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The 40 Percent Excise Tax on High-Cost Employer-Sponsored Health Coverage Effective in 2018

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Beginning in 2018, Internal Revenue Code ("Code") Section 4980I imposes a nondeductible excise tax ("Excise Tax") on employers, health insurance issuers, and/or entities administering plan benefits if the aggregate value of applicable employer-sponsored coverage exceeds a specified annual limit. The Excise Tax is equal to 40 percent of the aggregate value in excess of the annual limit.

Section 4980I was added to the Code by the Patient Protection and Affordable Care Act ("PPACA"). On February 23, 2015, the Department of the Treasury and the IRS ("Treasury") released Notice 2015-16, the first piece of preliminary guidance regarding Code Section 4980I. Notice 2015-16 describes the approaches Treasury is considering with regard to implementation of Code Section 4980I and requests comments on many issues. **Comments must be submitted by May 15, 2015.**

Notice 2015-16 states that it will be followed by a second notice describing and inviting comments on potential approaches to a range of additional issues under Code Section 4980I, including procedural issues relating to the calculation and assessment of

the Excise Tax. After considering the comments on both notices, proposed regulations under Code Section 4980I will be issued.

Since the enactment of PPACA, the Excise Tax has been referred to colloquially as the "Cadillac Tax," suggesting that it will only affect employers that provide very generous health benefit packages. Consultants and analysts who have evaluated the Excise Tax indicate that, in fact, it is very likely to impact a broad range of employer-sponsored plans – not only the richest.

Although the Excise Tax does not apply until the 2018 tax year, the release of Notice 2015-16 provides employers with an opportunity to understand how Treasury is approaching the Excise Tax and to submit comments to Treasury regarding its implementation. It is important that employers take steps now to understand how the tax applies, Treasury's positions on the tax as set forth in Notice 2015-16 and the approach it is taking to develop regulations, and what potential changes, if any, should be made to coverage offered to employees and their dependents.

This Benefits Blueprint provides an overview and commentary with respect to the statutory requirements of the Excise Tax and the Treasury guidance reflected in Notice 2015-16. A companion document with responses to certain "Frequently Asked Questions" related to the Excise Tax is also available on the Council website.

WHAT IS THE PURPOSE OF THE EXCISE TAX?

Congress included the Excise Tax in PPACA as a way to "bend the cost curve" by restraining health care spending – reflecting a belief of economists that health plans providing very high levels of coverage (i.e., low or no deductibles, copayments or other cost-sharing) promote over-consumption of health care.

In addition, the tax under Code Section 4980I was scored by the Congressional Budget Office ("CBO") and the Joint Committee on Taxation ("JCT") as raising revenue to finance the cost of other provisions of PPACA.

When scoring the impact of the Excise Tax, CBO and JCT estimated that at least 70 percent of the revenue raised by this provision would be associated with employers making changes to lower the value of their plans to avoid incurring the Excise Tax and, instead, increase taxable wages. As a result, less than 30 percent of the revenue raised would be generated by employers actually paying the Excise Tax.

Blueprint Note: In March 2015, CBO and JCT updated their estimates of the budgetary effects of major provisions of PPACA, including the Excise Tax. CBO and JCT now estimate the Excise Tax will raise $87 billion over the 2016-2025 period – a decrease of $62 billion (or 41 percent). Because premiums are projected to be lower, the CBO and

the JCT estimate that "fewer workers are expected to be enrolled in employment-based insurance plans whose costs exceed the Excise Tax thresholds." Additionally the agencies "now project that, on net, 1 million to 2 million fewer people will move out of employment-based coverage under the ACA than they projected previously. A smaller loss of employment-based coverage means that less nontaxable compensation in the form of health benefits will be converted to taxable compensation as a result of the ACA."

TO WHAT COVERAGE DOES THE EXCISE TAX APPLY?

The Excise Tax applies to "applicable employer-sponsored coverage," which generally means coverage under any group health plan made available to the employee by an employer "which is excludable from the employee's gross income under Code Section 106, or would be so excludable if it were employer-provided coverage (within the meaning of Code Section 106)."

Blueprint Note: The definition of "employee" for this purpose includes former employees, surviving spouses, and other "primary insured individual[s]," the last of which is undefined. Given the broad definition of "employee" as set forth in the statute, it appears that the Excise Tax will apply to coverage for active employees as well as retirees. Additionally, because the Excise Tax is ***not*** a market reform provision, but instead is a stand-alone excise tax provision in the Code, it appears that the Excise Tax will also apply to retiree-only plans (which are excepted from PPACA's market reform provisions).

"Applicable employer-sponsored coverage" encompasses insured and self-funded plans, and it also includes both employer- and employee-paid coverage. It also applies to governmental plans (although Treasury has indicated that a plan maintained primarily for members of the military by either the United States or an individual state or governmental entity is not subject to the Excise Tax). Finally, the Excise Tax also applies to coverage for self-employed individuals.

Blueprint Note: "Applicable employer-sponsored coverage" generally appears to encompass coverage paid for on a pre-tax or post-tax basis, regardless of whether it is paid for by the employer or the employee. Accordingly, with very limited exceptions, employers may not be able to avoid the Excise Tax by merely shifting coverage in excess of the statutory dollar thresholds to employees and/or to after-tax coverage. As explained in more detail below, one of the few exceptions is that *employee after-tax contributions* to health savings accounts ("HSAs") and Archer Medical Savings Accounts ("Archer MSAs") are not taken into account (although employer non-elective contributions and pre-tax employee contributions to HSAs and Archer MSAs are).

Notice 2015-16 states that Treasury currently believes all of the following are taken into account when determining "applicable employer-sponsored coverage":

- HRAs;
- FSAs;
- Executive physical programs;
- Employer contributions to HSAs and Archer MSAs, also including pre-tax salary reduction contributions; and
- On-site medical clinics (if they offer more than de minimis medical care).

Blueprint Note: Per Notice 2015-16, health flexible spending arrangements ("FSAs") and health reimbursement arrangements ("HRAs") are considered by Treasury to be applicable employer-sponsored coverage for purposes of the Excise Tax. This is because these arrangements, whether paid for by an employee with pre-tax dollars (such as with FSAs) or by an employer (such as with HRAs or employer "flex" credits to an FSA) are excludable from the accountholder's gross income by reason of Code Section 106.

Regarding HSAs and Archer MSAs, to the extent the contributions are made by an employee via salary reduction with pre-tax dollars or by an employer as excludable contributions, contributions will qualify as applicable employer-sponsored coverage. Treasury confirmed, however, in Notice 2015-16 that amounts contributed to an HSA or MSA by an employee via after-tax payroll deduction or otherwise with after-tax dollars do not qualify as applicable employer-sponsored coverage. This is because these amounts are not excludable from the employee's income by reason of Code Section 106, but rather are eligible for deduction by the employee on the employee's annual federal tax return by reason of Code Section 223 (for HSAs) or Code Section 220 (for MSAs).

The statutory language of Code Section 4980I also makes clear that coverage for on-site medical clinics constitutes applicable employer-sponsored coverage. A report issued by the JCT on March 21, 2010 entitled "Technical Explanation of the Revenue Provisions of the 'Reconciliation Act of 2010,' as Amended, in Combination with the 'Patient Protection and Affordable Care Act'" ("JCT Report") provided that applicable employer-sponsored coverage includes on-site medical clinics if they offer more than a de minimis amount of care to employees and executive physical programs. Notice 2015-16 reiterates that it is anticipated that Treasury regulations will provide that applicable coverage does not include on-site medical clinics that offer only de minimis medical care to employees.

Blueprint Note: Treasury notes in Notice 2015-16 that existing 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." While not explicitly stated, Notice 2015-16 implies that this would be the standard for determining if an on-site health clinic provides de minimis medical care.

Treasury requests comments as to whether on-site facilities that provide first aid and other limited services to employees for no charge are applicable coverage. Treasury specifically asks how to treat 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).

Treasury also seeks comment on how to determine the cost of medical care for on-site medical clinics, and whether it should be based on the nature and scope of the benefits, a specific dollar limit on the cost of services provided, or some combination of these two standards.

TO WHAT COVERAGE DOES THE EXCISE TAX NOT APPLY?

For purposes of the Excise Tax, "applicable employer-sponsored coverage" specifically does *not* include certain types of coverage. Such excluded coverage is not taken into account for purposes of determining (i) whether there is a liability under Code Section 4980I, and (ii) the amount of any such liability.

The statutory language provides that the following are excluded from the definition of applicable employer-sponsored coverage:

- Coverage (whether through insurance or otherwise) described in Code Section 9832(c)(1) (*other than coverage for on-site medical clinics*):
    - Coverage only for accident, or disability income insurance, or any combination thereof;
    - Coverage issued as a supplement to liability insurance;
    - Liability insurance, including general liability insurance and automobile liability insurance;
    - Workers' compensation or similar insurance;
    - Automobile medical payment insurance;
    - Credit-only insurance; and
    - Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

- Coverage for long-term care.

- Any coverage under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye.

Blueprint Note: The statutory language excludes "[a]ny coverage **under a separate policy, certificate, or contract of insurance** which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye." The statutory language does not provide a similar, explicit exemption for self-funded stand-alone vision and dental plans.

Treasury requests comments on the following specific issue: In Notice 2015-16, Treasury indicates that it is considering whether to exercise its regulatory authority to propose an approach under which self-insured limited scope dental and vision coverage that qualifies as an excepted benefit would be excluded from applicable coverage. Treasury requests comments on any reasons why Treasury should not implement this approach.

- Coverage for a specified disease or illness described in Code Section 9832(c)(3) if offered as an independent, noncoordinated benefit and paid for with after-tax dollars (or, in the case of a self-employed individual, coverage that is not deductible).

- Hospital indemnity or other fixed indemnity insurance described in Code Section 9832(c)(3) if offered as an independent, noncoordinated benefit and paid for with after-tax dollars (or, in the case of a self-employed individual, coverage that is not deductible).

Blueprint Note: In general, coverage described in Code Section 9832(c)(3) is excluded from the definition of "applicable employer-sponsored coverage" only if it is paid for with after-tax dollars (or, in the case of a self-employed individual, it is not deductible). However, if the coverage is paid for by an employee via salary reduction with pre-tax wages (*e.g.*, through a Code Section 125 plan), or by an employer either directly or through premium reimbursement, it appears that such coverage will qualify as applicable employer-sponsored coverage and count against the statutory dollar thresholds.

Blueprint Note: It is important to note that not all excepted benefits set forth in Code Section 9832(c) are excluded from the definition of applicable employer-sponsored coverage for purposes of the Excise Tax. Because there is *not* a blanket exclusion for excepted benefits, employers must take care in determining whether a particular type of coverage is excluded from the definition of employer-sponsored coverage for

purposes of the Excise Tax.

Treasury requests comments on the following specific issue: Notice 2015-16 states that Treasury is considering excluding employee assistance plans ("EAPs") that qualify as an excepted benefit, under regulations released in October 2014. Treasury requests comment on any reasons why it should not implement this approach.

Blueprint Note: Neither the statutory language nor Notice 2015-16 includes an express exception from the Excise Tax for wellness plans. Many wellness plans are integrated with a major medical plan. This is, in part, because wellness programs providing material amounts of medical care within the meaning of Code Section 213 may not qualify as a PPACA-compliant plan on their own. Thus, many employers couple wellness plans with PPACA-compliant major medical plans. With respect to such coupled or integrated arrangements, the major medical plan will also be subject to a valuation for purposes of the Excise Tax. Thus, any additional value with respect to the wellness plan could be accounted for as part of valuing the related major medical plan.

HOW IS THE EXCISE TAX DETERMINED?

The Excise Tax is equal to 40 percent of the aggregate value of applicable employer-sponsored coverage that exceeds a specified annual limitation. The Excise Tax is triggered for a calendar year if there is an "excess benefit" with respect to applicable employer-sponsored coverage at any time during the calendar year.

"Excess benefit" is determined on a monthly basis, and, for this purpose, means the amount, if any, by which the "aggregate cost" of an employee's applicable employer-sponsored coverage for the month exceeds 1/12 of the "annual limitation" for the calendar year including that month. The annual limitation for 2018 is $10,200 for self-only coverage and $27,500 for coverage other than self-only.

> **Example:** In 2018, Employee A and his family are enrolled in self-insured employer-sponsored coverage with an aggregate annual cost of $33,000. Neither Employee A nor his family is enrolled in other applicable employer-sponsored plans. Assuming no adjustments are made to the annual dollar limitations as discussed below, the plan would be liable for an Excise Tax for 2018 equal to $2,200 (40% * ($33,000 - $27,500) = $2,200).

IRS Notice 2015-16 indicates that future rulemaking will provide that an employee will be treated as having self-only coverage unless (i) the employee is enrolled in coverage that provides minimum essential coverage to the employee and at least one other beneficiary, and (ii) the benefits provided under the minimum essential coverage do not vary based on whether any individual covered under the coverage is the employee or another beneficiary.

Additionally, any coverage provided under a multiemployer plan (as defined in Code Section 414(f)) shall be treated as coverage other than self-only coverage. Thus, even if an individual is enrolled in self-only coverage with respect to a multiemployer plan, the increased dollar threshold for family coverage will apply for purposes of determining any Excise Tax liability with respect to that individual.

As noted above, the statute provides that there is one annual limitation that applies to self-only coverage, and another annual limitation that applies to other-than-self-only coverage.

It is possible, however, that an employee could have both self-only and other-than-self-only coverage simultaneously (for example, the employee could be enrolled in self-only major medical coverage and also have an HRA that could be used to pay for dependent medical expenses). Treasury indicates that the dollar threshold in this situation will be determined through future rulemaking, and Notice 2015-16 sets forth two possible approaches. Under the first 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 that accounts for the majority of the aggregate cost of applicable coverage. The second contemplated approach would apply a composite dollar limit determined by prorating the dollar limits for each employee according to the ratio of the cost of the self-only coverage and the cost of the other-than-self-only coverage provided to the employee.

In either instance, employers should consider the possibility that they may have to take into account different benefit packages enrolled in by employees, some that may provide self-only coverage and others that may offer coverage other than self-only, and monitor different dollar thresholds for different employees based on the coverage that is elected.

Treasury requests comments on the potential approaches described above, including any potential administrative difficulties in applying them, as well as any other approaches that might address the issue.

Blueprint Note: All employers treated as a single employer for purposes of Code Section 414(n) are treated as a single employer for purposes of the Excise Tax. To the extent that a given employee receives coverage from more than one controlled group member, it appears that the coverage would need to be aggregated for purposes of applying the statutory dollar thresholds with respect to the employee. Such aggregation will be difficult to administer and will require that employers belonging to the same controlled group work together to determine the cost of aggregated coverage.

WHAT ADJUSTMENTS ARE MADE FOR PURPOSES OF DETERMINING THE APPLICABLE DOLLAR THRESHOLDS?

For 2018, the "annual limitation" is (i) $10,200 for self-only coverage and (ii) $27,500 for coverage other than self-only coverage, multiplied by a "health cost adjustment percentage" ("Base Limitation"), adjusted as provided below. For 2018, the Base Limitation is further increased by an age and gender adjustment. For 2019 and later years, the Base Limitation is adjusted for inflation and is further increased by an age and gender adjustment.

The Base Limitation for 2018 is equal to 100 percent of the applicable dollar amount, plus the excess (if any) of (1) 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 ("FEHBP") for plan year 2018 (determined by using the benefit package for such coverage in 2010) exceeds such cost for plan year 2010, over (2) 55 percent.

In 2019, the Base Limitation is indexed for inflation tied to the CPI-U, plus one percentage point, rounded to the nearest $50. In 2020 and later years, the threshold amounts are indexed to the CPI-U, rounded to the nearest $50.

Blueprint Note: Many employers and policymakers have expressed concerns that the Excise Tax threshold is indexed to the rate of consumer inflation rather than medical costs or medical inflation. Indexing limits based on changes to the CPI-U likely will not be adequate to keep up with the cost of medical inflation. Historically, medical costs have increased at a much faster rate than general inflation, so the tax likely will be imposed on many more plans each year. Employers that are subject to the employer mandate under Code Section 4980H are required to offer employer-sponsored coverage that meets PPACA's minimum value requirements in order to avoid employer shared responsibility penalties. Such minimum value coverage will progressively approach the Code Section 4980I thresholds in future years.

Congress was also aware of these issues when PPACA was enacted. The Senate Finance Committee issued a report accompanying the health care reform bill reported out of Committee in October of 2009. The report included additional views of Senators Kerry, Rockefeller, Schumer, Stabenow, and Menendez. The five Senators agreed with the goal of restraining health care spending. However, they noted, "we remain concerned the thresholds are too low and will impact plans that are not overly generous and that in 2019 far too many plans will be impacted by the Excise Tax. We plan to continue to work with Chairman Baucus on this issue to ensure that provision bends the cost curve, but not at the expense of middle income Americans." S. Rep. No. 111-89, at 444 (2009).

Age and Gender Adjustment

The age and gender adjustment is equal to the excess (if any) of (1) the premium cost of the Blue Cross/Blue Shield standard benefit option under the FEHBP for the type of coverage provided to an individual in a taxable period if priced for the age and gender characteristics of all employees of the individual's employer, over (2) the 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.

Blueprint Note: The statutory language is not entirely clear on how each of these adjustments relate to one another. Accordingly, questions remain regarding how these adjustments can be coordinated or otherwise "stacked" together. Future guidance will need to specify how these adjustments are coordinated. The JCT Report includes the following example, which is helpful in showing how the adjustments are intended to work together.

> **Example**: If the growth in the cost of health care during the period between 2010 and 2018, calculated by reference to the growth in the per employee cost of standard FEHBP coverage during that period (holding benefits under the standard FEHBP coverage constant during the period) is 57 percent, the threshold amounts for 2018 would be $10,200 for individual coverage and $27,500 for family coverage, multiplied by 102 percent (100 percent plus the excess of 57 percent over 55 percent), or $10,404 for individual coverage and $28,050 for family coverage. The new threshold amounts (as indexed) would then be increased for any employee by the age and gender adjusted excess premium amount, if any. For an employee with individual coverage in 2019**,** if standard FEHBP coverage priced for the age and gender characteristics of the workforce of the employee's employer is $11,400 and the Secretary estimates that the premium cost for individual standard FEHBP coverage priced for the age and gender characteristics of the national workforce is $10,500, the threshold for that employee would be increased by $900 ($11,400 less $10,500).

Treasury requests 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."

Adjustments for Qualified Retirees and Certain High-Risk Professions

An additional special adjustment applies to individuals who are either (i) "qualified retirees" or (ii) "participants 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 and telecommunications lines." With respect to such individuals, the dollar thresholds specified above are increased by $1,650 for self-only coverage, and $3,450 for coverage other than self-only coverage (indexed for inflation).

The term "qualified retiree" means any individual who (i) is receiving coverage by reason of being a retiree, (ii) has attained age 55, and (iii) is not entitled to benefits or eligible for enrollment under the Medicare program under title XVIII of the Social Security Act.

Treasury requests comments regarding how an employer would determine that an employee is not eligible for enrollment under the Medicare program.

The term "employees engaged in a high-risk profession" means certain law enforcement officers, certain employees in fire protection activities, individuals who provide out-of-hospital emergency medical care, certain individuals whose primary work is longshore work, and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. The term includes an employee who is retired from a high-risk profession described in the preceding sentence, if such employee satisfied the requirements of the preceding sentence for not less than 20 years during employment.

Treasury requests comments on a number of issues related to "high-risk professions," including:

- How an employer would determine whether the majority of employees covered by a plan are engaged in a high-risk profession;
- What the term "plan" means in that context;
- How an employer would determine that an employee was engaged in a high-risk profession for at least 20 years; and
- Whether further guidance on the definition of "employees engaged in a high risk profession" would be beneficial, taking into consideration that various categories set forth in the statutory language are determined by laws not under the jurisdiction of Treasury or IRS.

HOW IS THE AGGREGATE COST OF APPLICABLE COVERAGE DETERMINED?

The "aggregate cost" of applicable employer-sponsored coverage is determined by adding the costs of each type of applicable employer-sponsored coverage. Treasury clarified in Notice 2015-16 that the applicable coverage for purposes of determining the Excise Tax is the applicable coverage in which the employee is enrolled.

The cost of coverage is determined using rules similar to those that apply for purposes of Code Section 4980B (i.e., the rules that apply for determining the

"applicable premium," or the cost of coverage, for COBRA purposes). Code Section 4980B(f)(4) generally provides that the term "applicable premium" means the cost to the plan for the coverage for *similarly situated* beneficiaries. Therefore, it is understood that, in determining the cost of applicable employer-sponsored coverage for purposes of Code Section 4980I, the general principles for determining the cost of COBRA coverage will apply.

Notice 2015-16 indicates that Treasury anticipates making material changes to the existing COBRA rules for purposes of valuing coverage with respect to Code Section 4980I, and that future guidance for determining the COBRA applicable premium is likely to attempt to harmonize the COBRA rules with the rules under Code Section 4980I to the extent practicable. Notice 2015-16 further states that, "[a]lthough the rules for determining the cost of applicable coverage under [Code Section] 4980I generally can be expected to be similar to the rules for determining the COBRA applicable premium, some differences may be appropriate."

Blueprint Note: The COBRA rules provide that the determination of any COBRA applicable premium is to be made in advance for a 12-month period. Similarly, Treasury contemplates that the method for calculating the cost of applicable coverage would be elected prior to the determination period for which the cost is determined. For example, a self-insured plan using the calendar year as the 12-month determination period would elect the method (actuarial or past cost) before the beginning of the calendar year. If the plan elected the past cost method, it would also have elected its measurement period as well. Under these rules, the amount of any Excise Tax would generally be known at the beginning of the taxable year generating the liability.

Determining "Similarly Situated Individuals"

In order to determine the cost of coverage for employees, employers need to know how to determine the different costs for different groups of "similarly situated employees" (similar to how employers can charge different COBRA rates for different employees, based on the cost to the plan for "similarly situated beneficiaries" under the COBRA rules).

The general approach that Treasury is considering for allowing employers to identify how to categorize groups of "similarly situated employees" starts by taking 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.

Step 1 – Mandatory Aggregation Based on Benefit Package: The initial groups of similarly situated employees would be determined by aggregating all employees covered by a particular benefit package provided by the employer. For example, if an employer offered an HMO, two PPOs, and a high-deductible health plan, each would be

considered a separate benefit package, which would result in the employer having four separate benefit packages. If an employee was provided a choice between a standard plan and a high option (e.g., an option with lower deductibles and copays), employees covered under the high option would be grouped separately from those covered under the standard option.

Step 2 – Mandatory Disaggregation Based on Self-Only or Family Coverage: All employees covered by a benefit package would then have to be disaggregated based on whether the employee was enrolled in self-only or other-than-self-only coverage.

Step 3 – Permissive Aggregation Within Other-Than-Self-Only Coverage: Treasury is considering whether an employer would not have to determine separate "costs of coverage" for employees receiving family coverage based on the number of individuals covered in addition to the employee.

Blueprint Note: Permissive aggregation will generally benefit employers, because aggregating coverage under the limitation thresholds with coverage that triggers an Excise Tax should, mathematically speaking, reduce the aggregate potential tax liability.

Step 4 – Permissive Disaggregation Based on Other Distinctions: Treasury is considering whether to allow (but not require) an employer to subdivide further the group of employees that would be treated as similarly situated, based on either a broad standard (for example, bona fide employment-related criteria such as compensation, job categories, union groups, etc.) or a more specific standard (for example, current vs. former employees, bona fide geographic distinctions, number of individuals covered in addition to the employee).

Blueprint Note: Many employers are concerned that the Excise Tax does not take into account the variation in health coverage costs across geographic localities in the United States. The statutory language does not provide for an increased dollar threshold based on where an employer or its employees are located. Permissive disaggregation of groups of employees for purposes of determining similarly situated employees appears to be the only basis for an employer to distinguish the cost of benefits based on geographic considerations (assuming the approach is included in final regulations).

The statute contains specific language regarding retiree coverage and provides that a plan may treat pre-65 and post-65 retirees as similarly situated such that they have the same cost of coverage.

Blueprint Note: Because the statute provides that a plan may treat pre-65 and post-65 retirees as similarly situated for purposes of determining the aggregate cost of the subject coverage, the costs for both groups can be taken into account in determining a single aggregate cost for retiree coverage. Because pre-65 retiree coverage tends to be

more expensive than post-65 retiree coverage, being able to treat the groups as similarly situated for purposes of determining aggregate cost may lower the aggregate cost of an employer's retiree plans for purposes of applying the Excise Tax.

Treasury requests comments on the potential approach described above with respect to determining groups of similarly situated employees, including areas in which additional guidance would be beneficial.

With respect to the potential approach to mandatory aggregation of employees who are enrolled in the same benefit package, comments are requested on the extent to which benefit packages must be identical to be considered the same for this purpose and, if differences are permitted, the nature and extent of those permitted differences.

With respect to the two potential approaches for permissive disaggregation, comments are requested on which approach is preferable. If the second approach (under which specific criteria for permissive disaggregation are enumerated) is preferable, comments are requested on what specific criteria should be permitted.

Comments are also requested on whether additional guidance would be beneficial under Code Section 4980I(d)(2)(A), which states that, for applicable coverage provided to 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."

Self-Insured Plans

In Notice 2015-16, Treasury indicates that the methods currently prescribed by COBRA for self-insured plans to compute the COBRA applicable premium – the "actuarial basis" method and the "past cost" method – will also apply for determining the cost of applicable coverage for self-insured plans under Code Section 4980I. The actuarial basis method provides that the COBRA premium (or cost of coverage) can be determined by a plan on an actuarial basis, while the past cost method provides that the COBRA premium (or cost of coverage) can be determined based on the cost to the plan for similarly situated beneficiaries during a preceding determination period, adjusted for inflation. A plan must use the actuarial basis method unless the plan administrator elects to use the past cost method and the plan is eligible to use that method.

- **Actuarial Basis Method:** Treasury suggests that the cost of applicable coverage for a group of similarly situated individuals would be equal to a reasonable estimate of the cost of providing coverage under the plan for individuals in that group for the determination period, using reasonable actuarial principles and practices. Under this standard, an estimate of cost would be an estimate of the

actual cost the plan is expected to incur for a determination period, not the minimum (or maximum) exposure that the plan could have for that period.

- **Past Cost Method:** Treasury is considering whether to issue guidance providing that plans choosing the past cost method 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 beginning of the current determination period. The measurement period would have to be applied consistently. The costs that must be taken into account in computing costs under the past cost method could 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. Those costs could include either claims incurred during the measurement period (whether paid or unpaid) or claims submitted during the measurement period (regardless of when incurred).

- **Changing Methods:** Treasury is considering proposing a rule (that would apply for both COBRA and Code Section 4980I purposes) that generally would require a plan to use the valuation method that it chooses for a period of at least five years. The only exception would be based on the prohibition under COBRA rules on using the past cost method if there is a significant difference between periods in coverage under, or in employees covered by, the plan. In that case, the plan might be required to use the actuarial basis method for the two years following the significant change.

Treasury requests comments on the following specific issue: Notwithstanding the guidance described above, Treasury is soliciting comments 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.

Although Code Section 4980I appears to require that the cost of coverage be determined in accordance with COBRA principles, in Notice 2015-16, Treasury notes that it has been suggested that the cost of applicable coverage could instead be determined by reference to the cost of similar coverage available elsewhere (for example, based on actuarial values, metal levels, or the cost of coverage available on an Exchange).

Treasury requests comments on 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.

HRAs

As noted above, while an HRA is "applicable employer-sponsored coverage" for purposes of the Excise Tax, it may be challenging for some employers to determine the cost of applicable coverage under an HRA. In Notice 2015-16, Treasury lays out possible approaches for how to value the cost of an HRA. One approach would base the cost of applicable coverage under an HRA on the amounts made newly available to a participant each year. Another approach would permit employers to determine the cost of coverage by adding together all claims and administrative expenses attributable to HRAs for a particular period.

Treasury requests comments on the following specific issue: Notice 2015-16 indicates 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 (since this would effectively double-count the cost for Code Section 4980I purposes). Others 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.

WHO PAYS THE TAX?

Notice 2015-16 states that Treasury intends to issue a separate notice (before publication of proposed regulations) describing and requesting comments on potential approaches to procedural issues relating to calculation and assessment of the Excise Tax.

Under the statute, the sponsoring employer is required to determine the total amount of the Excise Tax. Once it has calculated the amount of the Excise Tax, the employer must allocate the amount among those entities liable for paying the tax.

Code Section 4980I(c) provides that entities are liable for paying the portion of the Excise Tax as follows:

- The health insurance issuer is liable for paying the share of the Excise Tax attributable to health insurance coverage that it underwrites.

Blueprint Note: It is likely that issuers will seek to utilize contractual provisions to protect themselves against unexpected Excise Tax liability. For example, issuers might respond by requiring employers to: (i) indemnify issuers against any Excise Tax liability; (ii) establish reserves for payment of any resulting liabilities; and/or (iii) agree to covenants prohibiting the offering of benefits that would result in Excise Tax liability to the issuer. Interestingly, if issuers were to build potential Excise Tax liability into their premiums, the added expense could have the perverse result of creating additional Excise Tax liability.

- The employer is liable for paying the share of the Excise Tax attributable to HSA and MSA contributions that are applicable employer-sponsored coverage.

- The "person that administers the plan benefits" is liable for paying the share of the Excise Tax attributable to "any other applicable employer-sponsored coverage."

Blueprint Note: Treasury has not yet provided any guidance regarding how it will interpret the statutory language regarding "the person that administers the plan benefits." One interpretation could be that the person "administer[ing]" the plan benefits is the ERISA plan administrator as listed on the Form 5500. If so, in almost all instances, the sponsoring employer will be responsible for this portion of the Excise Tax – even where the sponsoring employer has contracted with a third party (such as an administrative services organization ("ASO")) to administer the benefits.

Blueprint Note: One open question is whether at least some of the Excise Tax may be paid from an ERISA plan's assets. With respect to self-funded plans, because the Excise Tax is imposed upon the employer and/or the plan administrator, and not the plan itself, the extent to which any Excise Tax liability could be charged back to the plan is questionable. Notably, the Patient-Centered Outcomes Research Institute ("PCORI") fee generally cannot be paid as an ERISA plan expense because it is imposed on the plan sponsor. In contrast, contributions due under the Transitional Reinsurance Program ("TRP") are chargeable to an ERISA plan and this appears to be because the contributions under the TRP – by statute – are the responsibility of the plan itself. With respect to the Excise Tax, the liability would belong not to the plan by statute, but to the employer or plan administrator. It is unclear whether any of the tax can be charged back to the plan directly. We expect future guidance will clarify this issue.

The statutory language makes clear that the Excise Tax is a *nondeductible* tax.

Blueprint Note: Because the Excise Tax is not deductible, the actual cost to the employer and/or issuer is actually greater than its stated 40 percent rate because of the lost deduction by the party to which the Excise Tax is allocated.

WHAT ARE THE PENALTIES FOR FAILING TO PROPERLY CALCULATE AND/OR PAY THE EXCISE TAX?

If an employer does not accurately calculate the portion of the excess benefit (if any) attributable to each coverage provider (i.e., the employer, issuer, or another person administering coverage), and, as a result, a provider pays insufficient tax, the provider must pay the amount of the additional tax, and the employer will have to pay a penalty equal to 100 percent of the missed portion of the Excise Tax that was underpaid by the provider due to the miscalculation (in addition to any Excise Tax it must otherwise pay). The employer must also pay underpayment interest.

Blueprint Note: Given the 100 percent additional penalty tax for employers, employers will have plenty of incentive to diligently calculate and report to each provider such provider's share of any Excise Tax liability. Notably, the Treasury Secretary may waive all or a portion of the penalty if the failure is due to reasonable cause and not to willful neglect and to the extent the penalty would be excessive or otherwise inequitable relative to the failure involved.