

American Benefits Council

Benefits Briefing: IRS Notice 2015-16

April 7, 2015

Seth Perretta
Principal



Overview of the Excise Tax

- 40% nondeductible excise tax
- Effective beginning with 2018 tax year
- Applies to employer-sponsored group coverage (with limited exceptions)
- The tax raises a host of legal and business issues for employers as well as carriers and ASOs
- The IRS and Treasury are just now starting the rulemaking and comment process

Current State of IRS/Treasury Rulemaking

- Statutory language of IRC section 4980I
- IRS recently issued Notice 2015-16
 - Comments due by May 15, 2015
 - Indicates planned issuance of follow-on notice (expected late spring/early summer)
- Proposed and final regulations to follow in sequence

Current State of IRS/Treasury Rulemaking

This notice describes potential approaches with regard to a number of issues under § 4980I, which could be incorporated in future proposed regulations, and invites comments on these potential approaches. The issues addressed in this notice primarily relate to (1) the definition of applicable coverage, (2) the determination of the cost of applicable coverage, and (3) the application of the annual statutory dollar limit to the cost of applicable coverage. The Department of the Treasury (Treasury) and the Internal Revenue Service (IRS) invite comments on the issues addressed in this notice and on any other issues under § 4980I.

Current State of IRS/Treasury Rulemaking

Treasury and IRS anticipate issuing another notice, before the publication of proposed regulations under § 4980I, describing and inviting comments on potential approaches to a number of issues not addressed in this notice, including procedural issues relating to the calculation and assessment of the excise tax. After considering the comments on both notices, Treasury and IRS anticipate publishing proposed regulations under § 4980I. The proposed regulations will provide further opportunity for comment, including an opportunity to comment on the issues addressed in the preceding notices.

"Background"

- Lots of statements contained in the "Background" section regarding the statutory language of IRC section 4980I
- These statements appear to be intended to be non-interpretive
- For example:
 - States that tax applies to coverage under any group health plan that "is excludable from the employee's gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106)"

"Background"

- Other statements:
 - 40% nondeductible excise tax on any excess benefit provided to an employee
 - Excess benefit is the excess, if any, of the aggregate cost of the applicable coverage of the employee for the month over the applicable dollar limit
 - The term "employee" includes a former employee, surviving spouse, or other "primary insured" individual

"Background"

- Other statements (cont'd):
 - Cost of applicable coverage is determined under rules "similar to the rules of [COBRA]."
 - In determining the cost of coverage for purposes of the tax, any amount attributable to the tax itself is not taken into account
 - The amount of the tax is to be determined separately for self-only and other-than-self-only coverage
 - The statute prescribes special rules for determining the cost of applicable coverage for retirees, health FSAs, Archer MSAs and HSAs

"Background"

- Other statements (cont'd):
 - The statute "specifies per-employee baseline dollar limits for 2018 (\$10,200 for self-only coverage and \$27,500 for other-than-self-only coverage)
 - The baseline dollar limit that applies is based upon the coverage provided to the employee as of the beginning of the month
 - An employee is treated as having self-only coverage unless the coverage:
 1. Is at least minimum essential coverage (MEC);
 2. Is being provided to the employee and at least one other beneficiary; and
 3. The benefits do not vary based upon whether the covered person is employee or another beneficiary

"Background"

- Other statements (cont'd):
 - These baseline dollar limits are subject to a "health cost adjustment percentage" for 2018
 - The baseline dollar limits are subject to annual indexing thereafter
 - The statute provides for various adjustments to increase the applicable dollar limit in certain instances, including age and gender
 - There is also an adjustment for 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

"Background"

- Other statements (cont'd):
 - The entity that "shall pay" the tax is:
 1. The "health insurance issuer" regarding insured coverage
 2. The "employer" regarding employer contributions to an Archer MSA or HSA
 3. The "person that administers the plan" in the case of any other applicable coverage

Definition of Applicable Coverage

- Notice restates aspects of statute:
 - Applies to any group health plan "which is excludable from the employee's income under section 106 or would be so excludable if it were employer-provided (within the meaning of such section 106)"
 - Quotes other part of statute, which states that coverage gets counted "without regard to whether the employer or employee pays for the coverage"
 - Also quotes similar language from JCT Technical Explanation

Definition of Applicable Coverage

- Notice restates aspects of statute:
 - Coverage includes coverage under a group health plan for self-employed individuals

Definition of Applicable Coverage

- As mentioned, the Notice restates the general definition of applicable coverage from the statute
- Then the Notice goes on to state that "other subsections of § 4980I explicitly address the following types of coverage and indicate that they constitute applicable coverage."
 - Health FSAs
 - Archer MSAs/HSAs (other than after-tax employee contributions)
 - Governmental plans
 - Coverage for on-site medical clinics
 - Retiree coverage
 - Multiemployer plans
 - HIPAA-excepted hospital or fixed indemnity coverage if paid for with after-tax dollars

Definition of Applicable Coverage

- The Notice explains that the statute "also lists certain types of coverage that are excluded" from applicable coverage:
 - Accident coverage or disability income insurance (or combination thereof) (Code section 9832(c)(1)(A))
 - Supplemental coverage to liability insurance (Code section 9832(c)(1)(B))
 - Liability insurance, including general or automobile (Code section 9832(c)(1)(C))
 - Workers' compensation or similar insurance (Code section 9832(c)(1)(D))
 - Automobile medical payment insurance (Code section 9832(c)(1)(E))
 - Credit-only insurance (Code section 9832(c)(1)(F))
 - Other insurance coverage, as specified in regulations, that is similar and under which benefits for medical care are secondary to other insurance benefits (Code section 9832(c)(1)(H))

Definition of Applicable Coverage

- The Notice explains that the statute "also lists certain types of coverage that are excluded" from applicable coverage (**cont'd**):
 - Coverage, whether through insurance or otherwise, for long-term care
 - Coverage "under a separate policy, certificate, or contract of insurance" which provides benefits substantially all of which are for the treatment of the mouth or eye
 - HIPAA-excepted specified disease coverage if paid with after-tax dollars (Code section 9832(c)(3))
 - HIPAA-excepted hospital or fixed indemnity coverage if paid for with after-tax dollars (Code section 9832(c)(3))

Definition of Applicable Coverage

- HSAs and Archer MSAs

Treasury and IRS anticipate that future proposed regulations will provide that (1) employer contributions to HSAs and Archer MSAs, including salary reduction contributions to HSAs, are included in applicable coverage, and (2) employee after-tax contributions to HSAs and Archer MSAs are excluded from applicable coverage.

Section 4980I(d)(2)(C) includes a special rule for determining the cost of coverage under HSAs and Archer MSAs. This rule provides that “in the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of the employer contributions under the arrangement.” Employer contributions to an HSA or Archer MSA are excludable under subsection (d) or (b), respectively, of § 106, and therefore are applicable coverage. This includes employee pre-tax salary reduction contributions to an HSA, which are treated as employer contributions for purposes of § 106 and are excludable under § 106(d).

In contrast, employee after-tax contributions to an HSA or Archer MSA are not excludable under § 106 but rather are deductible by an employee under § 223 (HSAs) or § 220 (Archer MSAs). Therefore, employee after-tax contributions to HSAs and Archer MSAs are not employer contributions under §§ 106(b) or (d). Accordingly, employee after-tax contributions to HSAs and Archer MSAs are not applicable coverage.

Definition of Applicable Coverage

- On-site medical clinics
 - Regulators acknowledge express statutory carve-out for on-site medical clinics from the definition of excepted coverages as listed in Code section 9832(c)(1)
 - But Notice goes on to state:
 - "Treasury and IRS, however, anticipate that the forthcoming proposed regulations will provide that applicable coverage does not include on-site medical clinics that offer only **de minimis** medical care to employees."

Definition of Applicable Coverage

- On-site medical clinics (cont'd)
 - Regulators look to JCT report and COBRA regulations for support for excepting certain on-site medical clinics

Treasury and IRS note that COBRA regulations provide that “[t]he provision of health care at a facility that is located on the premises of an employer or employee organization does not constitute a group health plan if—(1) [t]he health care consists primarily of first aid that is provided during the employer's working hours for treatment of a health condition, illness, or injury that occurs during those working hours; (2) [t]he health care is available only to current employees; and (3) [e]mployees are not charged for the use of the facility.” Treas. Reg. § 54.4980B-2, Q&A-1(d).

Definition of Applicable Coverage

- On-site medical clinics (cont'd)
 - But regulators are requesting comments on the treatment of on-site clinics that also provide some additional services

In addition, Treasury and IRS seek comment on the treatment of clinics that meet the criteria described in the COBRA regulations and provide certain services in addition to (or in lieu of) first aid, for example: (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).

Comments are requested on how Treasury and IRS should treat medical care in the case of on-site medical clinics, including whether the standard should be based on the nature and scope of the benefits or denominated as a specific dollar limit on the cost of services provided, or some combination of these two standards. In addition, comments are requested on how to determine the cost of coverage provided by an on-site medical clinic that is applicable coverage.

Definition of Applicable Coverage

- Limited scope dental and vision benefits
 - Notice acknowledges statutory language regarding exception for coverage provided "under a separate policy, certificate, or contract of insurance"
 - BUT, Notice goes on to state that "[a]s previously noted, generally whether coverage is insured or self-insured is not relevant" for purposes of the tax
 - THEREFORE....

Treasury and IRS are considering whether to exercise their regulatory authority under § 4980I(g) to propose an approach under which self-insured limited scope dental and vision coverage that qualifies as an excepted benefit pursuant to the recently issued regulations under § 9831 would be excluded from applicable coverage for purposes of § 4980I. See Treas. Reg. § 54.9831-1(c)(3). Comments are requested on any reasons why Treasury and IRS should not implement this approach.

Definition of Applicable Coverage

- Employee Assistance Plans (EAPs)

Under recently issued regulations, the Departments added employee assistance programs (EAPs) that meet certain criteria to the list of excepted benefits to ensure that employers are able to continue to offer certain EAPs as benefits that are supplemental to other coverage. Treas. Reg. § 54.9831-1(c)(3)(vi) (79 FR 59130, 59133).]

Treasury and IRS are considering whether to exercise authority under § 4980I(g) to propose that EAPs that qualify as an excepted benefit pursuant to the recently issued regulations under § 9831 would be excluded from applicable coverage for purposes of § 4980I. Comments are requested on any reasons why Treasury and IRS should not implement this approach.

Definition of Applicable Coverage

- Employee Assistance Plans (EAPs)
 - HIPAA-excepted EAPs:
 - The program does not provide significant benefits in the nature of medical care (including with respect to amount, scope and duration)
 - The benefits under the employee assistance program are not coordinated with benefits under another group health plan
 - No employee premiums or contributions are required as a condition of participation in the employee assistance program
 - There is no cost sharing under the employee assistance program

Definition of Applicable Coverage

- Wellness programs
 - **Not** specifically addressed in the Notice
 - Unless specifically excepted, would appear to have to get counted **if** constitute a "group health plan"
 - Some wellness programs may **not** constitute a "group health plan"
 - Are there services or benefits provided that could qualify as Code section 213 medical care?
 - Are the incentives tied to premium subsidies or surcharges, or are the incentives contributions to medical savings accounts?
 - If the wellness program is bundled with a major medical plan, then may already be valued as part of valuing medical plan
 - Questions regarding how to value a wellness program if it is a group health plan
 - How do wellness incentives affect valuation and/or tax liability?

How to Value Coverage

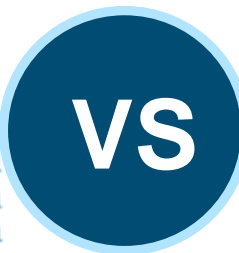
- Issue of "enrolled" versus "made available"

(b) Excess benefit

For purposes of this section—

(1) In general

The term "excess benefit" means, with respect to any applicable employer-sponsored coverage made available by an employer to an employee during any taxable period, the sum of the excess amounts determined under paragraph (2) for months during the taxable period.



§ 49801. Excise tax on high cost employer-sponsored health coverage

(a) Imposition of tax

If—

(1) an employee is covered under any applicable employer-sponsored coverage of an employer at any time during a taxable period, and

(2) there is any excess benefit with respect to the coverage,

there is hereby imposed a tax equal to 40 percent of the excess benefit.

How to Value Coverage

- Notice states that the coverage to be considered is the coverage in which the "employee" is **enrolled** versus merely made available

Although other subsections of the statute refer to the coverage "made available" to the employee, §§ 49801(a) and (b) explicitly provide that the applicable coverage that is compared to the dollar limit for purposes of determining the excise tax is the applicable coverage in which the employee is enrolled, rather than coverage offered to the employee but in which the employee does not enroll (the cost of which could be above or below the dollar limit). See also JCT Report, at 65.

How to Value Coverage?

- As mentioned, the statute says coverage is to be valued using rules "similar to" COBRA
- The Notice then sets forth the general valuation methods under existing COBRA rules

(2) Determination of cost

(A) In general

The cost of applicable employer-sponsored coverage shall be determined under rules similar to the rules of section 4980B(f)(4), except that in determining such cost, any portion of the cost of such coverage which is attributable to the tax imposed under this section shall not be taken into account and the amount of such cost shall be calculated separately for self-only coverage and other coverage. In 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.

How to Value Coverage

- The Notice then goes on to address certain specific additional valuation rules contained in the statute:
 - Cost of coverage does not include "any portion of the cost of such coverage which is attributable to the tax" itself
 - Cost must be calculated separately for self-only and other-than-self-only coverage
 - Multiemployer plan coverage is to be treated as other-than-self-only coverage
 - A plan may elect to treat a pre-65 retiree and a 65+ retiree as similarly situated
 - With respect to health FSAs, the cost is equal to employee salary reduction plus employer flex contributions
 - For Archer MSAs/HSAs, cost is equal to the amount of employer contributions, including pre-tax salary reduction

Potential Approaches for Determining Cost of Coverage

C. Potential Approaches for Determining Cost of Applicable Coverage

As noted earlier, § 4980I(d)(2)(A) provides that the cost of applicable coverage is determined “under rules similar to the rules of section 4980B(f)(4)” regarding the determination of the COBRA applicable premium.

A number of issues arise in computing the COBRA applicable premium on which specific guidance has not been provided, including how to determine which nonCOBRA beneficiaries are similarly situated, the specific methods self-insured plans may use to determine the COBRA applicable premium, and how to determine the COBRA applicable premium for HRAs. This section IV.C describes potential approaches with respect to each of these issues for purposes of § 4980I.

Treasury and IRS also continue to consider whether the potential approaches described below should apply for purposes of determining the COBRA applicable premium.

Potential Approaches for Determining Cost of Coverage

- Similarly situated individuals
 - "Treasury and IRS anticipate that ... for any specific type of applicable coverage, the cost of that applicable coverage for an employee will be based on the average cost of that type of applicable coverage for that employee and all similarly situated employees"
 - Question: Is "similarly situated" determined within the single plan? Across the plans of the member company? Across the plans of the member companies within the controlled group?

Potential Approaches for Determining Cost of Coverage

- Similarly situated individuals
 - "Under the potential approach ... Each group of similarly situated employees would be determined by starting with all employees covered by a particular benefit package 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"

Potential Approaches for Determining Cost of Coverage

- Determining similarly situated individuals
 - **STEP 1:** Similarly situated employees would be determined by mandated aggregation of all employees covered by a particular benefit package provided by the employer. For this purpose a benefit package is a similar level of coverage (e.g., **low-deductible plan, PPO, HMO, high-deductible plan** – or sub-classes of one of the foregoing)



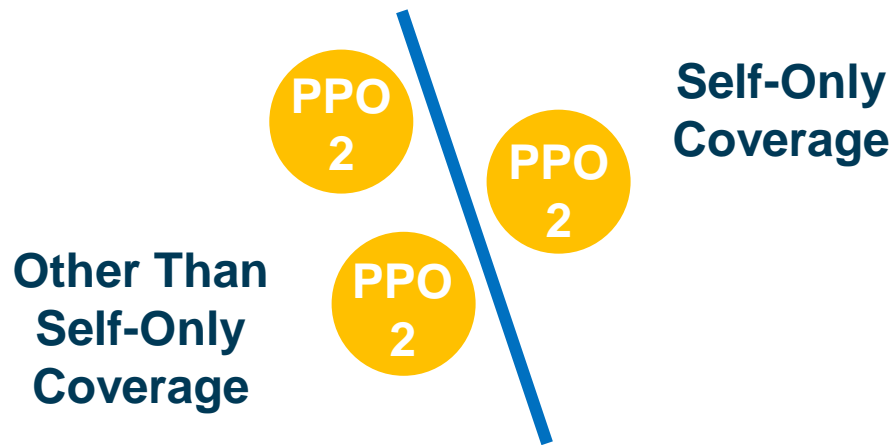
Potential Approaches for Determining Cost of Coverage

- Determining similarly situated individuals
 - **STEP 1:** Similarly situated employees would be determined by mandated aggregation of all employees covered by a particular benefit package provided by the employer. For this purpose a benefit package is a similar level of coverage (e.g., low-deductible plan, PPO, HMO, high-deductible plan – **or sub-classes of one of the foregoing**)



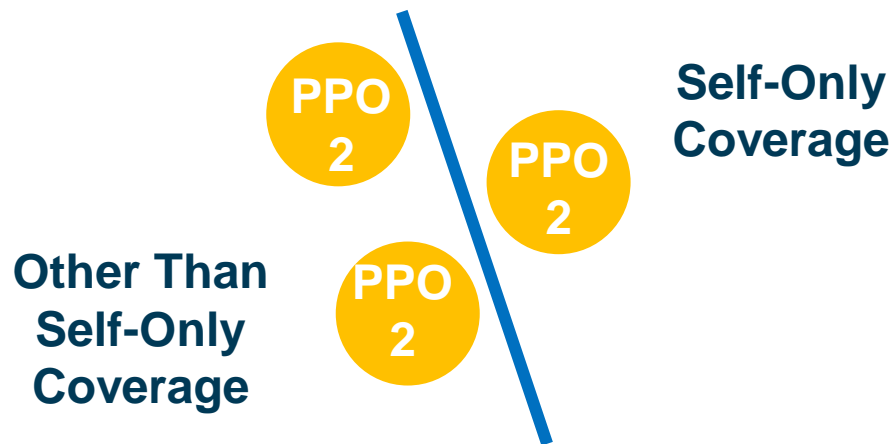
Potential Approaches for Determining Cost of Coverage

- Determining similarly situated individuals
 - **STEP 2:** After aggregating all employees covered by a particular benefit package, the employer would then be required to disaggregate the employees within the group covered by the benefit package based on whether an employee had enrolled in self-only coverage or other-than-self-only coverage



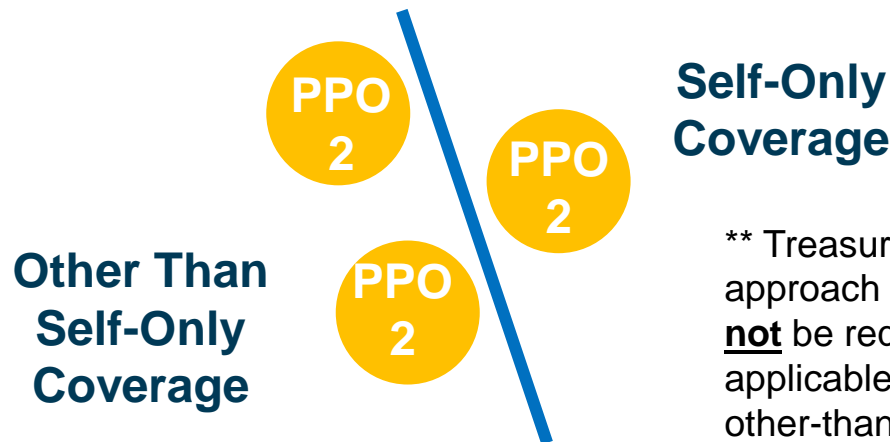
Potential Approaches for Determining Cost of Coverage

- Determining similarly situated individuals



Potential Approaches for Determining Cost of Coverage

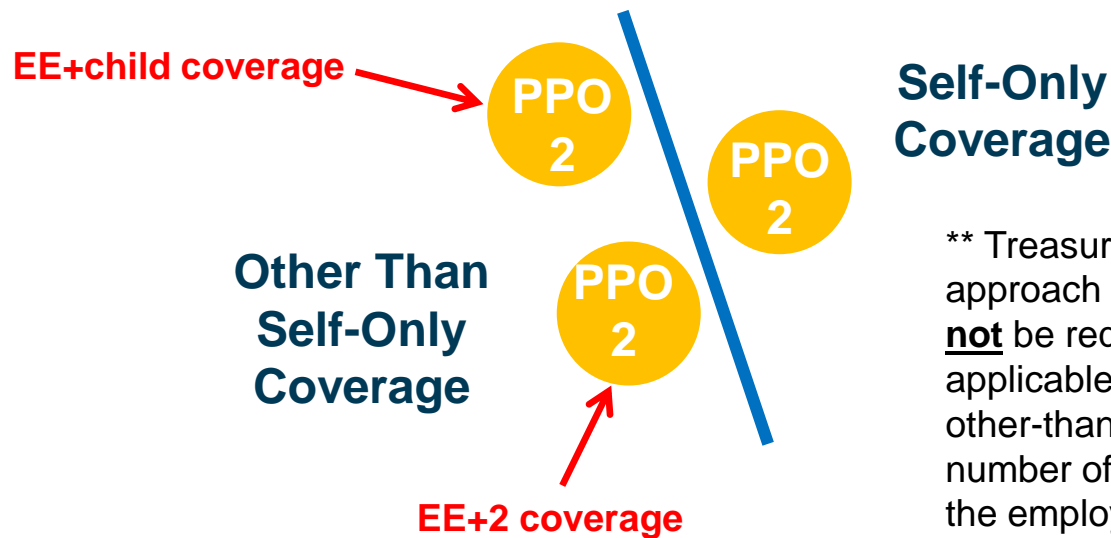
- Determining similarly situated individuals



** Treasury and IRS are considering an approach under which an employer would **not** be required to determine the cost of applicable coverage for employees receiving other-than-self-only coverage based on the number of individuals covered in addition to the employee (even if the actual cost of such coverage varied on this basis). **Under this potential approach, an employer could treat all employees who are enrolled in the same benefit package and who receive coverage for one or more individuals in addition to the employee as similarly situated for purposes of determining the cost of applicable coverage for that group.**

Potential Approaches for Determining Cost of Coverage

- Determining similarly situated individuals



** Treasury and IRS are considering an approach under which an employer would **not** be required to determine the cost of applicable coverage for employees receiving other-than-self-only coverage based on the number of individuals covered in addition to the employee (even if the actual cost of such coverage varied on this basis). **Under this potential approach, an employer could treat all employees who are enrolled in the same benefit package and who receive coverage for one or more individuals in addition to the employee as similarly situated for purposes of determining the cost of applicable coverage for that group.**

How to Value Coverage?

- Determining similarly situated individuals
 - **STEP 3:** Treasury is considering whether to provide rules for permissive disaggregation that would allow, but not require, an employer to subdivide further the group of employees that would be treated as similarly situated
 - Specifically, Treasury is considering whether disaggregation should be permitted based on:
 - **a broad standard** (such as limiting permissive disaggregation to bona fide employment-related criteria, including, for example, nature of compensation, specified job categories, collective bargaining status, etc. while prohibiting the use of any criterion related to an individual's health), **OR**
 - **a more specific standard** (such as a specified list of limited specific categories for which permissive disaggregation is allowed)

Potential Approaches for Determining Cost of Coverage

- Treasury and IRS are inviting comments on the process described above:
 - Are there areas where additional guidance would be helpful?
 - Regarding mandatory aggregation by benefit package:
 - How similar do the benefit packages need to be?
 - If differences are to be permitted, the nature and extent of such differences
 - Regarding permissive disaggregation:
 - Which approach is preferable?
 - What criteria should be permitted?
 - Is additional guidance needed regarding how to apply valuation rule with respect to combined pre-65 and 65+ retirees?

Potential Approaches for Determining Cost of Coverage

When developing comments on these approaches, stakeholders are requested to be mindful of § 4980I(d)(2)(A), which provides that the cost of applicable coverage under § 4980I is generally determined under rules similar to the rules applicable to COBRA. Accordingly, future guidance on determining the COBRA applicable premium is likely to attempt to harmonize the COBRA rules with the rules under § 4980I to the extent practicable. With respect to COBRA, allowing some employers to make distinctions that they have not previously made when offering coverage to participants and beneficiaries could result in a standard that is susceptible to abuse. A list of exclusive criteria is likely less susceptible to such abuse. However, Treasury and IRS are also concerned that, for purposes of COBRA, prohibiting any further disaggregation after mandatory disaggregation would be too restrictive because it would not allow distinctions that have traditionally been made in the group market. Although the rules for determining the cost of applicable coverage under § 4980I generally can be expected to be similar to the rules for determining the COBRA applicable premium, some differences may be appropriate. Treasury and IRS invite comments on these issues.



Potential Approaches for Determining Cost of Coverage

- The Notice also includes specific contemplated approaches regarding how to value coverage that is **self-insured**

Potential Approaches for Determining Cost of Coverage

- Statute says to use rules "similar to" COBRA valuation rules
 - Section 4980B(f)(4)(B) prescribes two methods for self-insured plans to compute the COBRA applicable premium:
 1. The actuarial basis method
 2. The past cost method

**Actuarial Basis
Method**



Plan cost is equal to a reasonable estimate of the cost of providing coverage for similarly situated beneficiaries determined on an actuarial basis, taking into account "such factors as the Secretary may prescribe in regulations"

Potential Approaches for Determining Cost of Coverage

- Statute says to use rules "similar to" COBRA valuation rules
 - Section 4980B(f)(4)(B) prescribes two methods for self-insured plans to compute the COBRA applicable premium:
 1. The actuarial basis method
 2. The past cost method

**Past Cost
Method**



The sum of (I) the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period... adjusted by (II) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12-month period ending on the last day of the sixth month of such preceding determination period

Potential Approaches for Determining Cost of Coverage

- Changing between methods
 - IRS/Treasury is concerned about possibility of abuse from frequent changes
 - IRS/Treasury is considering proposing a **COBRA** rule requiring one method be used for at least 5 years
 - With limited exception that the past cost method would not be available for use if there is a significant difference between (i) periods in coverage, or (ii) employees covered by the plan
 - IRS/Treasury is considering whether to adopt a similar standard for purposes of the excise tax
 - Comments are requested regarding:
 - Concerns about allowing an employer to use the past cost method only for years in which claims are unusually low
 - Whether allowing the use of different methods from year to year would cause administrative concerns or raise issues

Potential Approaches for Determining Cost of Coverage

- Regarding the actuarial basis method
 - Current COBRA regs require an estimate of actual cost based on the costs the plan is expected to incur for a determination period, not the minimum (or maximum) exposure the plan could have for the period
 - IRS/Treasury request comments on all aspects of the actuarial basis method, including:
 - Whether regulations should require some accreditation of individuals making actuarial estimates
 - Whether it would be preferable to specify a list of factors that must be satisfied to make an actuarial determination of the estimated cost
 - Whether a similar standard should apply as well for COBRA

Potential Approaches for Determining Cost of Coverage

- Regarding the past cost method
 - Notice states that for **COBRA** purposes, IRS/Treasury is considering whether to issue guidance providing that plans may use as the 12-month measurement period for a current determination period any 12-month period ending not more than 13 months before the start of the current determination period
 - Example: Determination period for 2018 calendar year plan could be the 12-month period corresponding with the 2016 plan year
 - Notice states that IRS/Treasury is considering whether to adopt a similar standard for purposes of the **excise tax**

Potential Approaches for Determining Cost of Coverage

- Regarding the past cost method
 - Costs taken into account –
 - IRS/Treasury anticipate the proposed regulations will describe the costs that must be taken into account. The **costs** could include:
 - Claims
 - Should it be claims incurred during the measurement period (whether paid or unpaid) or claims submitted during the measurement period (regardless of when incurred)?

Potential Approaches for Determining Cost of Coverage

- Regarding the past cost method
 - Costs taken into account –
 - IRS/Treasury anticipate the proposed regulations will describe the costs that must be taken into account. The **costs** could include:
 - Premiums for stop-loss or reinsurance policies

Potential Approaches for Determining Cost of Coverage

- Regarding the past cost method
 - Costs taken into account –
 - IRS/Treasury anticipate the proposed regulations will describe the costs that must be taken into account. The **costs** could include:
 - Administrative expenses

Potential Approaches for Determining Cost of Coverage

- Regarding the past cost method
 - Costs taken into account –
 - IRS/Treasury anticipate the proposed regulations will describe the costs that must be taken into account. The **costs** could include:
 - Reasonable overhead expenses of the employer (such as salary, rent, supplies and utilities)
 - Comments are invited regarding:
 - Whether additional guidance is needed
 - Whether a presumption should be adopted that, for self-insured plans with a third party administrator, reasonable overhead expenses are reflected in the third party administrator fee
 - Whether a safe harbor should be adopted that would allow a self-administered, self-insured plan to assume that the amount of reasonable overhead expenses is equal to a defined percentage of claims

Potential Approaches for Determining Cost of Coverage

- Regarding the past cost method
 - Costs taken into account –
 - IRS/Treasury anticipate the proposed regulations will describe the costs that must be taken into account. The **costs likely would NOT include:**
 - Account reserves for future potential costs
 - Claims incurred to the extent subject to reimbursement under a stop-loss or reinsurance policy

Potential Approaches for Determining Cost of Coverage

- Health Reimbursement Arrangements (HRAs)
 - "Anticipate that future guidance will provide that an HRA is applicable coverage" for purposes of the tax
 - No specific valuation rules for HRAs contained in the statute. Thus, Notice says general valuation rules should apply
 - IRS/Treasury have not provided much guidance on how to value HRAs for COBRA purposes, except to say that the COBRA rate may not be based on the reimbursement amount available from the HRA

Potential Approaches for Determining Cost of Coverage

- Health Reimbursement Arrangements (HRAs)
 - Notice indicates IRS/Treasury is considering various valuation methods, including counting only those amounts made newly available each year
 - THEREFORE: carryover amounts or amounts made available prior to 2018 would be disregarded
 - Notice acknowledges that even this approach could overvalue HRAs since total contributions might not be spent during the current measurement period
 - IRS/Treasury is considering a rule that would permit employers to determine the cost of coverage by (i) adding together all claims and administrative expenses attributable to HRAs for a particular period, and (ii) dividing that sum by the number of employees covered for that period

Potential Approaches for Determining Cost of Coverage

- Health Reimbursement Arrangements (HRAs)
 - Should some HRAs be excluded or some of the coverage?
 - What about HRAs that can be used to purchase excepted coverage?
 - What about HRAs that only reimburse premiums for other applicable coverage?

Potential Approaches for Determining Cost of Coverage

- Possibility of other methods for determining cost of coverage
 - External benchmark based upon cost of benchmark plan
 - Valuation based on actuarial value (AV) standard

** IRS/Treasury is requesting comments regarding whether any alternative approaches to determining the cost of applicable coverage would be consistent with the statutory requirements of Code section 4980I and, if so, would be useful.



Applicable Dollar Limits

- Applicable dollar limits
 - Base Thresholds: \$10,200 for self-only coverage, \$27,500 for other-than-self-only coverage
 - Subject to certain adjustments as well as initial (2018) and annual indexing

Applicable Dollar Limits

- Applicable dollar limits
 - Notice acknowledges that an "employee" may be enrolled in both self-only coverage (e.g., major medical) and other-than-self-only coverage (e.g., FSA, HRA or HSA)

Treasury and IRS are considering an approach to clarify the application of the dollar limit when an employee simultaneously has one type of coverage that is self-only coverage and another type of coverage that is other-than-self-only coverage. Under this potential approach, the applicable dollar limit for an employee would depend on whether the employee's primary coverage/major medical coverage is self-only coverage or other-than-self-only coverage. For this purpose, an employee's primary coverage/major medical coverage would be the type of coverage (self-only or other-than-self-only) that accounts for the majority of the aggregate cost of applicable coverage. For example, if an employee has applicable coverage with an aggregate cost of \$12,000, \$3,000 of which is self-only coverage and \$9,000 of which is other-than-self-only coverage, the other-than-self-only coverage dollar limit would apply to the full \$12,000. If self-only coverage and other-than-self-only coverage make up equal amounts of the aggregate cost of applicable coverage, the other-than-self-only dollar limit would apply to the employee.

Applicable Dollar Limits

- Base Thresholds:

- "Health cost adjustment percentage" =

$$100\% + \left(\% \blacktriangle \text{ FEHBP 2018 vs 2010} - 55\% \right)$$

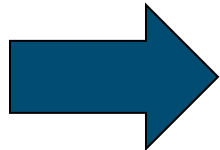
(ii) Health cost adjustment percentage

For purposes of clause (i), the health cost adjustment percentage is equal to 100 percent plus the excess (if any) of—

- (I) the percentage by which the per employee cost for providing coverage under the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for plan year 2018 (determined by using the benefit package for such coverage in 2010) exceeds such cost for plan year 2010, over
- (II) 55 percent.

Applicable Dollar Limits

- Limited adjustments permitted
 - Age
 - Gender
 - Qualified retirees
 - Qualifying plans covering certain high-risk professionals



NO geographic adjuster
NO adjuster for claims risk generally

"Treasury and IRS intend to include rules regarding these adjustments in proposed regulations and invite comments on the application and adjustment of the dollar limits"

Applicable Dollar Limits

- Limited adjustments permitted
 - Age
 - Gender

** IRS/Treasury is requesting comments regarding whether it would be desirable and possible to develop safe harbors that appropriately adjust dollar limit thresholds for employee populations with age and gender characteristics that are different from those of the national workforce.

(iii) Age and gender adjustment

(I) In general

The amount determined under subclause (I) or (II) of clause (i), whichever is applicable, for any taxable period shall be increased by the amount determined under subclause (II).

(II) Amount determined

The amount determined under this subclause is an amount equal to the excess (if any) of—

(aa) the premium cost of the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for the type of coverage provided such individual in such taxable period if priced for the age and gender characteristics of all employees of the individual's employer, over

(bb) 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.

Applicable Dollar Limits

- Limited adjustments permitted
 - Qualified retirees
 - \$1,650 for self-only coverage
 - \$3,450 for all other coverage
 - Subject to indexing

(iv) Exception for certain individuals

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—

(I) the dollar amount in clause (i)(I) shall be increased by \$1,650, and

(II) the dollar amount in clause (i)(II) shall be increased by \$3,450,¹

Applicable Dollar Limits

- Limited adjustments permitted
 - Qualified retirees
 - Who is a "qualified retiree"?
 - **NOT** enrolled in Medicare, but at least 55, and not currently employed

** IRS/Treasury requests comments on how an employer should determine that an employee is not eligible for enrollment under the Medicare program.

(2) Qualified retiree

The term "qualified retiree" means any individual who—

(A) is receiving coverage by reason of being a retiree,

(B) has attained age 55, and

(C) is not entitled to benefits or eligible for enrollment under the Medicare program under title XVIII of the Social Security Act.

What Are the Dollar Thresholds?

- Limited adjustments permitted
 - Qualifying plans covering certain high-risk professionals
 - \$1,650 for self-only coverage
 - \$3,450 for all other coverage
 - Subject to indexing

(iv) Exception for certain individuals

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—

(I) the dollar amount in clause (i)(I) shall be increased by \$1,650, and

(II) the dollar amount in clause (i)(II) shall be increased by \$3,450,¹

What Are the Dollar Thresholds?

- Limited adjustments permitted
 - Qualifying plans covering certain high-risk professionals
 - What qualifies as a "high-risk profession"?
 - Law enforcement
 - Fire protection
 - EMTs
 - Construction
 - Mining
 - Certain agriculture
 - Forestry & Fishing
 - Also: current retiree if worked in high-risk profession for at least 20 years

(3) Employees engaged in high-risk profession

The term "employees engaged in a high-risk profession" means law enforcement officers (as such term is defined in section 1204 of the Omnibus Crime Control and Safe Streets Act of 1968), employees in fire protection activities (as such term is defined in section 3(y) of the Fair Labor Standards Act of 1938), individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders), individuals whose primary work is longshore work (as defined in section 258(b) of the Immigration and Nationality Act (8 U.S.C. 1288(b)), determined without regard to paragraph (2) thereof), and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. 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.

What Are the Dollar Thresholds?

- Limited adjustments permitted
 - Qualifying plans covering certain high-risk professionals

** IRS/Treasury is requesting comments regarding:

- How an employer determines whether the majority of employees covered by a plan are engaged in a high-risk profession and what the term "plan" means in this context
- How an employer determines that a retiree was engaged in a high-risk profession for at least 20 years
- Whether further guidance on the definition of "employees engaged in a high risk profession" would be beneficial.

Example of How This *Might* Work

- Acme Co. offers the following health-related benefits to its employees as well as their spouses and children up to age 26:
 - Two major medical plan options:
 - HSA-qualified HDHP (self-funded) with Employer HSA contribution of \$500. Employees can make HSA contributions via cafeteria plan
 - PPO major medical coverage (self-funded)
 - Two medical savings accounts depending on eligibility
 - FSA – Permits pre-tax employee salary reduction contributions up to the statutory maximum (\$2,550 for 2015); no employer flex credits
 - HSA – Contributions permitted up to statutory maximum (\$3,350 for individual and \$6,650 for family for 2015); no employer HSA contributions
 - Limited scope dental and vision coverage (self-insured)
 - Wellness plan – \$100 incentive for participating in biometric screening delivered as premium rebate on major medical coverage. \$50 per month surcharge for smokers who fail to complete a qualified smoking cessation program
 - On-site health center – Provides flu shots, treatment of injuries caused by work accidents, nonprescription pain relievers at no cost to employee

Example of How This *Might* Work

- Suzie is age 38. She is Chief of Marketing for Acme
- Suzie enrolls in the following for herself and her spouse:
 - PPO major medical plan
 - Self-insured dental plan
- Suzie elects to contribute \$1,800 to her health FSA
- Suzie is a smoker. She earns the \$100 premium rebate for participating in the biometric screening. She fails to complete the smoking cessation program and incurs \$600 of surcharges with respect to PPO-enrolled coverage
- Suzie never uses the on-site medical clinic except for first-aid related to a minor workplace mishap

Example of How This *Might* Work

- Acme needs to determine if there is any excise tax liability with respect to Suzie
 - **STEP 1: Determine subject coverage**
 - PPO coverage
 - FSA
 - Self-insured stand-alone dental????
 - Wellness plan????
 - Onsite medical clinic????

Example of How This *Might* Work

- Acme needs to determine if there is any excise tax liability with respect to Suzie
 - **STEP 2: Value the coverage**
 - Example: PPO major medical coverage
 - Notice suggests Acme needs to aggregate all like benefit packages
 - **BECAUSE SUZIE IS ENROLLED IN THE PPO, NEED TO LOOK TO ALL PPO COVERAGE**
 - Across one plan? What if Acme has two plans? What if Acme is part of larger controlled group?
 - Notice suggests Acme then needs to disaggregate based upon whether self-only or other coverage
 - **BECAUSE ENROLLED IN COVERAGE FOR SELF AND SPOUSE, SUZIE IS ENROLLED IN OTHER-THAN-SELF-ONLY COVERAGE AND SHOULD BE GROUPED WITH LIKE PERSONS**
 - Notice then suggests *possible* permissive disaggregation
 - **BUT WOULD THAT EVER BE HELPFUL?**
 - Notice then suggests need to use actuarial basis method or past cost method to value the coverage

Example of How This *Might* Work

- Acme needs to determine if there is any excise tax liability with respect to Suzie
 - **STEP 3: Add up all the valued coverage**
 - PPO coverage \$12,500
 - FSA \$1,800
 - Stand-alone dental? \$1,600
 - Wellness plan? ?????
 - Onsite medical clinic? ?????

Example of How This *Might* Work

- Acme needs to determine if there is any excise tax liability with respect to Suzie
 - **STEP 4: Determine applicable dollar limitation**
 - Base threshold: \$27,500
 - Possible upward adjustment based upon "health cost adjustment percentage"?
 - Other possible adjustments?
 - Age?
 - Gender?
 - High-risk professional?

Example of How This *Might* Work

- Acme needs to determine if there is any excise tax liability with respect to Suzie
 - **STEP 5: Compare total valuation of Suzie's subject coverage (STEP 3) with Suzie's applicable dollar limit (STEP 4)**

Example of How This *Might* Work

- Acme needs to determine if there is any excise tax liability with respect to Suzie
 - **STEP 6: Repeat process for each "employee"**
 - Remember "employee" is defined broadly to include former employees as well as a "primary insured"

What Next?

- Expecting follow-on IRS Notice
- Proposed and final regulations to follow thereafter
- Legislative activity beginning in earnest
 - *E.g.*, H.R.879 - Ax the Tax on Middle Class Americans' Health Plans Act (Rep. Ginta R-NH-1), Introduced on 2/11/15