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Leadership and Advocacy

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DELIVERED VIA EMAIL: 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: COMMENTS ON NOTICE 2015-16: SECTION 4980I – EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE

Dear Sir or Madam:

On behalf of the American Council on Education ("ACE") and the undersigned higher education associations, we appreciate the opportunity to comment on the important preliminary issues and questions raised in Notice 2015-16 (the "Notice") with respect to the § 4980I[1] excise tax on high-cost employer-sponsored health plans (the "Excise Tax"). Together, ACE and the undersigned higher education associations represent approximately 4,300 two- and four-year public and private non-profit colleges and universities.

This letter focuses primarily on the specific technical matters raised in the Notice. We wish, however, to emphasize two overriding themes that we suggest should guide your consideration of all issues with respect to the application of the Excise Tax – flexibility and transition.

> ***Flexibility***: Our member institutions meet the wide range of post-secondary education needs of Americans. However, the success of every college and university (whether large or small, public or private non-profit) is grounded in the health and well-being of its faculty and staff. Higher education institutions have adopted health plans designed to further their unique educational missions and serve a wide variety of employee populations. A primary goal in establishing the rules governing the

[1] All section references herein are to the Internal Revenue Code of 1986, as amended (the "Code"), unless otherwise indicated.

Excise Tax should be to ensure that it is applied equitably to a wide field of employer-provided health benefits arrangements. Generally, this should include allowing alternate reasonable ways of calculating how the Excise Tax is applied and creating simplified safe harbors enabling employers to demonstrate compliance with minimal burden.

Transition: The preliminary issues raised in the Notice are only the first of many that will need to be addressed before health plans and their sponsors can understand the potential implications of the Excise Tax, much less make the types of adjustments that may be necessary to comply with the new requirements. Although the 2018 effective date of the Excise Tax may seem distant at this time, key decisions with respect to health plan designs (which may require adjustment due to the Excise Tax) are already having to be made. The potential application of the Excise Tax in 2018 will be based, in large measure, on the health benefits provided to employees in 2017 – and planning for those 2017 benefits must begin early in 2016. For certain of the many collectively bargained arrangements in higher education, 2017 health plan design decisions may already be locked in or are being currently negotiated. In applying the Excise Tax in its initial years, it is important to consider that the tax was intended to improve the efficiency of individual health plans and the health marketplace. That will not be possible until some period (probably at least two years) after final rules are published due to the time required for plan sponsors to make the appropriate plan design changes.

Therefore, we urge that the general themes of flexibility and transition be taken into account with respect to shaping how the Excise Tax will be defined and applied, including the four major areas where comments were specifically requested in the Notice:

- The Definition of Applicable Coverage;
- The Determination of the Cost of Applicable Coverage;
- The Applicable Dollar Limit; and
- Possible Alternative Methods of Determining the Cost of Applicable Coverage.

Specific issues within each of those major areas are discussed below, along with our specific recommendations on how they should be addressed.

I. DEFINITION OF APPLICABLE COVERAGE

The Notice discusses the possible application of the Excise Tax to various types of coverage provided under an employer's group health plan. Below, we provide comments on some key types of coverage provided by many higher education institutions. With respect to each of the issues discussed below, we urge you to explicitly provide that the coverage discussed is not applicable coverage and is therefore not subject to the Excise Tax.

A. <u>Health HSAs and MSAs</u>

Notice: The Notice states that in the case of employer contributions to an HSA or MSA (including pre-tax salary deferral contributions by the employee) it is anticipated that the cost of coverage is equal to the amount of the employer contribution. In contrast, after-tax employee contributions to an HSA or MSA (which are deductible for income tax purposes, rather than excludible for income tax and employment tax purposes) would not be treated as applicable coverage.

Recommendation: Excise Tax treatment should not be different based on whether the employee makes deductible HSA or MSA contributions at the workplace or independent of the workplace. Nor should the employer's facilitation of those deductible HSA or MSA contributions (e.g., through payroll reduction) result in the employee contributions being counted toward the application of the Excise Tax. Guidance could further provide that such employer facilitation could include a provision that the employee would be automatically enrolled in the payroll reduction HSA with funds automatically deposited directly into an HSA or MSA. In any of these situations, the amounts should be deemed to have been paid to the employee as compensation and then contributed by the employee to the HSA. As a result, the provisions of § 106(d) should not make those amounts excludible from income. Instead, the rules of § 219(f)(5) (as incorporated for HSAs by § 223(d)(4)(C)) would apply, and the amounts so contributed would not be treated as applicable coverage for purposes of the Excise Tax.

B. <u>On-Site Medical Clinics</u>

Notice: The Notice states that the Treasury and IRS anticipate that on-site medical clinics "that offer only de minimis medical care to employees" will not be included. The current definition of de minimis medical care (in COBRA continuation coverage regulations Treas. Reg. § 54.4980B-2, Q&A-1(d)) is limited, providing that (a) the health care at the clinic must consist primarily of first aid provided during working hours for treatment of a health condition, illness, or injury that occurs during those working hours; (b) the clinic is available only to current employees; and (c) the employer does not charge employees for use of the facility.

The Notice requests comments on (1) whether additional treatments at on-site clinics might appropriately be provided within the de minimis exception; (2) whether the de minimis exception should be based on the nature and scope of the benefits or as a specified dollar limit on the cost of services provided; and (3) how to determine the cost of coverage provided by an on-site medical clinic.

Recommendations: On-site clinics at colleges and universities present unique issues because those clinics are often maintained primarily for the benefit of the students. Although primarily for students, these clinics also often provide a range of preventive health services, such as flu shots and immunizations, to employees in an effort to maintain the overall health of the campus community and to help ensure a safe learning environment. Those unique circumstances should be specifically addressed in connection with the Excise Tax.

1. Scope of De Minimis Exception

The on-site clinic de minimis exception should be modified as follows:

- The de minimis exception should not be limited to clinics available only to employees. We see no reason why an employer should be unable to avail itself of the de minimis exception simply because the employer has business reasons for offering on-site treatment for individuals other than employees. This is particularly relevant to colleges and universities, which generally provide on-site clinics for students for public health reasons. Under the Notice's proposed rule, a college or university would need to create a *separate* clinic for employees to avail themselves of the exception.

- The services permitted under the de minimis exception should be expanded to include:

  1) Flu shots and other immunizations;
  2) Allergy injections;
  3) Provision of nonprescription drugs;
  4) Storage of prescription drugs (e.g., refrigeration) for employees and assistance with injections, etc., with respect to such drugs;
  5) Treatment of work injuries beyond first aid, including any emergency treatment and checks and screening to monitor an employee's ability to return to a normal work schedule (e.g., following an injury); and
  6) Health and wellness promotion, including the provision of health education materials and classes (on topics like nutrition, exercise, stress reduction, and smoking cessation) and access to routine screening services (such as those related to hypertension, diabetes, cholesterol, weight, or substance abuse).

- The limitation on charging employees for use of the facility should not apply for purposes of the excise tax. Whether or not the employee pays for a portion of the services provided at an on-site clinic should not be a material consideration for purposes of determining whether the de minimis exception should apply.

- The requirement that the on-site clinic limit its services to injuries that occur during working hours should be clarified to ensure that it does not preclude treatment of emergencies at any time. Similarly, it should be clarified that the other services described above should not be subject to a working hours limitation, since they will often be utilized before or after working hours.

2. Methods of Calculating De Minimis On-Site Clinic Benefits

There should be alternative methods of demonstrating that the benefits provided at an on-site clinic are de minimis, and safe harbors should be provided as follows:

- The de minimis exception would apply if the nature and scope of the benefits provided are primarily of the type of services described above.

- Alternatively, the de minimis exception would apply if the average annual cost of services provided to employees at on-site clinics does not exceed 10% of the self-only applicable dollar limit in effect for the year.

- A safe harbor should be provided for situations where (1) the employer maintains the on-site clinic predominantly for reasons unrelated to the treatment of employees (e.g., to treat students at the campus), and (2) the utilization of the clinic by employees is de minimis (e.g., 10% or less). This de minimis safe harbor is especially important for those colleges and universities (especially for smaller institutions) that maintain on-site clinics for the benefit of their students, but also allow access by faculty and/or staff.

- An additional safe harbor should be provided for situations where (1) the employer maintains the on-site clinic predominantly for reasons unrelated to the treatment of employees (e.g., to treat students at the campus), and (2) where the services at the clinic are made available to all of the employees at the site, regardless of whether those individuals are covered under a health plan maintained by the employer. The availability of access to the clinic in these situations demonstrates that the provision of health and medical services to employees enrolled in the health plan is a de minimis reason for maintaining the clinic.

3. Cost Calculation for On-Site Clinics Not Meeting the De Minimis Rule

In calculating the costs of benefits provided at an on-site clinic that do not meet the de minimis rule, we recommend that the following conventions be applied:

- The costs of services that could have been provided under the de minimis exception should be disregarded in the cost calculation for on-site clinics.

- The cost of an on-site medical clinic should be based on annual marginal costs, thus excluding one-time capital expenditures.

- In any situation where the on-site clinic is utilized by individuals who are not employees, the cost calculation should be based on any reasonable allocation method selected by the employer. In making such allocations, guidance should specifically provide that in situations where the employer maintains the on-site

clinic predominantly for reasons unrelated to the treatment of employees (e.g., to treat students at a campus), all overhead costs should be allocated to the students. Those costs would be incurred regardless of whether employees utilize the facility.

C. Limited Scope Dental and Vision/Employee Assistance Programs

Notice: The Notice confirms that the Excise Tax exception for limited scope dental and vision benefits under a separate policy of insurance will apply consistently for insured and self-insured plans. The Notice requests comments on whether there is any reason why all limited scope dental and vision benefits described in recent Treas. Reg. § 54.9831-1(c)(3) should be excepted from the Excise Tax. Similarly, the Notice requests comments on whether there is any reason why certain Employee Assistance Programs (EAPs) described in recent final regulations (Treas. Reg. § 54.9831-1(c)(3)(vi)) should not be excepted from the Excise Tax calculations.

Recommendation: Limited scope dental and vision benefits and EAPs as described in Treasury regulations should not be applicable coverage under the Excise Tax.

D. Travel Insurance

Notice: The Notice discusses various types of insurance coverage in connection with the application of the Excise Tax, but does not specifically mention travel insurance.

Recommendation: It is common for colleges and universities to provide travel insurance for faculty while overseas engaged in a range of activities including teaching, research, accompanying students overseas, or attending academic conferences. Such coverage may include incidental health benefits (such as medical evacuation benefits or limited international medical coverage), but should not be counted as applicable coverage for purposes of the Excise Tax. Treas. Reg. § 57.2(h)(4) provides that for purposes of the annual fee imposed on covered entities engaged in the business of providing health insurance by section 9010 of the Patient Protection and Affordable Care Act, the term health insurance does not include travel insurance.[2] Similarly, it should be clarified that travel insurance as so defined would not be counted as applicable coverage in calculating the Excise Tax.

[2] For this purpose "the term travel insurance means insurance coverage for personal risks incident to planned travel, which may include, but is not limited to, interruption or cancellation of trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, the term travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed." Treas. Reg. § 57.2(h)(4).

E. Other Excepted Benefits

Notice: The Notice confirms that insurance coverage described in § 9832(c)(1) is excepted from the Excise Tax.

Recommendation: Section 9832(c)(1)(H) provides the authority to except "[o]ther similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits." Guidance should make clear that the Treasury and the IRS have the authority under § 4980I(g) to except other types of similar insurance coverage from the Excise Tax without the need to publish regulations.

F. Long-Term Care

Notice: The Notice repeats the statutory exception from the Excise Tax for "any coverage for long-term care," but does not define long-term care.

Recommendation: Clear guidance should be published on the scope of the long-term care exception to the Excise Tax. There is no definition of long-term care in the Code. However, in determining the scope of the "any long-term care" exception to the Excise Tax, it is significant that § 4980I does not cross-reference any of the other Code definitions that relate to long-term care (e.g., the definition of qualified long-term care services under § 7702B(c) or the long-term care excepted benefit definition of § 9832(c)(2)(B), which applies to benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof, but only if offered separately).

The plain reading of the § 4980I statutory language is that it applies a definition of long-term care that encompasses much more than those existing Code definitions. Thus, while the "any long-term care" Excise Tax exception would clearly encompass the payment by an employer-sponsored health plan of medical care that is "long-term care services" under the definition of § 7702B(c), a plain reading of the statute goes much further. For example, the failure to cross reference the long-term care excepted benefit definition of § 9832(c)(2)(B) not only excepts coverage in that section, but also clearly signals that the "only if offered separately" limitation does not apply to the definition of "any long-term care" for purposes of the Excise Tax. If Congress had intended it to apply then the statute would say so, as it does in other parts of the Affordable Care Act.

The reading of the statute outlined above is consistent with the basic policy objectives of the Excise Tax. As noted at the outset, the Excise Tax was intended to improve the efficiency of health plans and the health marketplace overall, and encourage plan designs with a cost below the applicable thresholds. Long-term care expenses, by their nature, are generally attributable to a small group of the sickest (and highest cost) employees and other covered individuals. As such, a health plan's expenditures on such long-term care expenses are likely to fluctuate unexpectedly year-to- year, and those types of uncontrollable, random fluctuations in cost are appropriately excepted from the application of the Excise Tax.

Based on the plain reading of the statute, guidance should specifically confirm the following:

- Any employer-sponsored long-term care insurance coverage meeting the excepted benefit definition of § 9832(c)(2)(B) would not be applicable coverage for purposes of the Excise Tax.

- Any benefits paid under an employer-sponsored health plan that would constitute qualified long-term care services (as defined in § 7702B(c)) (i.e., including "necessary diagnostic, preventive, therapeutic, curing treating, mitigating, and rehabilitative services . . . required by a chronically ill individual . . . .") would not be applicable coverage for purposes of the Excise Tax.

- Any benefits paid under an employer-sponsored health plan with respect to an individual requiring long-term care for a chronic condition over an extended period of time (whether or not chronically ill as defined in § 7702B(c)) would not be applicable coverage for purposes of the Excise Tax. For this purpose, long-term care could be defined as care for a chronic condition that lasts for more than a specified period of time. For example, the definition of a "long-term care hospital" under the Social Security Act is a hospital which has an average stay of greater than 25 days.[3] A similar 25-day standard could be applied in defining the "any long-term care" exception to the Excise Tax, i.e., any benefits paid by an employer for treatments lasting more than 25 days would not be treated as applicable coverage for purposes of the Excise Tax calculations.

G. Wellness Programs

Notice: Although wellness programs are not specifically addressed in the Notice, there are situations where such programs may be treated as being a part of a group health plan and, thus, included in applicable coverage for purposes of the Excise Tax.

Recommendation: Guidance should make clear that certain wellness and preventive activities and services will not be treated as provided under a group health plan and, as a result, the costs of those activities and services will not be counted as applicable coverage for purposes of the Excise Tax. The activities and services that would be deemed not to "provide health care" for purposes of the group health plan definition of § 5000(b)(1) should include the following:

- Flu shots and other immunizations provided to maintain the overall health of a broader community. This is particularly critical in higher education settings where it is important to ensure that students, faculty, and staff are all immunized for communicable diseases.

[3] See § 1866(d)(1)(B)(ii) of the Social Security Act.

- Any checks or screenings provided to monitor an employee's ability to return to a normal workload or schedule (e.g., following an injury).

- Costs of health and wellness promotion, including the provision of health education materials and classes (on topics like nutrition, exercise, stress reduction, and smoking cessation).

- Access to routine screening services (such as screening related to hypertension, diabetes, cholesterol, weight, or substance abuse).

These exceptions should apply regardless of whether the activities or services are provided at an on-site clinic or elsewhere.

II. DETERMINATION OF THE COST OF APPLICABLE COVERAGE

The Notice requests comments on four issues associated with the determination of the cost of coverage for purposes of the Excise Tax: (1) the definition of "similarly situated" individuals; (2) the calculation methods for self-insured plans; (3) the treatment of Health Reimbursement Arrangements (HRAs); and (4) the "determination period" for valuing coverage. Those general issues and the specific questions raised in the Notice are addressed below.

A. Similarly Situated Individuals

Notice: The Notice indicates that the regulators anticipate that (like the COBRA continuation coverage rules of § 4980B(f)(4)) the cost of coverage for an employee will be based on the average cost of that type of coverage for that employee and all "similarly situated" employees. The Notice identifies a potential approach being considered which would identify similarly situated employees through the following steps:

a) Employees would be subdivided by their "benefit package." For this purpose, the "benefit package" would be considered different if there are differences in benefits offered (e.g., high deductible vs. low deductible; HMO vs. PPO; HMO vs. HMO).
b) Then, each benefit package would be based on the mandatory disaggregation rules of the statute (essentially segregating "self-only coverage" from "other-than-self-only coverage").
c) Then, by allowing (but not requiring) certain permissive aggregation within the "other-than-self-only coverage" group (e.g., employee plus one, employee plus two, or family coverage).

Recommendation: For purposes of the approach identified above, our recommendations with respect to the specific questions raised in the Notice are as follows:

- Question Presented: The extent to which benefit packages must be identical to be considered the same for purposes of the first step, and the nature and extent of those permitted differences?

Response: For purposes of the Excise Tax calculations, relatively minor differences in basic types of benefit packages should be ignored. For example, an employer-sponsored health plan that offers the choice between two benefit packages should be allowed to treat the two benefit packages as one benefit package if the actuarial value of the two packages are comparable (e.g., within 10%) and the costs of the two packages are also comparable (e.g., within 10%).

- Question Presented: Whether permissive disaggregation should be limited to the COBRA continuation coverage calculations or whether it should also be allowed for the Excise Tax calculations?

  Response: As a general matter, we believe that consideration of changes to the long-standing COBRA continuation rules should not be made at the same time that employers are being asked to evaluate and make changes under the new Excise Tax regime. Although we appreciate that the two provisions are linked in that the Excise Tax calculations are to be determined under rules "similar to" the COBRA rules, it is clear that the rules need not be identical. If and when the COBRA rules are modified, permissive disaggregation for purposes of those rules would appear to be warranted, but any such permissive disaggregation should not result in adopting a similar disaggregation approach for Excise Tax purposes.

- Question Presented: Whether permissive disaggregation should be limited under (a) a broad standard (such as 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 (b) a more specific standard, such as a specified list of limited specific categories for which permissive disaggregation is allowed (e.g., allow groups of similarly situated employees enrolled in a single benefit package to be disaggregated only into current and former employees and/or to be disaggregated based on bona fide geographic distinctions)?

  Response: As noted above, any changes in the COBRA rules are best delayed until after the implementation of the Excise Tax. If and when the COBRA rules are modified, we recommend employers be given flexibility to use any reasonable method to disaggregate groups.

B. Measuring Cost in Self-Insured Plans

Notice: The Notice indicates that the regulators anticipate that the two methods self-insured plans can use for calculating COBRA continuation coverage premiums (the actuarial basis method and the past cost method) will also generally apply to the Excise Tax calculation.

Recommendation: Our recommendations with respect to the specific questions raised in the Notice are:

- Question Presented: Limiting changes between the two methods for COBRA purposes to once every five years is being considered. The only exception would be if there is a significant change in the plan or the employees covered, in which case a plan using the past cost method would be required to use the actuarial basis method for two years. Should a similar 5-year rule be applied to the Excise Tax?

  Response: No. For purposes of the Excise Tax calculations, the employer should be able to use any reasonable method with respect to any year and no restrictions should be placed on changing methods from one year to the next. As noted above, we recommend that consideration of any COBRA changes be delayed until after the Excise Tax regulations are finalized.

- Question Presented: With respect to the actuarial cost method, the regulators are considering a broad standard for Excise Tax purposes that measures the cost of applicable coverage for a group of similarly situated individuals "using reasonable actuarial principles and practices." Comments are requested on (1) whether regulations should require some accreditation of individuals making actuarial estimates, (2) whether it would be preferable to specify a list of factors that must be satisfied to make an actuarial determination, and (3) whether a similar standard should apply for COBRA purposes?

  Response: For purposes of the actuarial cost method, an approach based on using reasonable actuarial principles and practices would appear to be appropriate. At least initially, we recommend that guidance not be overly prescriptive in regulating the individuals making the actuarial estimates or in specifying specific factors that must be satisfied. Treasury and the IRS may, however, wish to reserve the right to adopt such guidelines in the future. Finally, as previously noted, we do not feel changes in the COBRA rules are necessary or wise at this time.

- Question Presented: With respect to the past cost method, the regulators are considering guidance for COBRA purposes that would allow plans choosing the past cost method to use as the measurement period for a current determination period, any 12-month period ending not more than 13 months before the beginning of the current determination period (with an appropriate inflation adjustment). The measurement period would have to be applied consistently, absent bona fide business reasons for a change. Comments are requested on this approach for COBRA purposes and whether a similar rule should be provided for purposes of the Excise Tax.

  Response: The approach outlined above with respect to the measurement period for a current determination period should be adopted for purposes of the Excise Tax. Unlike other COBRA changes discussed above, this change would be entirely optional in nature, and thus not necessarily cause any disruption in current COBRA compliance practices.

- Questions Presented: With respect to the past cost method, the Notice anticipates that costs will include: (1) claims, (2) premiums for stop-loss or reinsurance policies, (3) administrative expenses, and (4) reasonable overhead 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 states that the regulators expect that (1) reserves for potential future costs, (2) claims incurred to the extent subject to reimbursement under a stop-loss or reinsurance policy, or (3) any portion of the cost of coverage attributable to the Excise Tax would not be taken into account. The Notice then invites comment on the following questions:
    - Whether cost of claims should be based on claims incurred during the measurement period (whether paid or unpaid) or claims submitted during the measurement period (regardless of when incurred)?
    - With respect to overhead expenses, whether additional guidance would be beneficial, including (1) 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, and (2) 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?
    - Whether similar approaches should be utilized for COBRA calculations?

  Responses: Employers should be provided with the option to use any reasonable method in performing Excise Tax calculations. As a result, the employer should be able to determine the cost of claims for any year based on either the claims incurred during the measurement period (whether paid or unpaid) or claims submitted during the measurement period (regardless of when incurred). There should also be flexibility to switch between methods, subject to rules that ensure that switching would not allow certain expenses to go uncounted.

  In addition, the presumption with respect to costs for self-funded plans with a third party administrator should be adopted. Reasonable safe harbors should also be provided with respect to overhead allocations and those safe harbors (and the general rule) should clearly provide that such allocations should only relate to the types of services (e.g., claims processing) that an insurer would typically perform in an insured plan. Also, all amounts relating to the Excise Tax should be excluded from the cost of applicable coverage, including not only the tax itself, but also costs attributable to the non-deductibility of the tax that could be passed on to a plan. However, none of these approaches should be mandated at this time for purposes of COBRA calculations.

C. HRAs

Notice: The Notice indicates that future guidance will provide that HRAs are subject to the Excise Tax and raises a range of questions about the appropriate treatment of HRAs under the Excise Tax.

Recommendation: Our recommendations with respect to the specific questions raised in the Notice are addressed below.

- Question Presented: Various methods for calculating the cost of applicable coverage under an HRA are being considered, including basing cost on the amounts newly made available each year (the "newly available method"). Such an approach would, in certain cases, overvalue the HRA and, as a result, an alternative ("per employee") approach is also being considered that would permit employers to determine the cost of HRA coverage by adding together all claims and administrative expenses attributable to the HRAs and dividing by the number of employees (and presumably retirees and other former employees with unused HRA benefits). A third alternative approach would be to use the actuarial basis method to determine the cost of coverage under an HRA (the actuarial basis method).

  Response: Colleges and universities, like most employers, have adopted a range of HRA practices, including increasing consumer consciousness and creating a mechanism to set aside funds for retiree health. Employers should, with respect to any year, be able to use any of the three methods outlined in the Notice. For this purpose, an employer utilizing the newly available method or the actuarial basis method should be able to switch to the use of the per employee method in any future year. An employer that switches from the per employee method to one of the other two methods could be required to meet such special rules as are deemed necessary to prevent carried over HRA contributions from not being counted for purposes of the Excise Tax.

  Retiree-only HRAs are becoming increasingly popular and are proving to be an effective way to help close the gap for those that retire before Medicare eligibility. Retiree-only HRAs generally operate in one of two ways. First, the employer will credit contributions to the HRA during the working career of the employee; no distributions are available in-service. At retirement, the employee receives an account which can be drawn down for medical expenses but generally no new contributions or credits are made to the HRA. Second, the employer may simply make an HRA amount available each year beginning at retirement (no pre-funding). The calculation of aggregate cost of an HRA should reflect the plan design.

- Question Presented: In addition, the Notice states that some have suggested that the cost of applicable coverage should not include an HRA that can be used only to fund the employee contribution toward coverage. Similarly, some stakeholders have suggested that the cost of applicable coverage should not include an HRA that can be used to cover a range of benefits, some of which would not be applicable

coverage. Comments are requested on (1) the frequency with which HRAs allow reimbursement only for employee contributions toward coverage (or only for types of coverage that are not applicable coverage); (2) how the cost of an HRA should be determined if the HRA can be used by employees to fund employee contributions for other medical expenses (or used both for coverage that is applicable coverage and coverage that is not); and (3) in any of these circumstances, whether the standard should depend on how employees choose to use the HRA, and on the administrability of any approach.

Response: While we believe an HRA that can be used only to fund an employee contribution towards coverage would be rare, we recommend that it be excluded from applicable coverage. This would likely be relevant only for retiree-only HRAs, because "employer payment plans" for active employees do not comply with the Affordable Care Act. (Notice 2013-54.) Generally, retiree-only HRAs allow reimbursement for most medical care expenses under § 213(d)(1), but some allow for reimbursement only for insurance premiums. Retiree-only HRAs integrate well with a key policy goal of the Affordable Care Act – ensuring that early retirees and the unemployed have a means to purchase insurance on an Exchange.

An employer should be allowed to exclude the value of an HRA that may be used for coverage that is not applicable coverage, using reasonable actuarial principles, but should not be required to make such a calculation.

- Question Presented: Comments are also requested on the relative complexity of applying multiple methods for determining the cost of applicable coverage under an HRA, other potential approaches, and whether similar rules should apply for purposes of COBRA calculations.

  Response: Giving the employer the choice of multiple methods will not add significant complexity once a method is chosen, whereas selecting a one-size-fits-all method will potentially result in inequitable application of the Excise Tax. As in other areas, we recommend that changes in the COBRA calculations not be mandated at this time. This is particularly true in the context of HRAs. The application of COBRA to HRAs, and the determination of the COBRA premium, continues to be an issue of complexity even after the release of Notice 2002-45. Employers that offer HRAs have mostly adapted to this complexity. The policy concerns inherent in determining rules for COBRA coverage of HRAs are very different than determining the value of coverage for the Excise Tax. Guidance on the Excise Tax in this area is essential.

D. Determination Period

Notice: The COBRA premium determination is made in advance for a 12-month period and, as a result, the method for calculating premiums is also selected in advance. The Notice states that the regulators anticipate that the method for determining the cost of applicable coverage (actuarial or past cost) would also be elected prior to the

determination period for which the cost is determined. Under that approach, the amount of any liability for the Excise Tax would generally be known at the beginning of the year. The Notice invites comment on the feasibility of a method for determining the cost of applicable coverage using actual costs: that is, for a self-insured plan, basing the cost of applicable coverage for a year on the actual costs paid by the plan to provide health coverage for that year. This method would not be available for determining COBRA premiums.

Recommendation: The general approach of determining the cost of applicable coverage in advance should be adopted as a safe harbor for purposes of the calculation of the applicability and extent of any Excise Tax obligations. However, an employer should always be able to calculate liability under the Excise Tax based on demonstrated actual costs for the year. For example, an employer that might have Excise Tax liability for a particular calendar year based on the past cost method for a particular benefit package, could always eliminate (or reduce) the Excise Tax liability based on a demonstration that actual costs for that calendar year[4] were below the Applicable Limits for that year.

III. APPLICABLE DOLLAR LIMIT

A. Employees with Both Self-Only and Other-Than-Self-Only Coverage

Notice: In cases where an employee receives coverage that is self-only and other coverage that is other-than-self-only, a potential approach under consideration would base the applicable dollar limit for an employee on whether the employee's primary coverage is self-only or other-than-self-only. For this purpose primary coverage would be the type of coverage that accounts for the majority of the aggregate cost of the employee's applicable coverage. An alternate approach under consideration would apply a composite dollar limit by pro-rating the dollar limit for each employee based on the ratio of the aggregate cost of self-only vs. other-than-self-only coverage. Comment is requested on these approaches.

Recommendation: Both suggested approaches are reasonable and employers should be allowed to use either method in determining the Applicable Dollar Limit for any employee that has some coverage that is self-only and other coverage that is other-than-self-only.

B. Age and Gender and Other Dollar Limit Adjustments

Notice: The applicable dollar limits for an employer in any year are increased by the excess (if any) of the cost of the BC/BS standard benefit under the Federal plan for a population of the same age and gender of the employer's workforce over the cost of that same BC/BS plan based on the age and gender of the national workforce. Comments are requested on whether it would be desirable and possible to develop safe harbors under this provision.

[4] The use of the word year in this context is simply for convenience. Potential liability for the Excise Tax would need to be calculated on a month-by-month basis for each individual.

Recommendation: Because many higher education institutions employ faculty and staff that are generally older than the national average, and often have a higher percentage of women in the work force than average, appropriate age and/or gender adjustments to the Excise Tax's applicable dollar limit will be critical. Standards for those adjustments should be published well in advance of the year to which they apply and we urge you to provide simplified safe harbors allowing simple adjustments to the applicable limits.

Notice: The applicable dollar limit is increased for retirees age 55 or older who are not entitled to or eligible for Medicare benefits (e.g., are not drawing Social Security disability benefits). Comment is requested on how an employer will determine if a retiree is not eligible for Medicare.

Recommendation: Employers should be allowed to rely on pre-age 65 retirees' statements regarding Medicare eligibility, and an employee should only be deemed eligible for enrollment in Medicare if the individual is actually enrolled in Medicare Parts A and B or C.

IV. OTHER METHODS OF DETERMINING COST OF COVERAGE

Notice: The Notice indicates that some have suggested that the cost of applicable coverage could be determined by reference to the cost of similar coverage available elsewhere (e.g., a Health Insurance Exchange) and invites comments on whether any alternative approaches are available consistent with the statute.

Recommendation: In order to ensure the equitable application of the Excise Tax, all methods of determining the cost of coverage should be considered and made available if reasonable. This will be particularly important during the uncertainty associated with the transition into the application of the Excise Tax. Specifically, we suggest adoption of the following provisions:

- A permanent rule to clarify that the Excise Tax would not apply to the extent that the Applicable Threshold is less than the cost of minimum value coverage described in § 36B(c)(2)(C)(ii) (i.e., a 60% actuarial value plan). Without this exception, the Excise Tax would apply to health benefits that a large employer is required to provide to employees in order to avoid a sizeable potential tax under § 4980H. It is logical to assume that Congress did not intend that result.

- An actuarial value safe harbor for at least the first two calendar years beginning after final regulations are published. Under this safe harbor, any Excise Tax liability with respect to an employer-sponsored health plan could be based on the excess, if any, of the of the plan's actuarial value over the actuarial value of a comparable Gold Level plan offered in the federal marketplace.

- Similarly, for at least the first two calendar years beginning after final regulations are published, employers should be allowed to value self-insured plans using the same method that they currently use for COBRA.

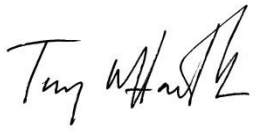
- A special rule exempting health benefits provided by an employer under a collective bargaining contract entered into prior to the publication of final regulations.

V. Conclusion:

Again, we appreciate the opportunity to provide comments on Notice 2015-16. As noted at the outset, taking into account the need for flexibility and transition in any guidance considered with respect to the Excise Tax will go a long way in helping to make application of the tax more equitable and workable for employers in higher education.

If you have any questions regarding our comments or if we may be of any assistance in providing additional information, especially as it may relate to health coverage typically provided by institutions of higher education, please do not hesitate to contact Steven Bloom at 202-939-9461 or sbloom@acenet.edu.

Sincerely,



Terry W. Hartle
Senior Vice President

TWH/ldw

On behalf of:

American Association of Community Colleges
American Association of State Colleges and Universities
American Council on Education
Association of American Universities
Association of Community College Trustees
Association of Governing Boards of Universities and Colleges
Association of Jesuit Colleges and Universities
Association of Public and Land-grant Universities
College and University Professional Association for Human Resources
Council for Christian Colleges and Universities
National Association of College and University Business Officer
National Association of Independent Colleges and Universities