group to yield the average cost for that group (group average cost). A group average cost would be calculated in this way for each of the age and gender groups.

3. *Determination of group ratios.* Each group average cost would be divided by the FEHBP average cost to establish the ratio (group ratio) of the group average cost to the FEHBP average cost. The group ratio would be expressed as a fraction or percentage and would be determined periodically, but less frequently than annually.

4. *Determination of group premium cost.* The group ratio would be multiplied by the most recent annual premium cost of the FEHBP standard option to determine the annual premium cost for each age and gender group (group premium cost). The dollar amounts representing each group premium cost would then be used to populate the adjustment tables, to be published annually.

5. *Determination of national premium cost.* To determine the national premium cost, each group premium cost would be multiplied by the fraction of employees in the national workforce who are in that group. The product of each of these calculations would be added together to yield the national premium cost, which would be a single dollar amount that would be published annually.

6. *Determination of the employer's premium cost.* Each employer would determine the fraction of its employees who are in each age and gender group. The employer would then multiply the group premium cost from the relevant adjustment table by the fraction of its employees in each group. The product of each of these calculations would be added together to yield the employer's premium cost, which would be a single dollar amount.

7. *Determination of adjustment.* The employer's premium cost would then be compared to the national premium cost. If the employer's premium cost exceeds the national premium cost, the excess dollar amount would be added to the dollar limit for that employer for purposes of determining the amount of any excess benefit.

With respect to step one, two different approaches are under consideration. One approach would rely on actual claims data from the FEHBP standard option. An alternative approach would rely on national claims data reflecting plans with a design similar to that of the FEHBP standard option. It is anticipated that only one approach will be adopted and that it will be applied in a uniform manner.

Treasury and IRS seek comments on this approach to the age and gender adjustment, including the alternative approaches to step one and whether the approach to the age and gender adjustment should take into account the age rating scale adopted in regulations for the individual and small group market.

VII. NOTICE AND PAYMENT

A. Notice of Calculation of Applicable Share of Excess Benefit

Section 4980I(c)(4)(A) imposes a notification requirement on the employer. Specifically, that section requires the employer to calculate for each taxable period the amount of the excess benefit subject to the tax imposed by § 4980I(a) and the applicable share of that excess benefit for each coverage provider, and to notify the Secretary and each coverage provider of the amount so determined for each coverage provider at the time and in the manner as the Secretary may prescribe.

Treasury and IRS are considering both the form in which that information must be provided to the various coverage providers and IRS, and the time at which that information must be provided. Comments are requested on the administrative and other issues raised by this notice requirement, taking into account that this process may be affected by the rules governing the period over which the cost of applicable coverage is determined as discussed in section V.B of this notice.

Treasury and IRS anticipate that calculation errors that affect the cost of applicable coverage may, in some instances, affect multiple coverage providers due to the allocation of the tax. Comments are invited on how instances of reallocation might be mitigated or avoided.

B. Payment of the § 4980I Excise Tax

Section 4980I(c)(1) provides that each coverage provider is liable for the excise tax on its applicable share of the excess benefit with respect to an employee for any taxable period, but does not specify the time and manner in which the excise tax is paid. Treasury and IRS are considering designating the filing of Form 720, Quarterly Federal Excise Tax Return, as the appropriate method for the payment of the tax. Although Form 720 generally is filed quarterly, under this approach a particular quarter of the calendar year would be designated for the use of Form 720 to pay the excise tax under § 4980I.⁷

VIII. REQUEST FOR COMMENTS

Treasury and IRS invite comments on the issues addressed in this notice and on any other issues under § 4980I. This includes an invitation to submit further comments on issues addressed in Notice 2015-16. For example, in response to Notice 2015-16, some commenters expressed concern about coordination between the excise tax under

⁷ This procedure is used for payment of the fee imposed on issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans to help fund the Patient-Centered Outcomes Research Institute. The fee is required to be reported only once a year on the second quarter Form 720 and paid by its due date, July 31. See *Fees on Health Insurance Policies and Self-Insured Plans for the Patient-Centered Outcomes Research Trust Fund*, 77 Fed. Reg. 72721, 72726-27 (December 6, 2012) and the Form 720 and accompanying instructions.

§ 4980I and the assessable payments under § 4980H.⁸ Comments are invited on the circumstances in which the interaction between the provisions of § 4980H and § 4980I may raise concerns and on whether and how these provisions might be coordinated consistent with the statutory requirements of these provisions and in a manner that is administrable for employers and the IRS.

Although many comments submitted in response to Notice 2015-16 are not reflected in this notice, those comments are under consideration. Those comments and comments responding to this notice will be used to inform proposed regulations that will be issued in the future for further public notice and comment.

Public comments should be submitted no later than October 1, 2015. Comments should include a reference to Notice 2015-52. Send submissions to CC:PA:LPD:PR (Notice 2015-52), Room 5203, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (Notice 2015-52), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC 20044, or sent electronically, via the following e-mail address: Notice.comments@irs.counsel.treas.gov. Please include "Notice 2015-52" in the subject line of any electronic communication. All material submitted will be available for public inspection and copying.

IX. RELIANCE

This notice does not provide guidance under § 4980I upon which taxpayers may rely. No inference should be drawn from any provision of this notice concerning any provision of § 4980I other than those addressed in this notice or concerning any other section of the Affordable Care Act.

X. DRAFTING INFORMATION

The principal author of this notice is Karen Levin of the Office of Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this notice contact Ms. Levin at (202) 317-5500 (not a toll-free call).

⁸ Generally, under § 4980H, an applicable large employer that fails to offer to its full-time employees health coverage that is affordable and provides minimum value (as defined in § 36B(c)(2)(C)(ii)) may be subject to an assessable payment if a full-time employee enrolls in a qualified health plan for which the employee receives a premium tax credit. Commenters have noted that health coverage providing no more than minimum value (or only slightly more than minimum value) may exceed the applicable dollar limit under § 4980I in certain circumstances.