May 15, 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 2015-16 – 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 2015-16 ("Notice"), which is intended to initiate and inform the process of developing regulatory guidance 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 the initial step taken by the Department of the Treasury and the Internal Revenue Service (collectively, the "Department") in formulating guidance to implement the 40 Percent Tax as well as the Department's stated intent to issue another notice soliciting comment before publishing proposed regulations. However, it is imperative that the Department issue final guidance well in advance of the 2018

effective date of the 40 Percent Tax. In order to minimize the burdens and effects of the 40 Percent Tax on all stakeholders, and to implement and price appropriate benefit offerings in light of the 40 Percent Tax, employers need information regarding the applicable dollar limits and valuation rules well in advance of 2018. Moreover, with respect to future tax years, information regarding dollar threshold adjustments will also be needed well in advance of such tax years.

INTRODUCTORY COMMENTS

The Patient Protection and Affordable Care Act ("PPACA") was intended to build upon the employer-sponsored system. Over 150 million Americans rely on the employer-sponsored system for receiving health care coverage. Unfortunately, Code Section 4890I, which instituted 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 benefits 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) or offering coverage that is not subject to the 40 Percent Tax under Code Section 4980I. It is crucial that the Department signal clearly and early 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.

Although the Council does not believe that the administrative burdens and tremendous cost of the 40 Percent Tax can be fully alleviated by regulatory action, we urge the Department to take what steps it can to make the 40 Percent Tax as workable as possible. In this regard, we believe any final rules 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 burdens 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/or reduce overall health costs, including 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 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.

We appreciate your review of the Council's specific comments in response to the Notice, which are addressed below and are aimed at preserving this vital source of health care coverage.

RESULTS FROM OUR RECENT MEMBER SURVEY

In preparation of this comment letter, the Council surveyed its members[1] regarding various aspects of the 40 Percent Tax. The survey results represent the views of 93 plan sponsor companies with regard to the 40 Percent Tax and its implications for current and future health benefit strategy.

Our survey findings, as set forth below, illustrate the great concerns our members have about the 40 Percent Tax and the effect it is already having on employers and their employees with respect to current benefit offerings. This includes the significant potential for the 40 Percent Tax to require many employers to eliminate important benefit offerings for their employees in the very near term.

Modifying Benefits

The 40 Percent Tax is already affecting how employers, including our member companies, offer benefits. Its effect on employers and their employees will only grow over time, in part because of the limited annual indexing of applicable dollar limits. In the survey of the Council's membership, 43 percent of respondents stated that they "will make any plan changes required to avoid the tax." Only 11 percent of respondents indicated that they "do not anticipate triggering the tax and therefore are not making changes because of the tax."

Even with changes, many employers remain concerned that they will incur a 40 Percent Tax liability in 2018 or shortly thereafter. Of our members surveyed, 49 percent agreed with the statement: "[a]t least one of our plans will trigger the tax by 2018 or shortly thereafter, even though we are making changes to avoid the tax."

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[1] The informal survey, between May 1 and May 11, 2015, was sent to 281 plan sponsor member companies. Ninety-three of the 281 company representatives responded to the survey online via SurveyMonkey.com. Not all respondents answered all questions. In some cases, the results have been rounded to the nearest percentage point.

Reasons for Triggering the Tax

In terms of why employers may trigger the 40 Percent Tax, respondents cited such reasons as:

- employees located in geographic areas with higher health care costs.
- a workforce that is older than the average workforce and thus has relatively higher costs.
- employees that are generally higher-cost individuals (for example, those with a high prevalence of chronic conditions or other factors resulting in relatively higher claims experience).

Only 45 percent of respondents who anticipate triggering the tax indicated that they will do so in part because their plans are "very generous in terms of covered services" and impose minimal employee cost-sharing.

Effect on Wages

The Congressional Budget Office ("CBO") and the Joint Committee on Taxation ("JCT") estimate that only 25 percent of the revenue generated by the 40 Percent Tax will be a result of employers actually paying the tax because they offer coverage above the thresholds. The other 75 percent is expected to result from employers decreasing health benefits coverage and increasing employee cost-sharing to avoid triggering the tax. The estimate assumes employers will raise taxable wages by the same amount they are decreasing health benefits, thus increasing federal revenues.

As part of our member survey, we asked our members whether they anticipate increasing employee wages by the same amount if they decrease health benefits as a result of the 40 Percent Tax. Fully 84 percent of survey respondents indicated that they do *not* anticipate increasing wages as a result of decreased health benefits. Only 11 percent answered "possibly" with respect to the question of whether they anticipate increasing wages to reflect decreased health benefits, and no respondents answered "yes." Based on these results, we believe the actual amount of revenue raised as a result of implementing the 40 Percent Tax will be much lower than the amount estimated by CBO or JCT.

Effect on Medical Savings Accounts

As discussed in more detail below, the Council is very concerned about the adverse effects of the 40 Percent Tax on medical savings accounts. Medical savings accounts are a principal means by which employees, including lower-income individuals, cover unreimbursed out-of-pocket medical expenses. Over time, as the 40 Percent Tax pushes employers to increase employee cost-sharing to avoid triggering the 40 Percent Tax, reliance on these accounts will grow. Unfortunately, the 40 Percent Tax will also cause

employees to lose access to these important medical savings accounts.

Of the respondents to our survey, 92 percent indicated that they currently offer a health flexible spending arrangement ("FSA") and 33 percent indicated they currently offer a health reimbursement arrangement ("HRA") to employees. Of the two-thirds of employers who include a health savings account ("HSA") in their health plan, 81 percent make nonelective employer contributions to those accounts ("HSAs") on behalf of employees enrolled in qualifying high deductible health plans. More than half (51 percent) of respondents indicated they anticipate reducing contributions to HSAs or and another 12 percent anticipate eliminating HSAs altogether as a result of the 40 Percent Tax.

On-Site Clinics

On-site clinics are an important way that many of our members have sought to control plan costs or otherwise provide important wellness-related services or preventive care (such as diagnostic testing, occupational-related health screenings, and/or flu shots and vaccinations). In fact, 36 percent of respondents indicated that they offer employees health or wellness services at an on-site facility. Respondents indicated that they offer each of the following categories of services at the percentages set forth below:

- Immunizations – 80 percent
- Injections of antigens – 60 percent
- Aspirin and other nonprescription pain relievers – 70 percent
- Services related to treatment of on-site injuries –67 percent
- Prescription medicines – 37 percent

In addition to the categories listed above, respondents also indicated that they provide other services, such as wellness screens, blood tests, mental health services and primary care.

CERTAIN COVERAGES SHOULD BE EXCLUDED FROM THE DEFINITION OF "APPLICABLE EMPLOYER-SPONSORED COVERAGE."

Code Section 4980I generally applies to "applicable employer-sponsored coverage" that exceeds specified dollar thresholds ($10,200 for self-only coverage and $27,500 for other-than-self-only coverage in 2018, subject to potential adjustment). The Notice requests comments regarding whether certain types of employer-sponsored coverage should be excluded from applicable employer-sponsored coverage. The Council's comments in response to this specific request, as well as recommendations with respect to certain other arrangements, are set forth below.

1. Self-funded dental and vision coverage should be excluded.

The statutory language of Code Section 4980I expressly excepts from applicable employer-sponsored coverage "any coverage under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye."

The Council strongly supports the exclusion of insured and self-funded dental and vision coverage from applicable employer-sponsored coverage. As noted in the Notice, there is no policy rationale for treating self-funded coverage differently from insured coverage. Moreover, to subject self-funded, but not insured, coverage to the 40 Percent Tax would disadvantage employers with self-funded arrangements – as well as their employees – and would result in disparate treatment for self-funded plans with respect to the 40 Percent Tax.

2. HSAs that are not group health plans should be excluded; at minimum, pre-tax HSA contributions should be disregarded.

The Council strongly urges the Department to exclude from the definition of applicable employer-sponsored coverage amounts contributed to an HSA where the HSA does not constitute a group health plan. As set forth below, the Council believes there is a very reasonable reading of the statute, especially in light of existing guidance at the time of PPACA's enactment, that should result in the exclusion of all contributions to HSAs that are not group health plans from the scope of the 40 Percent Tax. At minimum, for the reasons discussed below, we believe the statute as well as public policy support excluding in all instances contributions made by employees to an HSA via pre-tax salary reduction through an employer's Code Section 125 plan.

Exclusion of HSAs that Do Not Constitute Group Health Plans

In order for the 40 Percent Tax to apply, the arrangement at issue must be "applicable employer-sponsored coverage." In order for coverage to be "applicable employer-sponsored coverage," it must first be a "group health plan," as defined in Code Section 5000(b). Accordingly, a precondition for application of the 40 Percent Tax is that the coverage at issue be part of a Code Section 5000(b) "group health plan."

Pursuant to prior rulemaking by the federal agencies, many, *many* HSAs are not treated as group health plans for federal law purposes. More specifically, Department of Labor Field Assistance Bulletin 2004-01 ("FAB 2004-01") provides that an HSA is not a welfare benefit plan for purposes of ERISA (and thus is not a group health plan) if the HSA is completely voluntary on the part of the employee and the employer does not:

1. limit the ability of eligible individuals to move their funds to another HSA beyond restrictions imposed by the Code;

2. impose conditions on utilization of HSA funds beyond those permitted under the Code;

3. make or influence the investment decisions with respect to funds contributed to an HSA;

4. represent that the HSA is an employee welfare benefit plan established or maintained by the employer; or

5. receive any payment or compensation in connection with an HSA.

Quite significantly, FAB 2004-01 was effective prior to and during the entire time PPACA (and its predecessor bills) was being negotiated and drafted. Thus, Congress and legislative counsel would have been aware of its existence and effect on the definition of "group health plan" with respect to HSAs. Accordingly, it seems likely, if not certain, that Congress would have taken FAB 2004-01 into account in drafting and enacting Code Section 4980I.

In light of the foregoing, the Council believes the statute provides ample authority for the Department to issue a rule excluding HSAs that do not constitute group health plans from applicable employer-sponsored coverage.[2]

Alternative Exclusion of Employee Pre-Tax Contributions

At minimum, the Council strongly urges the Department to exclude from the 40 Percent Tax HSA contributions made by an employee via pre-tax salary reductions through an employer's Code Section 125 plan. As noted above, we believe such a rule is supported both by the statute and public policy.

Code Section 4980I specifically references HSAs in several places. These references, when read in context with the other provisions of Code Section 4980I, clearly indicate Congress' intent that HSA employee pre-tax contributions be treated differently from nonelective employer contributions for purposes of Code Section 4980I.

More specifically, in determining the cost of coverage with respect to an HSA, Code Section 4980I(d)(2)(C) states that "the cost of coverage shall be equal to the amount of *employer contributions* under the arrangement" (emphasis added). While employer contributions have often been interpreted for purposes of federal tax law to include employee pre-tax contributions, other statutory language in Code Section 4980I strongly suggests an unqualified reference to "employer contributions" in Code Section

[2] In support of this interpretation, the Council notes that HSAs generally have not been treated as group health plans for many purposes under ERISA and the Code, including with respect to COBRA.

4980I(d)(2)(C) should be read to exclude employee pre-tax contributions.

To begin with, Code Section 4980I(d)(2)(B), which pertains to determining "cost" with respect to FSAs, states:

> In the case of applicable employer-sponsored coverage consisting of coverage under a flexible spending arrangement (as defined in section 106(c)(2)), the cost of the coverage shall be equal to the sum of—
>
> > (i) the amount of ***employer contributions under any salary reduction election*** under the arrangement, plus
> >
> > (ii) the amount determined under subparagraph (A) with respect to any reimbursement under the arrangement in excess of the contributions described in clause (i).
> >
> > (Emphasis added).

Significantly, in the subparagraph that immediately follows, in discussing how to determine "cost" with respect to HSAs, Congress only chose to reference "employer contributions" and did not include any reference to "employee contributions" or "employer contributions under any salary reduction election." More specifically, in subparagraph (C) to Code Section 4980I(d)(2), it states:

> In the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of ***employer contributions*** under the arrangement.

(Emphasis added). The bald reference to "employer contributions" in this subparagraph (C) regarding HSAs is in marked contrast to the language of subparagraph (B) where Congress elected to specifically call out employee pre-tax contributions. The Council believes the difference in statutory language between subparagraphs (B) and (C) as described herein can be read to indicate that Congress intended to apply the 40 Percent Tax only to nonelective employer contributions and not also pre-tax employee contributions (i.e., "employer contributions under any salary reduction election").

Excluding employee pre-tax contributions from applicable employer-sponsored coverage is sound public policy for a number of reasons.

First, the Council notes that the Department's interpretation of the statute is that after-tax employee contributions to HSAs are not taken into account for purposes of the 40 Percent Tax, but rather individuals may later deduct such contributions on his or her Form 1040, as permitted by Code Section 223. If pre-tax employee contributions are

made subject to the 40 Percent Tax, this will create an asymmetry between pre-tax employee salary reduction contributions and after-tax contributions eligible for a deduction by reason of Code Section 223. This is because employees who otherwise rely on workplace-based contributions to an HSA could find themselves with less access to such contributions. The Council is not aware of any policy rationale for such disparate treatment and believes that principles of tax equity and fairness compel the exclusion of pre-tax employee contributions from the scope of the 40 Percent Tax.

Second, if employee pre-tax contributions to HSAs are included in applicable employer-sponsored coverage, many employers may be forced now or in the near future to limit employees' ability to make pre-tax contributions to their HSAs so as to avoid triggering the 40 Percent Tax.

Third, it should be expected that lower-income and middle-income workers will make fewer HSA contributions on an after-tax basis than they would otherwise make on a pre-tax basis – even after accounting for their ability to take a deduction as part of their annual federal tax return by reason of Code Section 223. A simple example bears this out:

Assume there are two employees, Employee 1 and Employee 2. Furthermore, assume Employee 1 has annual wages of $25,000 and Employee 2 has annual wages of $150,000. The effective tax savings rate for Employee 1 when making pre-tax contributions via her employer's Code Section 125 plan is 22.7 percent (including federal income and payroll tax savings). The effective tax savings rate for Employee 2 (also including federal income and payroll tax savings) is 29.5 percent. However, to the extent Employee 1 and Employee 2 are no longer permitted to make pre-tax HSA contributions because their employers have been forced to restrict and/or limit access to pre-tax contributions, Employee 1 has a significantly reduced incentive to use after-tax income to make contributions to an HSA compared to Employee 2. This is true even if both Employee 1 and Employee 2 seek to utilize Code Section 223 to take a deduction from income for purposes of their federal income taxes. This is because Employee 1's effective tax savings rate is reduced by 33.8 percent from 22.7 percent to 15.0 percent. This is in contrast to Employee 2, the higher income employee, whose tax savings rate is reduced by only 4.9 percent from 29.5 percent to 28.0 percent. As a result of this change, Employee 1 ends up incurring significantly increased costs to fund her HSA, whereas Employee 2's costs remain largely the same. Specifically, Employee 1's costs increase by 10 percent, whereas Employee 2's costs only increase by 2 percent.

Below is a figure showing the effects on Employee 1 versus Employee 2:

Cost of maintaining HSA funding after shift to post-tax contributions, by wage level

	Employee #1	Employee #2
Scenario #1 – Pre-tax salary reduction contribution		
Gross wages	$25,000	$150,000
Elective pre-tax salary reduction HSA contribution	$1,750	$1,750
Taxable wages	$23,250	$158,250
Tax savings rate (based upon effective marginal Federal tax rate, including applicable FICA tax)	22.7%	29.5%
Effective cost of pre-tax HSA contributions	**$1,352**	**$1,234**
Scenario – After-tax contributions to HSA with corresponding Code section 223 deduction		
Gross wages	$25,000	$150,000
Taxable wages	$25,000	$150,000
Assumed after-tax HSA contribution	$1,750	$1,750
Tax savings rate (based upon effective marginal Federal tax rate)	15.0%	28.0%
Effective cost of post-tax HSA contributions (with a corresponding Code section 223 deduction)	**$1,487**	**$1,260**
Comparison of Scenarios #1 and #2		
Relative increase in cost of after-tax HSA contributions (even with corresponding Code section 223 deduction) compared to pre-tax HSA contributions	**$135 or 10%**	**$26 or 2%**

In addition to the reduced tax incentives and increased relative costs for Employee 1 in our example, it should be expected that lower-income employees, like Employee 1, may lack the resources to make after-tax contributions to an HSA. This is because many such individuals may be required to allocate such amounts to other essential household expenses, such as household bills, rent expense or mortgage payments.

The reality of reduced access to employee pre-tax HSA contributions is that certain American families (likely many lower- and moderate-income families) will be less able to pay out-of-pocket medical expenses. For the foregoing reasons, we urge the Department to exclude from the 40 Percent Tax pre-tax employee HSA contributions made via salary reduction.

3. HRAs that only reimburse premiums for "applicable employer-sponsored plans" should be excluded.

Per the Notice, HRAs can take many forms and serve many purposes. Some HRAs may reimburse all Code Section 213 "medical care" expenses whereas other HRAs may only reimburse a subset of such expenses. Regarding the latter, many of our members sponsor HRAs that only reimburse premium expenses incurred by participants with respect to employer-sponsored major medical group coverage (whether insured or self-funded). To the extent the major medical coverage is applicable employer-sponsored coverage, the Council believes that the underlying HRA should not be considered applicable employer-sponsored coverage.

Excluding premium-only HRAs is appropriate because a contrary rule would result in the double-counting of coverage with respect to the employee for purposes of the 40 Percent Tax (i.e., not only would the underlying major medical coverage be counted, but the employee's HRA that merely provides premium assistance with respect to the major medical coverage would also be counted). Such double-counting would inappropriately magnify the extent of coverage available to the employee and result in an inaccurate and exaggerated valuation for purposes of Code Section 4980I. For these reasons, the Council requests that an HRA be excluded from applicable employer-sponsored coverage if it only reimburses premiums for coverage that is applicable employer-sponsored coverage.

4. Limited purpose FSAs or HRAs should be excluded.

As noted above, the statutory language of Code Section 4980I indicates that Congress sought to exclude stand-alone dental and vision coverage from applicable employer-sponsored coverage. Accordingly, the Council believes there is sufficient statutory basis for the Department to issue a rule excluding from applicable employer-sponsored coverage health FSAs or HRAs that only reimburse dental or vision benefits as set forth in Revenue Ruling 2004-45. The establishment of such a rule would appear to be in accordance with congressional intent and would ensure that limited scope dental or vision benefits, regardless of whether provided through an FSA, an HRA or otherwise, receive equal treatment under federal tax law.

5. Employer activities aimed at improving an employee's well-being and/or health outcomes should be excluded, including employee assistance programs, wellness programs and on-site medical clinics.

Employers are increasingly implementing programs that are designed to improve employees' general well-being and health outcomes. Overall, these programs, including employee assistance programs ("EAPs") and wellness programs, are of great importance to employers and employees alike. These programs typically result in reduced employee absenteeism and pre-absenteeism, as well as higher employee

engagement and satisfaction. Additionally, such programs may, over time, facilitate a reduction in health care costs, which could in turn result in reduced health "spend" for employers and reduced premium increases for employees.

The Council urges the Department to promulgate rules with respect to Code Section 4980I that will help ensure that these types of programs and activities remain available to employers and employees alike. Accordingly, the Council recommends adoption of a rule that would exclude employer-sponsored plans, arrangements or activities intended to improve employee health and well-being from applicable employer-sponsored coverage.

The Council notes that a similar approach was adopted by the Department of Health and Human Services ("HHS") in connection with the medical loss ratio ("MLR") rules of Section 2718 of the Public Health Service Act ("PHSA"). PHSA Section 2718 imposes a requirement that a certain percentage of premium be used to provide benefits. There is an exception, however, for expenditures for activities that improve health care quality – these amounts are excluded from the denominator in determining the applicable ratio. The regulations issued by HHS provide that these expenditures include amounts spent on things such as "activities designed to implement, promote, and increase wellness and health activities," including wellness assessments and wellness/lifestyle coaching programs. The Council urges the Department to follow suit with respect to Code Section 4980I and except wellness programs and similar activities from the scope of the 40 Percent Tax.

At a minimum, the Council urges the Department to exclude EAPs and wellness programs from the scope of the 40 Percent Tax. As mentioned, these arrangements are an important component of employers' current suite of benefit offerings and contribute to increased worker engagement, reduced absenteeism and pre-absenteeism, and reduced plan costs over time.

EAPs

In the Notice, the Department states that it is considering whether to exercise its regulatory authority to propose that EAPs that qualify as excepted benefits pursuant to Treasury Reg. Section 54.9831-1(c)(3)(vi) be excluded from the definition of applicable employer-sponsored coverage.

The Council appreciates that the Department is considering excluding EAPs that qualify as excepted benefits from the definition of applicable employer-sponsored coverage and urges the Department to adopt such an exclusion in future rulemaking. As mentioned above, the Council requests a rule that would exclude from the scope of the 40 Percent Tax all employer plans, arrangements or activities that are intended to increase employee health or well-being; excluding EAPs that qualify as excepted benefits would be progress toward such request.

The Council notes that EAPs that constitute excepted benefits are already required to adhere to rules limiting the extent of services that may be provided, including that the EAP not provide "significant benefits" in the nature of medical care. Because of the built-in limitations on the scope of services that such EAPs may provide, the Council believes these EAPs should not be treated as applicable employer-sponsored coverage for purposes of Code Section 4980I. Moreover, the requested rule is appropriate because the employers would otherwise need to expend significant time and money in order to value the cost of the medical care provided with respect to the EAP – medical care that by definition must be very limited in amount. Perhaps most significantly, subjecting EAPs to the 40 Percent Tax could discourage employers from sponsoring EAPs. The Council does not believe such an outcome would be in the best interest of employees given the potential for EAPs to provide important assistance to employees and their families in times of personal need or distress.

Wellness Programs

The Council also urges the Department to exclude wellness programs from the definition of applicable employer-sponsored coverage. A growing number of employers sponsor wellness programs. The services offered by those wellness programs may include, among other things, preventive screenings, health coaching and disease management. The goals of employers in sponsoring these types of programs are varied but include improving employee health, increasing employee awareness of health risks, reducing absenteeism and pre-absenteeism and increasing worker engagement.

Congress recognized the increasing importance of wellness programs to employers and employees when, as part of a bipartisan amendment to PPACA, it codified the largely regulatory framework applicable to wellness programs under HIPAA. In so doing, it also provided for increased incentive limits for purposes of HIPAA-governed programs. Congress also implemented numerous other provisions demonstrating support for wellness initiatives, including the introduction of preventive care requirements and the favorable treatment for expenditures for "activities that improve health care quality" afforded by the MLR provisions.

Significantly, wellness programs typically provide limited "medical care" within the meaning of Code Section 213. The medical care is generally focused on preventive care including diagnostic testing, screenings, vaccinations, flu shots and/or health coaching and disease management. In this respect, wellness programs generally do not provide for a broad range of medical care services. In light of the foregoing, the Council urges the Department to exclude wellness programs from the definition of applicable employer-sponsored coverage. As noted above, a contrary position would be at odds with the approach already adopted by HHS in connection with the MLR rules of PHSA Section 2718.

Significantly, wellness programs often entail some expenditure by employers up front, whether it takes the form of service provider fees or the payment of incentives earned by employees. It is important to note that wellness programs have the potential to provide a return on investment, but such return is not immediate – rather, it must be measured over years (not days). As such, in order for employers to fully realize the value that wellness programs offer and to encourage them to continue to sponsor these programs (which provide valuable services to employees), we believe that wellness programs should be excluded from applicable employer-sponsored coverage. Otherwise, there is the real possibility that the upfront costs to establish and administer a wellness program could compel some employers to cease offering or establishing wellness programs as a result of the 40 Percent Tax. Such a result, the Council believes, should be avoided given the long-term positive effects associated with wellness program participation.

If the Department believes it is necessary to limit the category of wellness programs that may be excluded for purposes of the 40 Percent Tax, the Council urges the Department to exclude those wellness programs that do not offer health coverage for a broad range of services and treatments in various settings. Such a rule would align with the rules for wellness programs for purposes of the Transitional Reinsurance Program ("TRP"). In the TRP regulations, HHS stated that if a wellness program does not provide major medical coverage, which is defined to mean "health coverage for a broad range of services and treatments in various settings," then the wellness program does not need to be considered for purposes of the TRP. *See* 45 C.F.R. Section 153.20 and 45 C.F.R. Section 153.400(2)(viii). Moreover, such a rule would provide more than ample protections against any tendencies to use wellness programs as a means to circumvent the 40 Percent Tax.

On-Site Medical Clinics

As evidenced by our recent member survey findings, on-site medical clinics are an increasingly popular service offered by employers to their employees. Offering benefits through on-site clinics enables employers to provide a host of valuable services to their employees in a convenient setting at reduced costs (for example, the provision of flu shots or other immunizations or vaccinations). Of members surveyed, 36 percent indicated they offer on-site services to their employees.

In response to the Notice's specific request for comment, the Council urges the Department to wholly exclude on-site clinics from the definition of applicable employer-sponsored coverage. Although the statutory language appears to contemplate that on-site clinics be considered applicable employer-sponsored coverage, it is important to look to the technical explanation issued by the JCT, which indicates that the intent was not to include on-site medical clinics that provided only "de minimis"

care in the definition of "applicable employer-sponsored coverage."[3]

To our knowledge, most on-site clinics provide limited medical care, principally in the form of first-aid or preventive care. Although the extent and type of medical care provided generally may be limited, it is often of great importance to employers and employees alike. Enabling employees to get services such as flu shots at work often increases utilization rates and, in turn, reduces employees' time off from work – in terms of both the time it would take for an employee to obtain the same service off-site and the time absent from work if the employee does not obtain the service (e.g., flu shot) off-site.

If the Department believes it lacks sufficient authority to exclude on-site clinics altogether from the definition of "applicable employer-sponsored coverage," the Council urges it to establish safe harbors that would, at minimum, exclude clinics so long as they only provide for certain types or a certain extent of permitted medical care. These safe harbors could be as follows:

- An on-site clinic would be excluded based on a "de minimis" exception if it provides medical care consisting solely of one or more of the following services: (1) immunizations; (2) injections of antigens (for example, for allergy injections) provided by employees; (3) provision of a variety of aspirin and other nonprescription pain relievers; and (4) treatment of injuries caused by accidents at work (beyond first aid).

- An on-site clinic would be excluded based on a "de minimis" exception if the annual marginal costs of providing any benefits consisting of Code Section 213 medical care do not exceed 30 percent of the overall costs of any related group health plan.

6. Employer-sponsored Medicare Advantage Plans and Employer Group Waiver Programs should be excluded.

The Notice does not address whether employer-sponsored Medicare Advantage plans and Employer Group Waiver Programs ("EGWPs") are considered applicable employer-sponsored coverage. The Council urges the Department to expressly exempt such plans and programs from applicable employer-sponsored coverage.

Many employers sponsor Medicare Advantage plans and EGWPs for their retirees in order to provide them with comprehensive medical care post-retirement. Of our members surveyed, at least 24 percent and 29 percent of respondents indicated that they sponsor either an employer-sponsored Medicare Advantage plan or an EGWP,

[3] Joint Committee on Taxation, "TECHNICAL EXPLANATION OF THE REVENUE PROVISIONS OF THE "RECONCILIATON ACT OF 2010," AS AMENDED, IN COMBINATION WITH THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT" (JCX-18-10), March 21, 2010

respectively. (In addition, 51 percent of respondents indicated they sponsor Medicare supplemental coverage.)

Employers often heavily subsidize the premium costs associated with group Medicare Advantage plans or EGWPs, which helps reduce the costs for retirees enrolled in these plans or programs. If these employer-sponsored plans and programs are considered to be applicable employer-sponsored coverage, many employers may choose to stop sponsoring (and therefore stop subsidizing) these valuable plans and programs for retirees. In addition, individual Medicare Advantage and Medicare Part D policies are not subject to the 40 Percent Tax. Given the importance of these plans and programs (and the accompanying subsidies) to retirees, and in the interest of not adversely distinguishing between employer-sponsored programs and equivalent programs on the individual market, we strongly urge the Department to exclude employer-sponsored Medicare Advantage plans and EGWPs from the definition of applicable employer-sponsored coverage.

IN DETERMINING "COST," TREASURY AND THE IRS SHOULD ALLOW PLANS, AT THEIR DISCRETION, TO EXCLUDE COVERAGE THAT IS ATTRIBUTABLE TO PROVIDING ACA OR OTHER FEDERALLY-MANDATED BENEFITS.

PPACA requires many plans and policies to offer certain benefits. Through PPACA market reforms, all plans are required to offer preventive care. In addition, plans in the small group and individual markets must offer essential health benefits (including services such as maternity care, hospitalization, and emergency care). If plans and policies are subject to these requirements, they cannot merely choose not to offer preventive care and/or essential health benefits without incurring a penalty.

In addition to the above, many of our members are required by other federal laws to provide certain additional benefits to their employees (such as mandated vision tests for commercial pilots).

It is inconsistent federal policy to require, on the one hand, that employers offer certain benefits or services to their employees by reason of certain federal rules, but, with the other hand, impose potential, significant 40 Percent Tax liability where the cost of the coverage offered to employee exceeds the dollar thresholds for purposes of Code section 4980I. To ensure compliance with the market reforms and other federal requirements, and to enable employers to be able to offer a full range of benefits to their employees, the Council requests that the Departments allow employers to not take into account coverage that is attributable to providing mandated benefits in determining the cost of applicable employer-sponsored coverage.

THE STATUTE PROVIDES THE DEPARTMENT WITH AUTHORITY TO DETERMINE THE AMOUNT OF ANY "EXCESS BENEFIT" BASED UPON THE COVERAGE OFFERED TO AN EMPLOYEE. SUCH AN INTERPRETATION WILL HELP ENSURE THAT EMPLOYEES HAVE ACCESS TO THE MOST SUITABLE COVERAGE OPTIONS AND ENSURE THAT EMPLOYEES WITH ADVERSE HEALTH CONDITIONS ARE NOT ADVERSELY AFFECTED BY THE 40 PERCENT TAX.

The Notice indicates that the Department expects to interpret Code Section 4980I will apply based on the coverage in which the employee is enrolled instead of the coverage that is "provided" or "made available" to the employee. While the Council understands the basis for such interpretation and respects the Department's administrative authority with respect to Code Section 4980I, we urge the Department to permit employers to apply Code Section 4980I based on the coverage that is offered or otherwise made available to an employee versus the coverage in which the employee is enrolled.

In support of this interpretation, the Council notes that several references in Code Section 4980I indicate that Code Section 4980I looks to the coverage that is offered or otherwise made available to an employee. Specifically, Code Section 4980I(b)(1) defines "excess benefit" with respect to "coverage *made available*" to an employee (emphasis added).

Similarly, Code Section 4980I(d)(1)(A) defines "applicable employer-sponsored coverage" to mean "coverage under any group health plan *made available*" to an employee which is excludable (or would be excludable) under Code Section 106 (emphasis added). Finally, we note that Code Section 4980I(b)(3)(B) provides that the annual limitation that applies to an individual for a month is determined based on the type of coverage "provided" to the employee. Given the language contained in Subsections (b)(1) and (d)(1)(A), this reference to "provided" coverage could certainly be construed to mean the coverage that is offered or otherwise made available to the employee.

The Council recognizes that there is other statutory language in Code Section 4980I that could be read to suggest a more limited focus based solely on enrollment. Based upon the statutory references noted above, however, we think the statute gives the Department sufficient flexibility to construe Code Section 4980I to permit issuance of a rule that would allow employers to consider not only enrolled, but also other offered, coverage.

In addition to the regulatory basis for considering not only enrolled, but also other offered, coverage, the Council believes public policy strongly supports the establishment of such a rule. First, requiring employers to look to the cost of the coverage in which an employee is actually enrolled would increase the already significant burden on employers and other coverage providers in trying apply Code Section 4980I. This is because individual cost determinations would have to be done for

each employee depending on the specific coverage(s) in which he or she is enrolled. Allowing employers and other coverage providers to look to the coverage offered to the employee, rather than the coverage in which the employee is enrolled, would greatly facilitate employer calculations with respect to the 40 Percent Tax.

Second, if employers are required to determine the cost of enrolled coverage rather than the cost of coverage offered to an employee, then employers may decide to provide fewer coverage options to employees and their dependents. This is because higher cost individuals are more likely to enroll in plans with greater benefits (which likely have a higher cost than some other coverages that might be offered by an employer). Because the cost of these plans is likely higher than the cost of other coverages offered to employees, employers may elect to discontinue the high-benefit (i.e., high cost) option in favor of offering lower cost, less generous benefits to individuals who are chronically ill or in need of coverage that offers significant benefits.

Third, the Council believes that allowing employers to apply Code Section 4980I based on the coverage offered or otherwise made available to an employee is consistent with the Congressional intent of the provision. A goal of Code Section 4980I is to lower the cost of health care. By allowing employers to look to the coverage offered or made available to an employee, it will encourage them to continue to (or begin to) offer a lower-cost benefit package to avoid the 40 Percent Tax. This, in turn, will lead to a reduction in the cost of employer-sponsored health care in furtherance of Congress's intent.

Allowing employers to calculate the cost of coverage based on offered (versus only enrolled) coverage will greatly assist employers with regard to the 40 Percent Tax. It will enable employers to make representative calculations across multiple employees, and it will also increase the likelihood that employers will continue to offer multiple coverage options for employees. This will help to ensure that employees who may be less healthy or who may be chronically ill have access to suitable employer-sponsored coverage.

CLARIFICATION IS NEEDED AS TO WHO QUALIFIES AS AN "EMPLOYEE" AND AS A "PRIMARY INSURED INDIVIDUAL."

As mentioned above, the 40 Percent Tax applies to subject coverage with respect to an "employee," which is defined in Code Section 4980I(d)(3) to mean any (i) former employee, (ii) surviving spouse or (iii) "other primary insured individual."

Questions remain regarding who is an "employee" for purposes of the 40 Percent Tax, including with respect to who qualifies as a "primary insured individual." Significantly, this latter phrase is not defined in the statute.

In the interests of tax equity and certainty, the Council requests that any proposed rulemaking clarify who is an "employee" for purposes of Code Section 4980I(d)(3), including by setting forth a proposed definition of a "primary insured individual." Such clarification will help to ensure that all taxpayers share a common understanding of the extent and scope of the 40 Percent Tax.

EMPLOYERS NEED FLEXIBILITY IN DETERMINING THE COST OF COVERAGE. ADDITIONALLY, EMPLOYERS SHOULD BE PERMITTED TO UTILIZE CURRENT COBRA PRACTICES, IN CONTINUED GOOD FAITH RELIANCE ON CODE SECTION 4980B(F)(4), FOR PURPOSES OF COBRA AND THE 40 PERCENT TAX.

Employers will face significant administrative challenges in applying Code Section 4980I, including with respect to valuing coverage, determining applicable dollar thresholds and noticing and apportioning any tax liability among responsible parties. As discussed below, in light of these significant burdens, the Council strongly believes that valuation rules should provide employers with flexibility in determining the cost of coverage. In addition, the Council believes that employers should be permitted to utilize current COBRA valuation practices, in continued good faith reliance upon Code Section 4980B(f)(4), for purposes of both COBRA valuation and Code Section 4980I valuation.

1. **Employers should be permitted to utilize current COBRA practices for purposes of COBRA as well as for determining cost with respect to Code Section 4980I.**

Code Section 4980I(d)(2) provides that the cost of applicable employer-sponsored coverage is determined under "rules similar to" COBRA. Per the preamble to the final COBRA regulations:

> For any period beginning on or after the effective date of the final regulations with respect to topics not addressed in the final regulations, such as how to calculate the applicable premium, the plan and the employer must operate in good faith compliance with a reasonable interpretation of the requirements in Section 4980B. (Preamble to 1999 Final IRS COBRA Regulations, 64 Fed. Reg. 5160, 5161 (Feb. 3, 1999)).

Accordingly, entities have been permitted to use a good faith, reasonable interpretation of the COBRA statute for purposes of COBRA compliance. In doing so, many employers have longstanding and well developed processes in place to determine COBRA rates and have established relationships with providers to assist in these valuations.

The Council is very concerned about the statement in Notice 2015-16 that the Department is considering issuing proposed rules for purposes of COBRA valuation and that these rules might also apply for purposes of determining the cost of applicable

employer-sponsored coverage for purposes of Code Section 4980I. Employers already face significant challenges in administering Code Section 4980I. The Council is concerned about the additional burdens that would result if employers are required to implement a new set of rules for purposes of COBRA and/or for purposes of Code Section 4980I. Such an additional burden will result in increased administrative complexity, costs and confusion.

The Council is not opposed to further consideration of the merits of creating a single set of rules for use by employers for purposes of COBRA and Code Section 4980I. However, we believe such harmonization is not required by the statute (given the use of the phrase "similar to"). Moreover, we believe such harmonization should not be pursued to the extent it would have adverse consequences with respect to COBRA or Code Section 4980I.

In light of the foregoing reasons, the Council urges the Department to issue a Section 4980I rule that would permit employers to utilize their current COBRA valuation practices, in continued good faith reliance upon Code Section 4980B(f)(4), for purposes of COBRA valuation, as well as for determining cost with respect to Code Section 4980I.

2. Employers should have flexibility in aggregating coverage to determine cost for purposes of Code Section 4980I.

Code Section 4980I applies a 40 percent excise tax to the "excess benefit," which is the extent of the aggregate "cost" of all "applicable employer-sponsored coverage" with respect to an "employee" in excess of certain stated dollar limits. As mentioned above, Code Section 4980I(d)(2)(A) states that rules "similar to" COBRA shall apply in determining cost for purposes of the 40 Percent Tax.

The Notice describes a contemplated methodology that employers would need to follow for purposes of determining "cost." Specifically, it provides that each group of similarly situated employees would be determined by starting with all employees covered by a particular benefit package (e.g., an health maintenance organization and a preferred provider organization, or two preferred provider organizations and a high-deductible health plan) provided by the employer, then subdividing that group based on mandatory disaggregation rules and allowing further subdivision of the group based on permissive disaggregation rules (as explained below).

Most notably, the first step of the contemplated methodology requires mandatory aggregation by benefit package. Leaving aside the lack of clarity in the Notice regarding whether such aggregation by benefit package occurs within a plan, at the member-company level, or at the controlled-group level, the Council is very concerned about the imposition of mandatory aggregation and disaggregation rules, especially by benefit package, as doing so could have detrimental effects on employers and their employees, including employees who suffer from chronic illness or otherwise have higher risks or

claims experience.

Mandatory aggregation by benefit package can also lead to instability. That is, the statistical law of large numbers is another reason aggregating all risks into a single pool is sound practice. It increases the overall predictive power of an employer's experience. Splitting the pool into smaller and smaller pieces (by plan, by benefit package, or by enrollment tier) makes the respective costs for those smaller pieces increasingly volatile. This is bad for employers and employees, as rates will become less predictable and may fluctuate significantly from year to year.

When an employer offers multiple plan (i.e., benefit package) options to its employees, it should be expected that some degree of adverse selection will result – i.e., that younger or healthier employees will elect the lower cost option to a greater extent than so elected by relatively older or less healthy employees. The extent of adverse selection generally increases as the cost differential increases with respect to the lower cost/lower value plan option and the higher cost/higher value plan option.

To avoid exacerbating the adverse selection that is expected to result, employers often determine COBRA rates with respect to their plan options using a single risk pool. This is typically achieved by the employer as follows:

- STEP 1: Aggregate the medical claims of all self-insured plans for all employees in all locations.

- STEP 2: Assign a cost to each plan based on the relative actuarial value of each plan, after taking into consideration other factors, but generally without regard to the adverse selection of the plan.

Both steps are critical to the rate setting process. Step 1 is important because it helps reduce the extent of any adverse selection by pooling all medical claims for all employees of the employer across all business locations. This ensures that any geographic disparities and/or increased health risks or claims experience of the employee population are combined into, and reflected in, a single risk pool (rather than cordoned off by plan option or benefit package).

Step 2 is also very important because, in setting the rate, the employer assumes enrollment by the overall eligible employee population, rather than the specific health status and/or claims experience of those employees (and spouses and dependents) that may be more likely to enroll in a given plan or benefit option (such as sicker, older or chronically ill workers who may enroll to a relatively greater extent in a higher value/higher cost plan option). The positive effect of this is that any differential in cost with respect to benefit options is generally a reflection in differences in actuarial value or other aspects of how the plan delivers health care, rather than the actual or expected claims experience of the population enrolled in each benefit option.

In contrast to this common practice, the Notice contemplates requiring employers to mandatorily aggregate coverage based on benefit package in determining cost for purposes of Code Section 4980I. The Council is very concerned that the contemplated approach could magnify the effects of adverse selection and result in negative consequences for employees in the form of increased rates and, eventually, reduced coverage options – which would negatively impact both the healthy and less healthy employees.

For example, assume we have an employer with two benefit options: a less expensive option (i.e., "Leaner Option") with an actuarial value of 80 percent and a more expensive option (i.e., "Fuller Option") with an actuarial value of 90 percent. To the extent the employer continues to use a single risk pool when setting rates with respect to the two coverage options, this should minimize the effects of adverse selection on the rate setting. For example, per the chart below, this results in a differential of only $1,130 between the cost of self-only coverage for the fuller option and the leaner option (i.e., $10,150 - $9,020 = $1,130). In contrast, if the contemplated methodology of the Notice is used, this would result in a markedly larger differential of $6,780 between the cost of self-only coverage for the two options (i.e., $13,000 - $6,220 = $6,780).

The same is true with respect to the other than self-only coverage tier. The differential increases from $2,830 (i.e., $25,380 - $22,550 = $2,830) to $14,690 (i.e., $30,250 - $15,560 = $14,690) if mandatory aggregation by benefit package is required for purposes of determining cost.

Example A: Adverse Effects of Mandatory Aggregation by Benefit Package[4]		
	COMMON EMPLOYER PRACTICE: Aggregate into Single Risk Pool with Actuarial Factors	**NOTICE 2015-16 METHODOLOGY:** Disaggregate by Benefit Package Resulting in Separate Risk Pools

[4] The following assumptions based on a typical large employer experience apply to this example:

- The average employee incurs $10,000 in paid claims in a plan that covers 90 percent of costs.
- When family coverage is selected, the cost for the spouse/child(ren) covered is an additional $15,000 per year.
- 40 percent of employees choose single coverage with 60 percent selecting family.
- 3/4 of single employees are younger and healthier than average. 1/3 of employees selecting family coverage are younger and healthier than average.
- Healthier employees are assumed to cost 30 percent less than the average and make up half of all employees. The less-healthy employees are 30 percent more expensive than the average.

	Leaner Option (80% coverage)	Fuller Option (90% coverage)	Leaner Option (80% coverage)	Fuller Option (90% coverage)
Self-only	$9,020	$10,150	$6,220	$13,000
Other-than-self-only	$22,550	$25,380	$15,560	$30,250

The immediate effect of requiring employers to determine cost by benefit package for purposes of Code Section 4980I is that older, sicker and/or higher risk individuals are likely to incur significant premium increases with respect to their existing coverages. Additionally, over time, it should be expected that adverse selection would worsen to the extent cost differences are passed on to employees, with relatively healthier employees self-selecting into the Leaner Option to an ever greater extent over time. As the Fuller Option crosses the applicable dollar thresholds for purposes of the 40 Percent Tax, it should be expected that at least some employers will eliminate multiple plan options in an effort to realize broader risk pooling and reduced cost for purposes of Code Section 4980I – the result being that employees may lose access to suitable coverage options solely by reason of the valuation methods imposed by the 40 Percent Tax.

Similar to the above, the Council is also concerned that requiring employers to mandatorily disaggregate by coverage tier (i.e., self-only and other-than-self-only) could magnify the effects of adverse selection and result in increased costs for families and/or higher risk individuals. This is because younger workers, who may have lower claims expense, are less likely to be married and/or have children. Thus, requiring employers to disaggregate coverage by coverage tier should be expected to result in increased differentials in pricing between self-only and other-than-self-only coverage because those enrolled in other-than-self-only coverage should be expected to be a relatively older, less healthy population that utilizes more medical care.

In light of the foregoing, for purposes of determining "cost" under Code Section 4980I(d)(2), the Council strongly urges the Department *not* to require mandatory aggregation by benefit package and/or mandatory disaggregation by coverage tier. As illustrated above, the contemplated methodology could have significant adverse consequences for employers, as well as employees, including those with higher risk and/or claims experience, such as the aged, disabled and chronically ill. As an alternative to the contemplated methodology, the Council requests that employers be permitted to continue to use the same valuation methodology for purposes of determining cost under Code Section 4980I that they use for COBRA so long as such methodology is based on reasonable actuarial and/or underwriting principles and is in good faith reliance on the statutory language of Code Section 4980B.

3. Past Cost Method Should Exclude Overhead Expenses and Stop-Loss Coverage to an Employer.

As mentioned above, the statutory language of Code Section 4980I(d)(2)(A) provides that the "cost" of "applicable employer-sponsored coverage" is to be determined using rules " similar to" the COBRA rules of Code Section 4980B(f)(4). Code Section 4980B(f)(4)(B) permits self-insured plans to use one of two methods to compute a COBRA applicable premium: the actuarial basis method or the past cost method.

Per the Notice, the Department anticipates that future proposed regulations will set forth the costs that could be taken into account under the past cost method. These costs could include: (i) claims; (ii) insurance premiums for stop-loss or reinsurance; (iii) administrative expenses and (iv) "reasonable overhead expenses." Such reasonable expenses, says the Notice, could include expenses, "such as salary, rent, supplies and utilities of the employer, with those reasonable overhead expenses being ratably allocated to the cost of administering the employer's health plans." The Notice specifically requests comments on whether the proposed rule should include a presumption that reasonable overhead expenses already will be reflected in a plan's third-party administrator fee (if applicable) and/or whether a safe harbor should allow self-administered, self-funded plans to use a defined percentage of claims as a proxy for reasonable overhead expenses.

The Council strongly opposes requiring employers to consider any overhead expenses when applying the past cost method. Employers typically do not take account of such expenses when determining their active employee and COBRA rates with respect to their plans. To the extent such amounts are not being charged back to the plan and are not otherwise being taken into account for purposes of COBRA, it seems appropriate to exclude these amounts when using the past cost method for COBRA and/or for purposes of the 40 Percent Tax. We would also note that these overhead expenses would generally be incurred by the employer plan sponsor regardless of whether it offers health coverage to its employees. Thus, requiring consideration of these expenses under the past cost method would increase a plan's costs and could discourage some employers from self-funding their plans. For these reasons, we strongly oppose any rule that would require employers to consider overhead expenses when using the past cost method for purposes of COBRA and/or Code Section 4980I.

In addition to the above, the Council urges adoption of a rule that would exclude from the past cost methodology any stop-loss premiums so long as the stop-loss policy is between the plan sponsor and the carrier and any related premiums are not charged to the ERISA plan. As a significant portion of stop-loss premiums relate to risk charges rather than the expected cost of large claims, if the full stop-loss premium were included in the development of applicable coverage costs, it would overstate the value of benefits provided to employees.

4. **Medical savings accounts present unique issues in terms of valuation, and maximum flexibility should be provided to coverage providers in determining their value.**

The Council believes that medical savings accounts (i.e., HSAs, HRAs, and FSAs) present challenges in terms of valuation. Given the complicated administrative nature of the 40 Percent Tax, we believe that the Department should exercise its regulatory authority to allow employers significant flexibility in valuing such accounts for purposes of the 40 Percent Tax.

HSAs

As discussed above, we believe the Department should use its regulatory authority to exclude HSAs that do not constitute employee welfare benefit plans within the meaning of FAB 2004-01 (and thus do not constitute group health plans) from applicable employer-sponsored coverage. At a minimum, the Council urges the Department to exclude not only after-tax employee contributions to HSAs from applicable employer-sponsored coverage, but also employee pre-tax salary reductions to HSAs.

In connection with our alternative proposal, with respect to nonelective employer contributions, the statute indicates that the cost of the HSA should be equal to the amount of the employer contribution made to the HSA. Specifically, Code Section 4980I(d)(2)(C) states that, "the cost of the coverage shall be equal to the amount of employer contributions under the arrangement." In light of the express statutory language, the Council thinks an appropriate valuation rule should look only at the extent of nonelective employer contributions made during the relevant period.

HRAs

The Council reiterates its request, discussed above, that the Department exclude at least certain limited types of HRAs from the definition of applicable employer-sponsored coverage, including limited purpose HRAs and HRAs that are restricted to reimbursing premium expenses attributable to other coverage that is subject to Code Section 4980I.

With respect to HRAs that are applicable employer-sponsored coverage, the Council supports establishment of a rule that would permit employers to determine cost for purposes of Code Section 4980I based on the extent of employer contributions (notional or otherwise) that are made to the employee's HRA for the relevant period. Relatedly, we believe that only contributions made on or after January 1, 2018, should be required to be included in valuations. Moreover, so long as amounts are valued in the year in which contributed, they could be disregarded if they remain unused at the end of such year and roll forward into succeeding tax years.

FSAs

As noted above, the Council requests that limited scope FSAs be excepted from the scope of the 40 Percent Tax. With respect to FSAs that are applicable employer-sponsored coverage (such as general purpose FSAs), the Council requests that the Department permit employers to value the FSA coverage based on the extent of aggregate contributions made to the employee's FSA for the relevant period (whether in the form of employer flex credits or employee pre-tax contributions via salary reduction). The Council believes such a rule would help reduce the administrative complexities associated with valuing the FSA coverage. Additionally, any amounts that remain available after the close of the plan year by reason of an administrative grace period (*see* IRS Notice 2005-42) or carryover (*see* IRS Notice 2013-71) should be disregarded to the extent such amounts were previously taken into account for purposes of valuation.

Actual Usage

As suggested in the Notice, valuing FSAs and HRAs based upon annual contributions could overvalue such account, because the total contributions to the account for the given tax year may not be spent by the end of the year. This could be the result of forfeitures or it could be because unused amounts are available for rollover into the succeeding year. Accordingly, the Council is pleased that the Department is considering a valuation rule that would determine cost based not on the total annual contributions but rather based on the plan's average per capita costs. The Council is supportive of such an approach. However, given the increased administrative complexity and costs associated with this valuation method, compared to one that looks solely at annual contributions, the Council recommends that this option be just that – one option, for use at an employer's discretion, in determining cost with respect to an HRA or FSA.

AMOUNTS "ATTRIBUTABLE TO" THE 40 PERCENT TAX SHOULD EXCLUDE ALL AMOUNTS CHARGED (I) TO RECOUP THE AMOUNT OF THE TAX AND (II) TO COVER ANY RESULTING TAXES OR FEES RELATING TO THE TAX OR ADDITIONAL AMOUNTS COLLECTED.

Code Section 4980I(d)(2) provides, in relevant part, that the cost of applicable employer sponsored coverage does not include "any portion of the cost of such coverage which is attributable to the tax imposed under this section." The Council proposes that the Department interpret this provision to mean that amounts "attributable to" the 40 Percent Tax include not only the amounts charged to recoup the amount of the tax itself but also the amounts charged to cover any resulting taxes or fees associated with the tax or other amounts collected with respect thereto.

Employers and other coverage providers that may be liable for payment of the 40 Percent Tax face numerous costs in addition to the base amount of the tax. The true economic cost is, in fact, much greater than the amount of the tax itself, because of the nondeductible nature of the tax and that additional amounts of income will accrue to the employer with respect to amounts charged to recoup the base amount of the tax. We also note that issuers, when liable for the tax, may face additional expenses, including premium taxes. For these reasons, the Council believes that the Department should broadly define the amounts that are "attributable to" the tax.

EMPLOYERS NEED TIMELY INFORMATION REGARDING THE DOLLAR LIMITS THAT WILL APPLY IN 2018 AND LATER YEARS. THE COUNCIL URGES THE DEPARTMENT TO ISSUE SAFE HARBOR ESTIMATES FOR USE BY EMPLOYERS AND TO CLARIFY HOW ADJUSTMENTS TO THE LIMITS WORK TOGETHER.

The 40 Percent Tax is determined by comparing the "cost" of all "applicable employer-sponsored coverage" with respect to an "employee" against a dollar-based "applicable annual limitation." The 40 Percent Tax is equal to 40 percent of any "excess benefit," which is the aggregate cost of employer-sponsored coverage in excess of such applicable annual limitation, subject to certain potential adjustments. One of these potential adjustments is the "health cost adjustment percentage" of Code Section 4980I(b)(3)(C).

The "health cost adjustment percentage" is equal to 100 percent plus the excess (if any) of the percentage by which the per employee cost of coverage for the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for plan year 2018 (using the benefit package for such coverage in 2010) exceeds such cost for the 2010 plan year, over 55 percent.

In order to effectively plan for 2018, employers must have information regarding whether the applicable annual limitations will be increased based upon the health cost adjustment percentage. The Council understands, however, that this information will not be known with certainty until Fall 2017, when the costs (or estimated costs) with respect to the Blue Cross/Blue Shield standard benefit option become known.

Employers need to know as soon as possible, and in any event before Fall 2017, whether the health cost adjustment percentage will be triggered. Fall 2017 is too late in time given that many employers and carriers will need to make final plan design decisions with respect to 2018 by no later than Summer 2017. Moreover, to the extent employers need to reduce coverage to address the 40 Percent Tax, it is imperative that they understand what the dollar thresholds will be for 2018 as soon as possible so that they can begin to communicate these important changes to their employees – especially because the effects of any necessary benefit reductions will be felt directly by employees and their families in the form of reduced coverage and increased out-of-pocket

exposure.

Early and reliable information regarding the health cost adjustment percentage, if any, is also necessary in order for employers to satisfy certain financial and tax accounting disclosures (e.g., the Financial Accounting Standards Board Accounting Standards Codification 715-60, which requires disclosure regarding "other postretirement benefits" such as retiree health care benefits). Absent reliable information regarding the dollar limits that will apply for 2018, our members may have to make required financial disclosures with incomplete information.

On a related note, Code Section 4980I provides for limited adjustments to the applicable annual limitations based on age and gender as well as qualified retirees and certain high-risk professions. As with the health cost adjustment percentage, employers need early and reliable information in advance of 2018 regarding when and how these adjustments apply.

For the foregoing reasons, the Council urges the Department to provide an estimate of the health cost adjustment percentage, if any, as soon as possible but in no event later than July 1, 2016, and to permit issuers and other coverage providers to rely on that estimate in good faith for purposes of Code Section 4980I. Additionally, the Council requests that guidance be issued as soon as administratively practicable that will clearly explain when and how the adjustments referenced above will apply in 2018 and later years.

EMPLOYERS NEED TIMELY INFORMATION REGARDING THE INDEXED DOLLAR LIMITS THAT WILL APPLY AFTER 2018.

As mentioned above, the 40 Percent Tax is based upon the extent to which the cost of applicable employer-sponsored coverage exceeds certain dollar thresholds. These dollar thresholds are determined based upon the annual applicable limitations set forth in Code Section 4980I(b)(3)(C), with potential adjustments (i) based on the age and gender characteristics of the employer's workforce and (ii) with respect to qualified retirees and in connection with certain high-risk professions. These adjustments are described in Code Sections 4980I(b)(3)(C)(iii) and (iv), respectively. Per the statute, the applicable annual limitations and the adjustments regarding qualified retirees and high-risk professions are subject to annual indexing based on changes to the Consumer Price Index (Urban), i.e., CPI-U.

Employers must know with certainty, and well in advance of the start of each applicable tax year, what the indexed limits will be for such tax year, because they generally engage in plan design well in advance of the start of a plan year. As evidenced by our member survey, a number of employers anticipate triggering the 40 Percent Tax in 2018 or shortly thereafter. Accordingly, it is important that employers

have early and reliable information regarding the indexed limits so they can, among other things, avoid unnecessary benefit reductions, communicate any benefit changes to employees and their families and fulfill the aforementioned financial disclosure requirements.

With respect to 2019 and later tax years, the Council requests that the Department provide a projected or estimated index for purposes of Code Section 4980I(b)(3)(C)(v) well in advance of the tax year that can be relied upon by employers and other coverage providers in designing plans and policies. This adjustment would apply for purposes of indexing the applicable annual limitation and the qualified retirees/high-risk professions adjustment and would help to ensure that employers have information necessary to plan for the 40 Percent Tax.

PRINCIPLES OF TAX EQUITY AND ADMINISTRATION SUPPORT DEVELOPMENT OF SAFE HARBOR VALUATION METHODOLOGIES IN VALUING COVERAGE FOR PURPOSES OF CODE SECTION 4980I.

The Notice requests comments on whether the Department should issue alternative rules for use by employers in valuing coverage with respect to Code Section 4980I. Specifically, the Notice states:

> Treasury and IRS invite comments on whether any alternative approaches to determining the cost of applicable coverage would be consistent with the statutory requirements of § 4980I and, if so, would be useful.

(IRS Notice 2015-16 at 24 (Feb. 23, 3015).)

The Council supports the development of safe harbor methodologies for purposes of determining the amount of any 40 Percent Tax liability. The Council is very concerned that the contemplated cost-based methodology, if not paired with appropriate safe harbor alternatives, will result in disparate treatment of employers and could cause reduced coverage and/or increased out-of-pocket exposure for employees in higher cost areas or for the disabled or chronically ill for the following reasons.

First, the contemplated regime as set forth in the Notice does not provide a specific adjustment based on an employee's general adverse health risk or claims experience. Thus, notwithstanding the specific adjustments to the dollar thresholds for age and gender and qualified retirees and high risk professions, two identical plans can have materially different cost valuations for purposes of the 40 Percent Tax solely because one plan covers a population of employees with relatively worse health risk or higher claims experience. The consequence, therefore, is that an employer with a relatively sicker, chronically ill or higher risk employee population will be forced to reduce coverage to a greater extent than another employer solely because of the 40 Percent Tax.

As a result, the individuals for whom comprehensive coverage is most needed may be forced into relatively lower value coverage that leaves them underinsured and/or with significant out-of-pocket exposure. Such a result seems contrary to public policy and the goals of PPACA. If left unresolved, the Council is concerned that the current cost-based system could result in unjust discrimination against employees with increased health risks, including those who are disabled and chronically ill.

Second, the contemplated cost-based rule does not provide a specific adjustment for geographic differences. Accordingly, as above, two identical plans could have very different cost determinations for purposes of Code Section 4980I solely because one of the plans covers employees in relatively higher cost areas, such as employees located in higher cost metropolitan cities or rural areas where there may be a lower concentration of qualified medical professions and, thus, increased costs. Unless the Department establishes safe harbor methodologies or otherwise provide for a geographic adjustment to plan cost, employers with employees in these higher cost areas may be required to reduce the extent of coverage for these employees and their families as a result of the 40 Percent Tax. These families will then only have access to limited coverage and, as a result, will have to bear greater out-of-pocket medical expenses.

Third, employers of all sizes, including small employers, are subject to Code Section 4980I. Thus, it is imperative that the Department establish rules that will be easy for employers to implement and administer. The Council is very concerned that the contemplated cost-based methodology will be very difficult and costly for employers to administer. This is especially so for small employers that may lack resources or access to qualified experts who can assist with the administration of the 40 Percent Tax. The establishment of safe harbor methodologies (such as those based on actuarial value or other) could help reduce the burdens on employers posed by the 40 Percent Tax, reduce administrative complexity, and foster increased compliance.

Fourth, 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 Sections 4980I and the employer shared responsibility provisions of Code Section 4980H. As discussed below, the Council believes this dilemma is due in significant part to 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) – as well as the insufficient indexing of the thresholds. The establishment of appropriate safe harbor methodologies, including those set forth below, could help reduce and/or eliminate the likelihood that employers will eventually have to choose between incurring an excise tax liability under Code Section 4980I or under Code Section 4980H.

In light of the foregoing, the Council strongly supports the establishment of safe harbor alternatives to the contemplated cost-based methodology for purposes of determining any 40 Percent Tax liability, including the following:

- *AV-Based Safe Harbor:* The Council is very supportive of a safe harbor methodology whereby a plan does not trigger the 40 Percent Tax if its actuarial value ("AV") is less than 90 percent.

  The use of an AV-based safe harbor will ensure that employers with plans with similar AV ratings are treated the same under Code Section 4980I. Moreover, employers would not be disadvantaged solely because of the geographic location of their operations or because of the health factors of their employees. The use of an AV-based safe harbor also should help ensure that employers are not discouraged from offering multiple plan options or benefit packages. Additionally, this safe harbor would foster compliance with Code Section 4980I by decreasing the administrative complexity and burdens associated with the 40 Percent Tax calculation.

  In support of the establishment of an AV-based safe harbor, the Council notes that per the terms of PPACA and related guidance, issuers of small group coverage on the Small Business Health Options Program ("SHOP") generally are required to offer gold (and silver) level plans. It would seem without reason for Congress and the regulators to require issuers on the SHOP to offer plans that could result in a small employer being subject to the 40 Percent Tax.

  Accordingly, the Council believes a safe harbor for plans with AV of 90 percent or below is supported by Congress' own actions in requiring issuers participating in a SHOP to offer gold and platinum level plans to small employers – certainly such plans should not be subject to the 40 Percent Tax.

- *FEHBP Safe Harbor.* The Council also supports adoption of a safe harbor rule based upon the cost of coverage for the Blue Cross/Blue Shield standard option under the Federal Employees Health Benefits Program ("FEHBP"). Under this contemplated approach, employers could choose to measure the aggregate cost of applicable employer-sponsored coverage with respect to an employee against either (i) the applicable annual limitations of Code Section 4980I(b)(3) or (ii) the cost of coverage for the Blue Cross/Blue Shield standard option in the applicable tax year.

  In support of this safe harbor methodology, the Council notes that Code Section 4980I repeatedly references the Blue Cross/Blue Shield standard option. Moreover, the fact that Congress chose to provide for an initial "health cost adjustment percentage" to the 2018 annual limitations based upon the costs of the Blue Cross/Blue Shield standard option indicates Congress' acknowledgment that coverage costing less than the Blue Cross/Blue Shield standard option under the FEHBP should not trigger a 40 Percent Tax liability.

The Council's member survey results indicate broad support specifically for the use of an AV-based safe harbor. These comments reflect the fact that the AV-based safe harbor would significantly reduce the administrative complexity of complying with the 40 Percent Tax provisions. Additionally, because it treats all plans equally regardless of geographic difference or differences in claims risk or experience, the use of such a safe harbor seems appropriate from the perspective of not only sound tax administration but also tax equity and fairness. Safe harbor provisions can also provide important assurances that specific plan designs are below benefit levels that would trigger the 40 Percent Tax, creating stability and eliminating uncertainty for employers and their participants.

Attached, as an appendix to the letter, is an analysis undertaken for the Council by Ernst and Young LLP, demonstrating when certain plans required by PPACA will hit the 40 Percent Tax thresholds. Because PPACA generally requires issuers operating in the SHOP to offer silver and gold level coverage, the analysis estimates when such plans will trigger the tax. The analysis projects that gold level plans offered on the SHOP in half of 8 relatively high-cost local areas will be subject to the 40 Percent Tax immediately when it goes into effect in 2018. By 2025, 6 out of 8 areas are above the threshold and by 2030 all areas are above the threshold. This analysis validates the vital need for a safe harbor that would ensure plans with an actuarial value of 90 percent or below – including these gold (and silver) plans which are required to be offered on the SHOP – will not trigger the 40 Percent Tax.

It is clear that the contemplated cost-based methodology does not comport with the principles of tax equity and tax administration. The methodology, if not paired with appropriate safe harbors, will result in disparate treatment for employers as well as reduced coverage and increased out-of-pocket exposure for employees in higher-cost areas as well as for the disabled or chronically ill. For the foregoing reasons, the Council strongly recommends the establishment of safe harbor methodologies for purposes of determining the extent of 40 Percent Tax liability.

In Applying the Age and Gender Adjustments, Employers Should Be Permitted to Consider Age and Gender Demographics Based on Plan Eligibility or Enrollment; Timely and Reliable Information from the Department Is Important.

Code Section 4980I(b)(3)(C)(iii) provides for a potential age and gender adjustment to the dollar limits equal to the excess, if any, of (i) the premium cost of the Blue Cross/Blue Shield standard benefit option under the FEHBP for the type of coverage provided such individual in a taxable period if priced for the age and gender characteristics of all employees of an individual's employer, over (ii) that premium cost for the provision of such coverage under such option in such taxable period if priced for the age and gender characteristics of the national workforce.

The Council requests that the Department provide tables or other information with respect to each tax year that could be used by employers for purposes of determining whether the age and/or gender adjustment might be applicable. It is imperative that employers be able to calculate and determine the application of these adjustments in a timely basis so that they may reflect it in their plan design for a given year. Accordingly, the Council requests that any relevant information be provided in a timely manner so that the employer can reflect the adjustment (or lack thereof) in any final plan design or benefit offerings for the tax year at issue.

GUIDANCE CONFIRMING THAT EMPLOYERS HAVE BROAD DISCRETION IN TREATING RETIREES THAT HAVE ATTAINED AGE 65 AND THOSE THAT HAVE NOT ATTAINED AGE 65 AS SIMILARLY SITUATED EMPLOYEES WOULD BE APPRECIATED.

Code Section 4980I(d)(2)(A) states in relevant part that "[t]he cost of applicable employer-sponsored coverage shall be determined under rules similar to the rules of section 4980B(f)(4)" (i.e., the rules that apply for purposes of determining the COBRA "applicable premium"). Code Section 4980B(f)(4) in turn provides that the applicable premium is "the cost to the plan . . . for similarly situated beneficiaries with respect to whom a qualifying event has not occurred." Code Section 4980I provides that, for purposes of the 40 Percent Tax, "[i]n the case of applicable employer-sponsored coverage which provides coverage to retired employees, the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries." Notice 2015-16 requests comments on whether additional guidance would be beneficial with respect to this provision. The Council would appreciate guidance confirming that employers will have broad discretion in using the statutory right to aggregate retirees that have attained age 65 and those that have not yet attained age 65.

THE ANNUAL DOLLAR ADJUSTMENT FOR HIGH-RISK PROFESSIONALS AND ELECTRICAL AND TELECOMMUNICATION WORKERS SHOULD BE CONSTRUED TO REDUCE ADMINISTRATIVE BURDENS AND THE EXTENT OF POTENTIAL DISRUPTIONS IN BENEFITS AND/OR BENEFIT REDUCTIONS BY REASON OF THE 40 PERCENT TAX.

Code Section 4980I(b)(3)(C)(iv) provides a dollar adjustment to the annual limitations "in the case of an individual who is a qualified retiree or who participates in a plan sponsored by an employer the majority of whose employees covered by the plan are engaged in a high-risk profession or employed to repair or install electrical or telecommunication lines." Code Section 4980I(f)(3) defines the term "high-risk profession" for this purpose. Notably, such term includes an employee who is retired from a high-risk profession described in the preceding sentence, if such employee

satisfied the requirements of such sentence for a period of not less than 20 years during the employee's employment**.**

Notice 2015-16 requests comments regarding Code Section 4980I(b)(3)(C)(iv). Specifically, the Notice requests, in part, comments on how an employer determines whether the majority of employees covered by a plan are engaged in a high-risk profession (or presumably employed to repair or install electrical or telecommunication lines) and what the term "plan" means in that context. Comments are also requested on whether further guidance on the definition of "employees engaged in a high risk profession" would be beneficial, taking into consideration that various categories set forth in Section 4980I(f)(3) are determined by laws not under the jurisdiction of the Department.

In response to this request for comments, the Council recommends the adoption of a proposed rule that would allow an employer to avail itself of the dollar adjustment if at least a majority of its employees are engaged in a "high-risk" profession, or engaged to repair or install electrical or telecommunication lines, regardless of such employees' actual eligibility or enrollment in a given plan. A rule that requires an employer to look at actual plan eligibility or enrollment would be incredibly difficult to administer – and perhaps to meet – since employers may offer coverage to these categories of employees across numerous plans or benefits packages. Moreover, because actual plan eligibility and enrollment rates will vary from year to year, there would be the possibility that an employer could find itself unable to qualify for the dollar adjustment for a given year because less than the requisite percentage of qualifying individuals are eligible or enrolled in the plan.

It is very important that plans be able to reasonably anticipate the continued application for a multi-year period of any dollar adjustments provided by Code Section 4980I, including by reason of Code Section 4980I(b)(3)(C)(iv). Otherwise, employers could be required to materially reduce benefits with respect to a given year in order to stay below the applicable annual limitation. This obviously has the potential to be very disruptive for employees and employers alike and should be avoided.

In light of the foregoing, in determining a "majority" for purposes of Code Section 4980I(b)(3)(C)(iv), the Council strongly urges the Department to adopt a rule that looks solely at employment of qualifying high-risk professionals or employees engaged in the installation or repair of electrical or telecommunications lines, and not at plan eligibility and/or enrollment. If, however, the Department concludes that the statute compels consideration of actual eligibility or enrollment, the Council requests that the Department adopt a rule that would permit an employer to determine the requisite majority based upon actual enrollment or eligibility, at its discretion. Additionally, we urge the Department to adopt a rule that would allow employers to continue to apply the dollar adjustment even if a plan's enrollment and/or eligibility rates, as applicable, dips below the requisite threshold, so long as the employer reasonably believes in good

faith that high-risk professionals and/or individuals employed to repair or install electrical or telecommunication lines will again constitute at least a majority in the near future.

Relatedly, the Council supports issuance of a proposed rule that clarifies that an individual "employed to repair or install electrical or telecommunication lines" includes not only the employee that actually physically handles such lines, but also (i) any employee who goes into the field to assist with such repair or installation and (ii) any employee whose job, by classification (versus measured hours), is to support the business of repairing or installing such lines. The Council believes such a clarification is necessary to facilitate administration of, and compliance with, the rules of Code Section 4980I.

The Council also urges the Department to clarify in rulemaking that the dollar adjustment applies to all individuals covered by the plan at issue so long as the requisite majority standard is satisfied. Such a clarification is supported by congressional intent in enacting Code Section 4980I(b)(3)(C)(iv) as well as public policy. On its face, the provision of the dollar adjustment is based on Congress' recognition that high-risk professionals and employees in the telecommunication and electrical industries may have higher claims risk or claims experience. Thus, an increased annual limitation should be provided for purposes of the 40 Percent Tax. Given that employers typically do not charge employees different rates based upon their specific work activities, all individuals covered under these employers' plans will be subject to increased premiums as a result of higher claims risk or claims experience on account of their colleagues who are high-risk professionals or who install or repair electrical and telecommunication lines. Accordingly, it makes good policy sense to construe the statute to apply the dollar adjustment of Code Section 4980I(b)(3)(C)(iv) to all individuals enrolled in the plan or plans at issue.

We note that the literal language of Code Section 4980I(b)(3)(C)(iv) accords with this reasoning. Specifically, Code Section 4980I(b)(3)(C)(iv) provides for a dollar adjustment:

> ***In the case of an individual*** who is a qualified retiree ***or who participates in a plan*** sponsored by an employer the majority of whose employees covered by the plan are engaged in a high-risk profession or employed to repair or install electrical or telecommunications lines.
>
> (emphasis added)

As the highlighted language above is intended to demonstrate, the statute is clear on its face that the dollar adjustment applies to each individual "who participates" in the plan and not merely those employees who are engaged in a high-risk profession or who are employed to repair or install electrical or telecommunications lines. In light of the foregoing, we also urge the Department to clarify in any rulemaking that the dollar

adjustment provided by Code Section 4980I(b)(3)(C)(iv) applies to all individuals covered by the plan at issue so long as the requisite majority standard is satisfied.

PLANS SHOULD NOT TRIGGER THE 40 PERCENT TAX MERELY BY OFFERING AFFORDABLE, MINIMUM VALUE COVERAGE THAT SATISFIES THE REQUIREMENTS OF CODE SECTION 4980H.

As noted above, Council believes that there will come a point at which plans that seek to avoid an excise tax under Code Section 4980H by "playing" instead of "paying" will not be able to simultaneously avoid an excise tax under Code Section 4980I. In order to alleviate this issue, 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 liable for one of two 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 "play" for purposes of 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 would put employers in an untenable situation, threatening the vital employer-sponsored health coverage of over 150 million Americans. For these reasons, the Council requests the establishment of a safe harbor rule providing that an employer shall not incur any 40 Percent Tax liability solely for providing to its employee population the minimum level of coverage necessary to avoid an excise tax liability with respect to Code Section 4980H.

In light of the foregoing, the Council urges the Department to resolve this dilemma through the establishment of one or more of the proposed safe harbor valuation methodologies described above. As mentioned, these safe harbor methodologies should reduce the likelihood that any employer will need to make the unenviable choice of between having to incur an excise tax liability under either Code Section 4980H or Code Section 4980I.

*   *   *

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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Appendix: Comparing the Marketplace Qualified Health Plans to the 40 Percent Tax Thresholds

The Patient Protection and Affordable Care Act (PPACA) provides different indications of what is considered a minimum level of acceptable health care coverage – not high-cost coverage, just a minimum level of coverage. For individuals purchasing coverage on the Health Insurance Marketplace (Marketplace), PPACA uses the second-lowest cost silver plan available as the index on which to base the amount of the premium tax credit[1] – and for certain low-income individuals, PPACA couples the premium tax credit with additional cost-sharing subsidies to help offset out of pocket costs and enhance the value of the plans for these individuals. Additionally, health insurance issuers that are certified to issue qualified health plans (QHPs) on the individual Marketplace, generally must offer silver and gold level coverage on the Small Business Health Options Program (SHOP) Marketplace.[2] Finally, large employers are required to offer their full-time employees coverage that meets a "minimum value" standard, which is approximately a 60 percent actuarial value, or potentially face a 40 Percent Tax liability.[3]

It seems implausible that a silver level plan that sets the premium tax credit subsidy index, or the silver and gold level plans that insurers are required to offer on the SHOP Marketplace, or the minimum value plans that employers must offer to employees to avoid the employer shared responsibility tax, are the types of "high-cost" plans that may become subject to the 40 Percent Tax.

If left unchecked, there is a good chance that, in some locations, plans at these levels of benefits will trigger the 40 Percent Tax. Starting in 2018, the 40 Percent Tax will apply to the aggregate cost of applicable employer-sponsored coverage in excess of certain dollar thresholds ($10,200 for self-only coverage and $27,500 for other than self-only coverage, as adjusted). Over time, as per-capita health care costs are projected to rise more quickly than the 40 Percent Tax thresholds, the gap between these plans and the "high-cost" threshold narrows and in some cases ultimately disappears.

These types of plans are not "high-cost" plans. For example, silver plans in the individual and SHOP Marketplaces are objectively below-average in benefit generosity among health plans nationally. They typically have at least $2,000/$4,000 (single/family) in deductibles, which is well above U.S. average employer-provided deductibles of

[1] Section 36B of the Internal Revenue Code.

[2] 45 CFR § 156.200(g).

[3] Section 4980H of the Internal Revenue Code.

$1,213/$2,357 in 2013.[4] Coinsurance, copayments and out-of-pocket maximums for these plans are also typically above national averages for employer-based coverage. The Federal Marketplace's own website (Healthcare.gov) describes silver plans as recommended for people that don't expect to use regular medical services and don't take regular prescriptions.[5]

But in certain high-cost local areas, the second-lowest cost silver plans can be expensive relative to average premiums nationally. Table 1 below shows the annual premium in 2015 for the second-lowest cost silver plan in the SHOP Marketplace for 8 relatively high-cost local areas.[6] The premiums shown are for single coverage for a 50-year old individual, which was chosen to approximate the average cost of insured workers in employer-provided coverage in the U.S.[7] Also in Table 1, and in the corresponding chart below it, is a projection of such silver plan premiums over time compared to the projected 40 Percent Tax threshold. Silver plan premiums in the projection are grown according to the Marketplace premium growth assumptions of the Congressional Budget Office (CBO).[8] The 40 Percent Tax thresholds are grown according to CBO's economic forecast for Consumer Price Index-Urban (CPI-U) inflation.[9] Shaded premiums are above the threshold in the year shown.

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[4] Source: Medical Expenditures Panel Survey, Insurance Component (MEPS-IC), AHRQ.

[5] Source: https://www.healthcare.gov/choose-a-plan/plans-categories/

[6] Source: Healthcare.gov

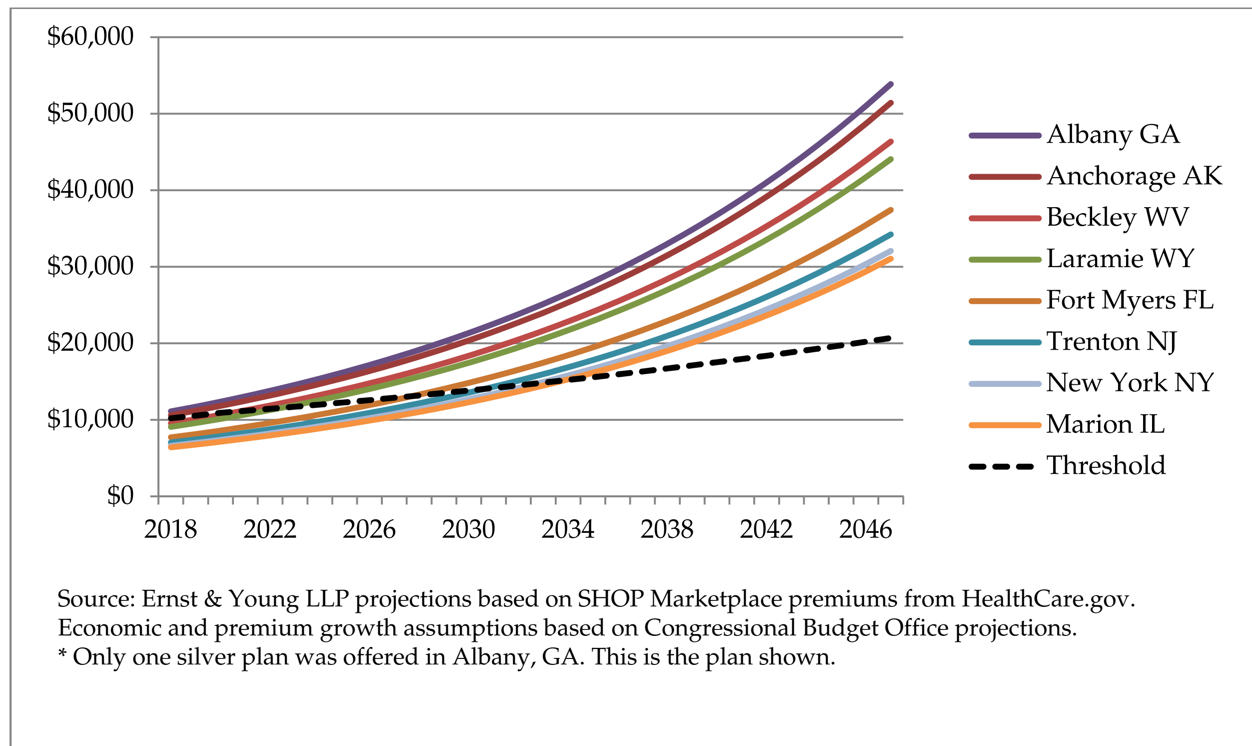
[7] This approximation was based on Current Population Survey data on workers covered by their own employment-based insurance and Society of Actuaries/Health Care Cost Institute age-cost curves.

[8] 8.5% annual growth in premiums 2016-2018, 5.6% annual growth in subsequent years. Note that premiums in the table are grown through 2040 at the same rate of growth (5.6%), while CBO only projects through 2025. Source: Congressional Budget Office, Updated Budget Projections: 2015 to 2025, March 2015,

[9] CBO, *The Budget and Economic Outlook: 2015 to 2025*, January 2015.

Table 1. Second-lowest cost silver plans in the SHOP Marketplace: current and projected premiums, in selected high-cost local areas

Location	2015	2018	2025	2030	2035	First year of 40 percent tax liability
Excise tax threshold:		$10,200	12,278	13,824	15,565	
Albany, GA*	$8,688	11,097	16,250	21,339	28,022	2018
Anchorage, AK	$8,292	10,591	15,509	20,366	26,745	2018
Beckley, WV	$7,476	9,549	13,983	18,362	24,113	2021
Laramie, WY	$7,104	9,074	13,287	17,449	22,913	2023
Fort Myers, FL	$6,036	7,710	11,290	14,825	19,468	2028
Trenton, NJ	$5,520	7,051	10,325	13,558	17,804	2031
New York, NY	$5,169	6,603	9,669	12,697	16,673	2033
Marion, IL	$5,004	6,392	9,360	12,291	16,140	2034

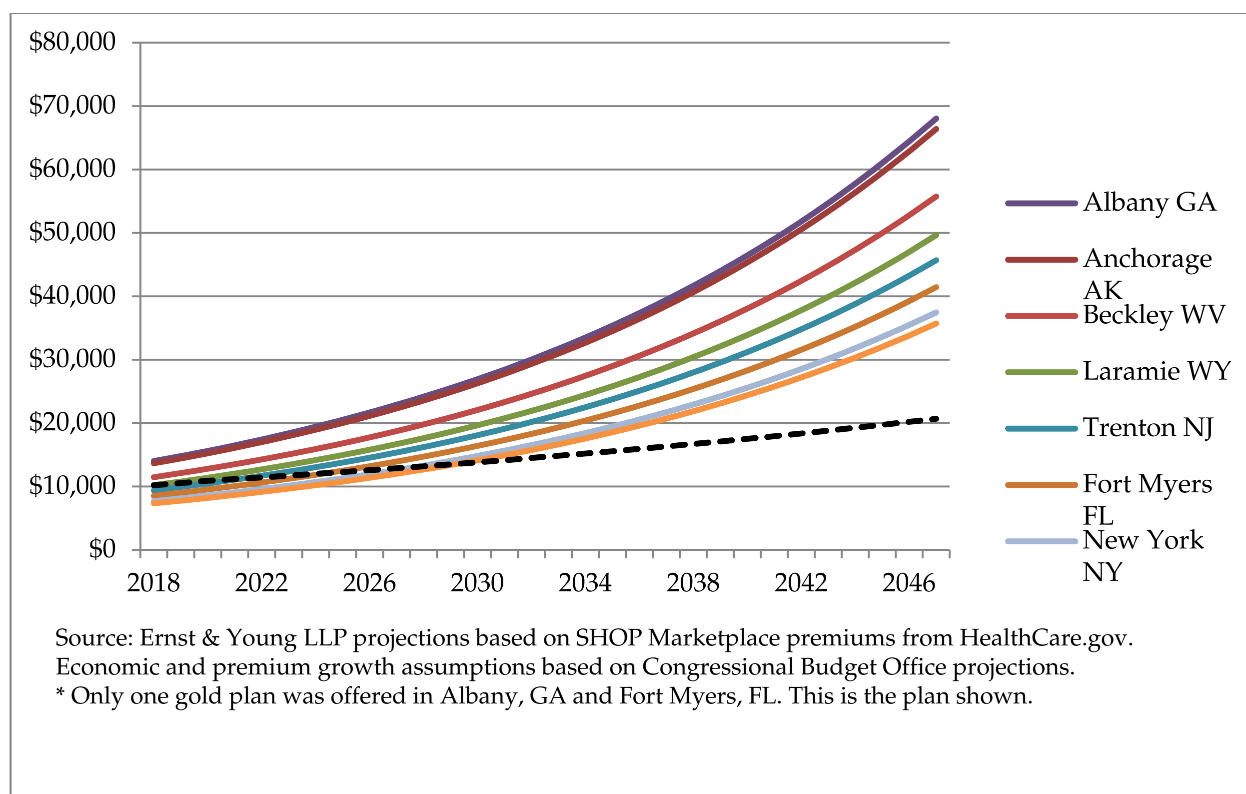


Source: Ernst & Young LLP projections based on SHOP Marketplace premiums from HealthCare.gov. Economic and premium growth assumptions based on Congressional Budget Office projections.
* Only one silver plan was offered in Albany, GA. This is the plan shown.

For the two highest-cost areas shown, the silver plan premium is projected to be above the threshold from the start, in 2018. By 2025, half of the 8 local areas shown are also above threshold. By 2035, all of the silver premiums projected are higher than the 40 Percent Tax threshold. Premiums for gold plans, which generally must be offered by a health insurance issuer on the SHOP Marketplace, exceed the threshold earlier in more local areas. Using the same methods described for the silver plans, gold plan premiums were projected as shown below in Table 2 and the corresponding chart.

Table 2. Second-lowest cost gold plans in the SHOP Marketplace: current and projected premiums, in selected high-cost local areas

Location	2015	2018	2025	2030	2035	2040	First year of 40 percent tax liability
Excise tax threshold:		$10,200	12,278	13,824	15,565	17,524	
Albany, GA*	$10,968	14,009	20,515	26,939	35,376	46,454	2018
Anchorage, AK	$10,704	13,672	20,021	26,291	34,524	45,336	2018
Beckley, WV	$8,988	11,480	16,811	22,076	28,989	38,068	2018
Laramie, WY	$8,004	10,223	14,971	19,659	25,816	33,900	2018
Fort Myers, FL*	$7,368	9,411	13,781	18,097	23,764	31,206	2022
Trenton, NJ	$6,684	8,537	12,502	16,417	21,558	28,309	2025
New York, NY	$6,040	7,715	11,297	14,835	19,481	25,582	2028
Marion, IL	$5,760	7,357	10,774	14,147	18,578	24,396	2030



Source: Ernst & Young LLP projections based on SHOP Marketplace premiums from HealthCare.gov. Economic and premium growth assumptions based on Congressional Budget Office projections.
* Only one gold plan was offered in Albany, GA and Fort Myers, FL. This is the plan shown.

Gold plans offered on the SHOP in half of the areas shown will be subject to the 40 Percent Tax immediately when it goes into effect in 2018. By 2025, 6 out of 8 areas are above the threshold and by 2030 all areas are above the threshold.

As group plans that are offered to employers, the SHOP plan premiums might provide a reasonable approximation of premiums for similar plans offered by other employers. However, unlike the individual Marketplace, which has a larger risk pool of

enrollees and a larger number of health plan options, the SHOP Marketplace have smaller pools of enrollees and fewer insurance options. In light of the SHOP Marketplaces' more limited success, a similar analysis was performed comparing the projected 40 Percent Tax threshold to the projected individual Marketplace premiums at the silver and gold levels in 14 high-cost areas. Overall, the application of the individual Marketplace premium projections compared to the excise tax threshold produced results that are qualitatively similar to those shown here for the SHOP Marketplace premiums.