Section 4980I — Excise Tax on High Cost Employer-Sponsored Health Coverage
IRS Notice 2015-16

On Monday, February 23, 2015, the IRS issued Notice 2015-16 ("Notice"). The Notice is intended to initiate and inform the process of developing regulatory guidance regarding the excise tax on high cost employer-sponsored health coverage under § 4980I of the Internal Revenue Code (Code). Section 4980I applies to taxable years beginning after December 31, 2017. Under this provision, if the aggregate cost of "applicable employer-sponsored coverage" provided to an employee exceeds a statutory dollar limit, which is revised annually, the excess is subject to a 40 percent excise tax.

The Department of the Treasury (Treasury) and the Internal Revenue Service (IRS) (collectively, the Agencies) invite comments on the issues addressed in this notice and on any other issues under § 4980I. Comments are due by May 15, 2015. The Agencies anticipate issuing another notice, before the publication of proposed regulations, inviting comments on potential approaches to a number of issues not addressed in the Notice, including procedural issues relating to the calculation and assessment of the excise tax.

I. Definition of Applicable Coverage

As outlined in the Notice, certain types of coverage are explicitly included and excluded from the definition of "applicable coverage." In addition to the types of coverage explicitly excluded and included in the definition of applicable coverage, the Agencies anticipate the following inclusions and exclusions from applicable coverage:

A. HSAs/Archer MSAs

The Agencies anticipates 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.

B. On-site Medical Clinics

The Agencies 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. Comments are requested on how the Agencies 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.

C. Limited Scope Dental and Vision Benefits

The Agencies 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. Comments are requested on any reasons why the Agencies should not implement this approach.

D. Employee Assistance Programs (EAPs)

The Agencies are considering whether 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 the Agencies should not implement this approach.

II. Determination of Cost Of Applicable Coverage

Section 4980I imposes a 40 percent excise tax on the excess, if any, of the aggregate cost of the applicable coverage of an employee for a month over the applicable dollar limit for the month. Section 4980I(d)(2)(A) provides that the cost of applicable coverage generally is determined under rules similar to the rules of §

4980B(f)(4), which apply for purposes of determining the COBRA applicable premium. Section 4980I also prescribes specific calculation rules that apply to certain types of arrangements.

A. Aggregate Cost of Applicable Coverage Based on Applicable Coverage in Which Employee is Enrolled

Although other subsections of the statute refer to the coverage “made available” to the employee, §§ 4980I(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.

B. Potential Approaches for Determining Cost of Applicable Coverage

The Notice outlines potential approaches for determining the cost of applicable coverage for purposes of the excise tax.

i. Similarly Situated Individuals

The Agencies anticipate that a somewhat similar standard will apply for § 4980I and 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. Under the potential approach that the Agencies are considering, 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.

- **Aggregation by 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. The employees enrolled in each different benefit package would be grouped separately. Benefit packages would be considered different based upon differences in health plan coverage.
- **Mandatory Disaggregation (Self-Only Coverage and Other-Than-Self-Only Coverage).** Within a particular benefit package, employees receiving self-only coverage would be grouped separately from those receiving family coverage.
- **Permissive Aggregation within Other-Than-Self-Only Coverage.** The Agencies 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).
- **Permissive Disaggregation.** The Agencies are 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.

ii. Self-Insured Methods

Section 4980B(f)(4)(B) prescribes two methods for self-insured plans to compute the COBRA applicable premium — the actuarial basis method and the past cost method. 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. The Agencies anticipate that, in general, these two methods will apply for purposes of determining the cost of applicable coverage for self-insured plans for purposes of § 4980I.

- **Actuarial Basis Method.** The actuarial basis method provides that, to the extent that a plan is a self-insured plan, the COBRA applicable premium is equal to a reasonable estimate of the cost of providing coverage for similarly situated beneficiaries that (i) is determined on an actuarial basis, and (ii) takes into account such factors as the Secretary may prescribe in regulations. The Agencies have not issued regulations prescribing factors to take into account.

- **Past Cost Method.** The past cost method provides that the COBRA applicable premium is equal to "(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." A plan administrator may not elect to use the past cost method "in any case in which there is any significant difference between the determination period and the preceding determination period, in coverage under, or in employees covered by, the plan…." The determination of any COBRA applicable premium must be made for a period of 12 months and must be made before the beginning of that period.

The Agencies are considering proposing a rule under § 4980B 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 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. The Agencies are also considering whether to adopt a similar standard for purposes of § 4980I.

III. Applicable Dollar Limit

Section 4980I(b)(3) provides two annual dollar limits — one for an employee with self-only coverage and one for an employee with other-than-self-only coverage. In general, the prorated annual limitation that applies for any month is determined based on whether self-only or other-than-self-only coverage is provided to the employee by the employer as of the beginning of the month.

A. Potential Approach for Application of Dollar Limit to Employees with both Self-Only and Other-Than-Self-Only Applicable Coverage

An employee may simultaneously have coverage to which the self-only dollar limit applies and coverage to which the other-than-self-only dollar limit applies. For example, an employee may have self-only major medical coverage and supplemental coverage (such as an HRA) that covers the employee and the employee's family.

The Agencies 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.

The Agencies are also considering an alternative approach that 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.

B. Dollar Limit Adjustments

Section 4980I(b)(3) provides two baseline per-employee dollar limits for 2018 ($10,200 for self-only coverage and $27,500 for other-than-self-only coverage) but also provides that various adjustments will apply to increase these amounts. The Agencies intend to include rules regarding these adjustments in proposed regulations.

i. Adjustments for Qualified Retirees

Section 4980I(b)(3)(C)(iv) provides that an additional amount is added to the dollar limits for an individual who is a "qualified retiree." For this purpose, a "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." The Agencies request comments on how an employer determines that an employee is not eligible for enrollment under the Medicare program.

ii. 2. Adjustments for High-Risk Professions

Section 4980I(b)(3)(C)(iv) provides that an additional amount is added to the dollar limits for an individual "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." "Employees engaged in a high-risk profession" means certain enumerated occupations and includes employees who are retired from high-risk professions if the employee engaged in such profession for at least 20 years. The Agencies request comments on 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 that context and how an employer determines that an employee was engaged in a high-risk profession for at least 20 years.

iii. Age and Gender Adjustments

Section 4980I(b)(3)(C)(iii) provides that the amounts of the dollar limits for an employer may be increased by an age and gender adjustment if the age and gender characteristics of an employer's workforce are different from those of the national workforce. Comments are requested on 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.