Section 4980I — Excise Tax on High Cost Employer-Sponsored Health Coverage

Notice 2015-16

I. PURPOSE AND OVERVIEW

This 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, which was added to the Code by the Affordable Care Act,[1] applies to taxable years beginning after December 31, 2017. Under this provision, if the aggregate cost of "applicable employer-sponsored coverage" (referred to in this notice as applicable coverage) provided to an employee exceeds a statutory dollar limit, which is revised annually, the excess is subject to a 40% excise tax.

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

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

This notice includes the following sections:

Section I: Purpose and Overview

Section II: Background

Section III: Definition of Applicable Coverage

Section IV: Determination of Cost of Applicable Coverage

Section V: Applicable Dollar Limit

[1] The "Affordable Care Act" refers to the Patient Protection and Affordable Care Act (enacted March 23, 2010, Pub. L. No. 111-148) (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010 (enacted March 30, 2010, Pub. L. No. 111-152) (HCERA), and as further amended by the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (enacted April 15, 2011, Pub. L. No. 112-10).

Section VI: Possibility of Other Methods of Determining Applicable Coverage

Section VII: Request for Comments

Section VIII: Reliance

Section IX: No Inference

Section X: Drafting Information

II. BACKGROUND

A. Section 4980I

Section 4980I was added to the Code by § 9001 of PPACA, as amended by § 10901 of PPACA, and as further amended by § 1401 of HCERA. Section 4980I is effective for taxable years beginning after December 31, 2017.

Section 4980I(a) imposes a 40% excise tax on any "excess benefit" provided to an employee, and § 4980I(b) provides that an excess benefit is the excess, if any, of the aggregate cost of the applicable coverage of the employee for the month over the applicable dollar limit for the employee for the month. Section 4980I(d)(3) provides that for this purpose the term "employee" includes "a former employee, surviving spouse, or other primary insured individual."

Section 4980I(d)(1)(A) provides that applicable coverage means "with respect to any employee, coverage under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106)."

Section 4980I(d)(2)(A) provides in relevant part that the cost of applicable coverage is determined under rules "similar to the rules of section 4980B(f)(4)." Section 4980B(f)(4) defines the term "applicable premium" for purposes of COBRA[2] continuation coverage (referred to in this notice as the COBRA applicable premium). Section 4980I(d)(2)(A) also provides that, in determining the cost of applicable coverage for purposes of § 4980I, any amount that is attributable to the tax imposed under § 4980I is not taken into account for purposes of determining the cost of applicable coverage and that the amount of the cost of applicable coverage is to be calculated separately for self-only coverage and other-than-self-only coverage. Section 4980I(d)(2)(B) and (C) prescribe special rules for determining the cost of applicable coverage for retirees, health flexible spending arrangements (health FSAs), Archer medical savings accounts (Archer MSAs), and health savings accounts (HSAs).

Section 4980I(b)(3)(C) provides for two annual applicable dollar limits — one for an employee with self-only coverage and one for an employee with other-than-self-only

[2] COBRA refers to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99-272 (April 7, 1986).

coverage. Section 4980I(b)(3)(C) specifies per-employee baseline dollar limits for 2018 ($10,200 per employee for self-only coverage and $27,500 per employee for other-than-self-only coverage) but further provides for various adjustments to increase the applicable dollar limits in certain circumstances. Section 4980I(b)(3)(C)(ii) provides that a "health cost adjustment percentage" will be applied to the baseline dollar limits for 2018 to determine the applicable dollar limits for that year. Section 4980I(b)(3)(C)(v) provides that a cost-of-living adjustment will be applied to determine the applicable dollar limits for taxable years after 2018. In addition, § 4980I(b)(3)(C)(iii) provides that the dollar limits are increased by an age and gender adjustment, if applicable for an employer. 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" or "who participates in a plan sponsored by an employer the majority of whose employees covered by the plan are engaged in a high-risk profession or employed to repair or install electrical or telecommunication lines."

In general, § 4980I(b)(3)(B)(i) provides that the applicable dollar limit, which applies on a monthly basis, is determined based on the type of coverage (self-only or other-than-self-only) provided to an employee as of the beginning of a month. Section 4980I(f)(1) provides that an employee is treated as having self-only coverage with respect to any applicable coverage of an employer, except that an employee is treated as having other-than-self-only coverage if the employee is enrolled in coverage that provides minimum essential coverage (MEC), as defined in § 5000A(f), to the employee and at least one other beneficiary, and the benefits provided under that MEC do not vary based on whether any individual covered under the coverage is the employee or another beneficiary. In addition, any coverage provided under a multiemployer plan (as defined in § 414(f)) is treated as other-than-self-only coverage. § 4980I(b)(3)(B)(ii).

Section 4980I(c)(1) and (2) specify that the entity that "shall pay" the excise tax under § 4980I is (1) the "health insurance issuer" in the case of applicable coverage provided under an insured plan, (2) "the employer" if the applicable coverage "consists of coverage under which the employer makes contributions to" an HSA or Archer MSA, and (3) "the person that administers the plan" in the case of any other applicable coverage. In each case, the employer must calculate the tax and notify the entity liable for the excise tax (and the IRS) of the amount of the excise tax "at such time and in such manner as the Secretary may prescribe." § 4980I(c)(4). Section 4980I(f)(10) provides that any excise tax paid pursuant to § 4980I is not deductible for federal tax purposes.

Section 4980I(g) provides that "[t]he Secretary may prescribe such regulations as may be necessary to carry out this section."

B. COBRA Continuation Coverage

Generally, the cost of applicable coverage under § 4980I is "determined under rules similar to the rules" under COBRA for determining the COBRA applicable premium. § 4980I(d)(2)(A). Under COBRA, the amount that a plan may charge for continuation coverage generally is limited to 102% of "the applicable premium."

§ 4980B(f)(2)(C). The "applicable premium" means, "with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee)." § 4980B(f)(4)(A). In general, the COBRA applicable premium must be determined for a period of 12 months (the determination period), and must be determined before the beginning of the determination period. § 4980B(f)(4)(C).

Section 4980B(f)(4)(B) specifies two methods for self-insured plans to determine the COBRA applicable premium:

(1) the actuarial basis method, under which the cost is equal to a reasonable estimate of the cost of providing coverage for similarly situated beneficiaries determined on an actuarial basis, taking into account "such factors as the Secretary may prescribe in regulations"; and

(2) the past cost method, which may be used at the election of the plan administrator except in cases in which there has been a significant change in coverage under the plan or in employees covered by the plan.

The current COBRA regulations provide that plans and employers must calculate the COBRA applicable premium in good faith compliance with a reasonable interpretation of the statutory requirements in § 4980B. Treas. Reg. § 54.4980B-1, Q&A-2.

C. Form W-2 Reporting of Applicable Coverage

Separately from § 4980I, the Affordable Care Act added § 6051(a)(14) to the Code, which requires employers to report on Form W-2, Wage and Tax Statement, the aggregate cost (determined under rules similar to the rules of § 4980B(f)(4)) of applicable coverage (as defined in § 4980I(d)(1)).[3] As currently implemented, this amount is reported in Box 12 of the Form W-2, Wage and Tax Statement, using Code DD. See General Instructions for Forms W-2 and W-3.

Notice 2012-9, 2012-4 I.R.B. 315, provides interim guidance applicable to the 2012 Forms W-2 and will continue to be applicable until further guidance is issued.[4] Notice 2012-9 provides guidance on which employers are subject to the § 6051(a)(14) reporting requirement, methods for reporting, and methods for determining the cost of coverage. Notice 2012-9 also provides transition relief for certain employers (for example, those filing fewer than 250 Forms W-2 in the prior year) and with respect to certain types of employer-sponsored coverage (for example, health reimbursement arrangements (HRAs)).

[3] Section 6051(a)(14) was added to the Code by § 9002 of PPACA.

[4] Notice 2012-9 restated and amended the interim guidance on informational reporting to employees of the cost of their employer-sponsored group health plan coverage that was initially provided in Notice 2011-28, 2011-16 I.R.B. 656. Notice 2010-69, 2010-44 I.R.B. 576, provided that reporting under § 6051(a)(14) was not mandatory for 2011 Forms W-2.

The interim guidance provided under Notice 2012-9 is intended solely for purposes of § 6051(a)(14). Treasury and IRS do not anticipate that the same guidance or rules will apply for purposes of § 4980I. However, Treasury and IRS anticipate that to the extent guidance under § 4980I provides improved methods for determining the cost of applicable coverage, consistent rules may be issued for purposes of § 6051(a)(14).

III. DEFINITION OF APPLICABLE COVERAGE

A. In General

Section 4980I(d)(1)(A) provides that applicable coverage means "with respect to any employee, coverage under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106)."

Section 4980I(f)(4) provides that the term "group health plan" for purposes of § 4980I has the meaning given such term by § 5000(b)(1). Under § 5000(b)(1), "[t]he term 'group health plan' means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families."

Section 4980I(d)(1)(C) provides that coverage that meets the basic definition of applicable coverage is applicable coverage "without regard to whether the employer or employee pays for the coverage." In addition, coverage that otherwise meets the definition of applicable coverage is applicable coverage without regard to whether the employer provides the coverage (and thus the coverage is excludable from the employee's gross income) or the employee pays for the coverage with after-tax dollars. See § 4980I(d)(1)(A); see also Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as Amended, In Combination with the "Patient Protection and Affordable Care Act", prepared by the Joint Committee on Taxation (March 21, 2010, JCX-18-10) (JCT Report). Also, the general definition of applicable coverage includes both insured and self-insured coverage. See § 4980I(f)(4), § 5000(b)(1); see also JCT Report, at 62.

Section 4980I(d)(1)(D) provides that applicable coverage includes coverage under a group health plan for self-employed individuals, within the meaning of § 401(c), "if a deduction is allowable under § 162(l) with respect to all or any portion of the cost of coverage."[5]

[5] In general, § 162(l) allows a self-employed individual a deduction for amounts paid for medical insurance for the individual and his or her family. The deduction is limited by the individual's income from

Section 4980I(d)(3) provides that "the term employee includes any former employee, surviving spouse, or other primary insured individual." Accordingly, applicable coverage includes retiree coverage to the extent it otherwise constitutes applicable coverage.

B. Types of Coverage Included in Applicable Coverage

While § 4980I(d)(1)(A) provides a general definition of applicable coverage, other subsections of § 4980I explicitly address the following types of coverage and indicate that they constitute applicable coverage:

(1) Health FSAs (§ 4980I(d)(2)(B));

(2) Archer MSAs (but see section III.D of this notice for certain contributions by individuals that are not included) (§§ 4980I(c)(2)(B), 4980I(d)(2)(C));

(3) HSAs (but see section III.D of this notice for certain contributions by individuals that are not included) (§§ 4980I(c)(2)(B), 4980I(d)(2)(C));

(4) Governmental plans, defined as "coverage under any group health plan established and maintained primarily for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government" (but see section III.C of this notice for the exclusion of military coverage) (§ 4980I(d)(1)(E));

(5) Coverage for on-site medical clinics (but see section III.E of this notice for a potential approach that would exclude on-site medical clinics that provide only de minimis medical care) (§ 4980I(d)(1)(B)(i));

(6) Retiree coverage (§§ 4980I(d)(3), 4980I(b)(3)(C)(iv));

(7) Multiemployer plans (as defined in § 414(f)) (§§ 4980I(b)(3)(B)(ii), 4980I(c)(4)(B)); and

(8) Coverage described in § 9832(c)(3) (which includes coverage only for a specified disease or illness and hospital indemnity or other fixed indemnity insurance), if the payment for the coverage or insurance is excluded from gross income or a deduction under § 162(l) is allowed with respect to it (§ 4980I(d)(1)(B)(iii)).

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the trade or business and is not allowed if the individual is eligible to participate in any subsidized health plan maintained by an employer of the taxpayer or of certain other individuals related to the taxpayer. § 162(l)(2)(A), (B).

Other types of coverage, such as executive physical programs and HRAs, meet the general definition of applicable coverage under § 4980I(d)(1)(A) and are not specifically excluded by another provision of § 4980I. Future guidance is expected to provide that executive physical programs and HRAs are applicable coverage. See also JCT Report, at 62.

C. Types of Coverage Excluded from Applicable Coverage

Section 4980I(d)(1) also lists certain types of coverage that are excluded from applicable coverage. Under § 4980I(d)(1)(B), the following are excluded from applicable coverage:

(1) Coverage described in § 9832(c)(1) (other than sub-paragraph (G) thereof), whether through insurance or otherwise.[6] Section 9832(c)(1) (other than § 9832(c)(1)(G)) includes:

   (a) coverage only for accident, or disability income insurance, or any combination thereof (§ 9832(c)(1)(A));

   (b) coverage issued as a supplement to liability insurance (§ 9832(c)(1)(B));

   (c) liability insurance, including general liability insurance and automobile liability insurance (§ 9832(c)(1)(C));

   (d) workers' compensation or similar insurance (§ 9832(c)(1)(D));

   (e) automobile medical payment insurance (§ 9832(c)(1)(E));

   (f) credit-only insurance (§ 9832(c)(1)(F)); and

   (g) other insurance coverage, as specified in regulations, similar to the coverage listed in § 9832(c)(1) and under which benefits for medical care are secondary or incidental to other insurance benefits (§ 9832(c)(1)(H));[7]

(2) Coverage, whether through insurance or otherwise, for long-term care;

(3) 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 structure within the mouth) or for treatment of the eye (but see section III.F of this notice for a potential approach to exclude all limited scope dental and vision benefits that qualify as excepted benefits (insured and self-insured)); and

(4) Coverage described in § 9832(c)(3) (which includes coverage only for a specified disease or illness and hospital indemnity or other fixed indemnity

[6] Section 9832 describes certain excepted benefits, which are generally not subject to the provisions of chapter 100 of the Code pursuant to section 9831. See also Treas. Reg. § 54.9831-1. Chapter 100 was added to the Code by the Health Insurance Portability and Accountability Act of 1996, and imposes certain portability and nondiscrimination requirements with respect to group health plan coverage. Chapter 100 was later augmented by other consumer protection laws and by the Affordable Care Act.

[7] No excepted benefits have been added by regulation under § 9832(c)(1)(H).

insurance), if the payment for the coverage or insurance is not excluded from gross income or a deduction under § 162(l) is not allowed with respect to it.

In addition, § 4980I(d)(1)(E) implies that coverage provided under a plan maintained primarily for members of the military or for members of the military and their families by the Government of the United States, the government of any State or political subdivision thereof, or any agency or instrumentality of any such government is not applicable coverage. See § 4980I(d)(1)(E) (providing that governmental plans are included in applicable coverage and defining governmental plans as "coverage under any group health plan established and maintained primarily for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.") (Emphasis added.)

D. HSAs/Archer MSAs

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

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

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

E. On-site Medical Clinics

Section 4980I(d)(1)(B)(i) excludes from the definition of applicable coverage each of the excepted benefits listed in § 9832(c)(1), other than the § 9832(c)(1)(G) exception for on-site medical clinics. Accordingly, coverage provided through an on-site medical clinic generally is applicable coverage. Treasury and IRS, however, anticipate that the forthcoming proposed regulations will provide that applicable coverage does not include on-site medical clinics that offer only de minimis medical care to employees. This

exception would be consistent with the JCT Report, and it also avoids the burden of calculating the incremental additional cost of coverage that would be provided under such an arrangement, which most employees likely would not consider part of their health coverage. See JCT Report, at 62 ("Employer-sponsored health insurance coverage includes . . . on-site medical clinics that offer more than a de minimis amount of medical care to employees . . . .").

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

In addition, Treasury and IRS seek comment on the treatment of clinics that meet the criteria described in the COBRA regulations and provide certain services in addition to (or in lieu of) first aid, for example: (1) immunizations; (2) injections of antigens (for example, for allergy injections) provided by employees; (3) provision of a variety of aspirin and other nonprescription pain relievers; and (4) treatment of injuries caused by accidents at work (beyond first aid).

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

F. Limited Scope Dental and Vision Benefits

Section 4980I(d)(1)(B)(ii) excludes from applicable coverage "any coverage under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye." Because this section refers only to dental and vision benefits that are provided under a "separate policy, certificate or contract of insurance," stakeholders have asked whether this means that stand-alone dental and vision benefits will be treated differently for purposes of § 4980I depending on whether they are insured or self-insured.

As previously noted, generally whether coverage is insured or self-insured is not relevant for purposes of § 4980I, including for purposes of identifying whether any particular coverage is applicable coverage. §§ 4980I(d)(1)(A), (f)(4); JCT Report, at 62. Treasury and IRS, the Department of Labor and the Department of Health and Human Services (the Departments) recently amended the excepted benefit regulations under § 9831 on limited scope dental and vision benefits "to achieve greater consistency between insured and self-insured coverage." 79 FR 59130, 59132 (Oct. 1, 2014).

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

G. Employee Assistance Programs (EAPs)

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

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

IV. DETERMINATION OF COST OF APPLICABLE COVERAGE

A. In General

Section 4980I imposes a 40% 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.

1. Determination of Applicable Premium under COBRA

Under § 4980B(f)(4), the COBRA applicable premium generally is based on the average cost of providing coverage for those covered under the plan who are similarly situated, instead of the cost of providing coverage based on the characteristics of each individual.

As noted earlier, Section 4980B(f)(4)(A) defines COBRA applicable premium to mean, “with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee).” Section 4980B(f)(4)(B) prescribes two methods for self-insured plans to determine the COBRA applicable premium: (i) the actuarial basis method; and (ii) the past cost method. Section 4980B(f)(4)(C) provides that the COBRA applicable premium must be determined for a 12-month determination period, and must be determined before the beginning of such period.

The COBRA regulations provide that, with respect to the determination of the COBRA applicable premium, plans and employers must operate in good faith compliance with a reasonable interpretation of the statutory requirements in § 4980B. Treas. Reg. § 54.4980B-1, Q&A-2.

2. Specific Rules under § 4980I

Section 4980I also includes additional calculation rules for determining the cost of applicable coverage.

(1) § 4980I Tax Not Included in Cost. Section 4980I(d)(2)(A) provides that the cost of applicable coverage under § 4980I does not take into account "any portion of the cost of such coverage which is attributable to the tax imposed under this section."

(2) Separate Costs for Self-Only and Other-than-Self-Only Coverage. Section 4980I(d)(2)(A) provides that the cost of applicable coverage must be calculated separately for self-only coverage and other-than-self-only coverage. Section 4980I(b)(3)(B)(iii) provides that any coverage under a multiemployer plan (as defined in § 414(f)) is treated as other-than-self-only coverage for purposes of § 4980I.

(3) Retirees. Section 4980I(d)(2)(A) provides that, in the case of applicable coverage provided to retired employees, the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries.[8]

(4) Health FSAs. Section 4980I(d)(2)(B) provides for health FSAs that the cost of applicable coverage is equal to the sum of salary reduction contributions plus the amount determined under the general calculation rule with respect to any reimbursement under the arrangement in excess of the salary reduction contributions. Thus, the cost of applicable coverage under a health FSA includes employer flex contributions used for the health FSA.

(5) HSAs and Archer MSAs. Section 4980I(d)(2)(C) provides for HSAs and Archer MSAs that the cost of applicable coverage "shall be equal to the amount of employer contributions under the arrangement." For this purpose, employer contributions include salary reduction contributions.

(6) Monthly Costs. Section 4980I(d)(2)(D) provides that for applicable coverage for which the cost is determined "on other than a monthly basis, the cost shall be allocated to months in a taxable period on such basis as the Secretary may prescribe."

[8] For a description of the additional amount added to the § 4980I dollar limit for "qualified retirees," see section V.C of this notice.

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

Section 4980I(a) provides that if "an employee is covered under any applicable employer-sponsored coverage of an employer" during a taxable period and "there is an excess benefit with respect to the coverage," an excise tax applies. (Emphasis added.) Section 4980I(b) provides that the "excess benefit" is the excess of "(A) the aggregate cost of the applicable employer-sponsored coverage of the employee for the month, over (B) an amount equal to 1/12 of the annual limitation" for the employee for the applicable calendar year. (Emphasis added.)

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 (the cost of which could be above or below the dollar limit). See also JCT Report, at 65.

C. Potential Approaches for Determining Cost of Applicable Coverage

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

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

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

1. Similarly Situated Individuals

The COBRA applicable premium for a qualified beneficiary entitled to COBRA continuation coverage is based on the cost of coverage for similarly situated nonCOBRA beneficiaries. § 4980B(f)(4)(A). The COBRA regulations define similarly situated nonCOBRA beneficiaries as the covered employees, spouses of covered employees, or dependent children of covered employees receiving coverage under the group health plan maintained by the employer or employee organization who are receiving that coverage for a reason other than COBRA, and who are most similarly situated to the situation of the qualified beneficiary immediately before the qualifying event. Treas. Reg. § 54.4980B-3, Q&A-3.

Treasury and IRS 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 Treasury and IRS 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. Under the potential approach that Treasury and IRS are considering for purposes of determining the groups of similarly situated employees, the initial groups of similarly situated employees would be determined by aggregating all employees (as defined in § 4980I(d)(3)) covered by a particular benefit package provided by the employer.[9] 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; there may be more than one benefit package provided under a group health plan. Employees would be grouped by the benefit packages in which they are enrolled, rather than the benefit packages they are offered. Thus, for example, if employees are provided a choice between a standard and a high option (such as an option with lower deductibles and copays), employees covered under the high option would be grouped separately from those covered under the standard option. The result would be the same if the choice instead was, for example, between an HMO option and a PPO option, between several different HMO options, or between several different HMO and PPO options.

Mandatory Disaggregation (Self-Only Coverage and Other-Than-Self-Only Coverage). After aggregating all employees covered by a particular benefit package, under this potential approach, the employer would then be required to disaggregate the employees within the group covered by the benefit package based on whether an employee had enrolled in self-only coverage or other-than-self-only coverage. For example, in a benefit package allowing employees to choose between self-only and family coverage, employees receiving self-only coverage would be grouped separately from those receiving family coverage. This potential approach is consistent with § 4980I(d)(2)(A), which provides that the cost of applicable coverage "shall be calculated separately for self-only coverage and other coverage."

Permissive Aggregation within Other-Than-Self-Only Coverage. However, within a group of employees who are receiving other-than-self-only coverage, § 4980I(d)(2)(A) does not require that the cost of applicable coverage be determined separately based on the number of individuals who are receiving coverage in addition to the employee (for example, employee plus one, employee plus two, or family coverage). As a result,

[9] All employers treated as a single employer under § 414(b), (c), (m), or (o) are treated as a single employer for purposes of § 4980I. § 4980I(f)(9).

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

Permissive Disaggregation. For the purposes of COBRA, Treasury and IRS are considering permitting (but not requiring) further disaggregation based on distinctions that have traditionally been made in the group insurance market. Because the cost of applicable coverage under § 4980I is generally determined under rules similar to the rules applicable to COBRA, Treasury and IRS are also considering permissive disaggregation for purposes of § 4980I. In particular, Treasury and IRS 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. Specifically, Treasury and IRS are considering whether disaggregation should be permitted based on (a) a broad standard (such as limiting permissive disaggregation to bona fide employment-related criteria, including, for example, nature of compensation, specified job categories, collective bargaining status, etc.) while prohibiting the use of any criterion related to an individual's health), or (b) a more specific standard (such as a specified list of limited specific categories for which permissive disaggregation is allowed). A more specific standard, for example, could permit 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, such as an employee's residence in or a business's location in different states or metropolitan areas and/or, for an employee receiving other-than-self-only coverage, based on the number of individuals covered in addition to the employee (that is, different rating units).

Treasury and IRS invite comments on the potential approach described in this section 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 set out in the previous paragraph, 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 § 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."

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

2. 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.

Actuarial Basis Method. As set forth in § 4980B(f)(4)(B)(i), 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. Treasury and IRS have not issued regulations prescribing factors to take into account.

Past Cost Method. As set forth in § 4980B(f)(4)(B)(ii), 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." Section 4980B(f)(4)(iii) provides that 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…." Section 4980B(f)(4)(C) provides that 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. See section IV.D of this notice for a discussion of a possible approach using actual costs incurred during the

plan year to calculate the cost of coverage under the past cost method for purposes of § 4980I (but not COBRA).

Treasury and IRS 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, and seek comment on this approach. See § 4980I(d)(2)(A).

a. Changing Between Methods

In the COBRA context, Treasury and IRS are concerned about the possibility of abuse if a plan switches between the actuarial basis method and the past cost method frequently. Consequently, Treasury and IRS 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 under § 4980B(f)(4)(B)(iii) 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 and IRS are considering whether to adopt a similar standard for purposes of § 4980I. Comments are requested on this possibility, on whether there should be concerns about allowing an employer to use the past cost method only for years in which claims are unusually low, and on whether allowing the use of different methods from year to year would cause administrative concerns or raise other issues.

b. Actuarial Basis Method

Under § 4980B(f)(4)(B)(ii)(I), a self-insured plan making an actuarial estimate of the cost of providing coverage must take into account factors prescribed in regulations. For purposes of § 4980I, Treasury and IRS are considering whether to propose a broad standard under which 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.

Treasury and IRS invite comments on all aspects of this potential approach, including whether proposed regulations should require some accreditation of individuals making actuarial estimates, whether it would be preferable to specify a list of factors that must be satisfied to make an actuarial determination of the cost of applicable coverage, and whether a similar standard should apply for purposes of determining the COBRA applicable premium.

c. Past Cost Method

i. Measurement Period under Past Cost Method

Under § 4980B(f)(4)(B)(ii), a plan electing to use the past cost method determines the COBRA applicable premium based on the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding 12-month determination period, as adjusted under § 4980B(f)(4)(B)(ii)(II). For COBRA purposes, Treasury and IRS are 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. Thus, for example, under this potential approach, a plan could use the determination period ending one year before the current determination period as the measurement period for computing costs for the current determination period, or it could use a measurement period beginning 18 months before and ending six months before the beginning of the current determination period. The measurement period would have to be applied consistently. For example, if a plan used a 12-month measurement period ending three months before the beginning of the current determination period, the plan would be required to consistently use the same measurement period for future years, absent bona fide business reasons for a change.

The rule provided under § 4980B(f)(4)(B)(ii)(II), which applies an adjustment factor to the costs determined over the 12-month measurement period under the past cost method, would continue to apply under this potential approach.

Treasury and IRS are considering whether to adopt a similar standard for purposes of § 4980I. Comments are requested on this approach, including any administrative issues that may need to be addressed, as well as whether this approach should also be made applicable for § 4980I purposes.

ii. Costs Taken into Account under Past Cost Method

Treasury and IRS anticipate that proposed regulations would describe the costs that must be taken into account in computing costs under the past cost method. The costs 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.

With respect to the cost of claims, 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). Treasury and IRS invite comments on which of these two approaches is preferable, the type of data employers and insurers traditionally track (that is, data based on claims incurred or on claims submitted), and, if relevant, the maximum length of time after the end of the plan year

that should be permitted to account for claims submitted after, but incurred during, the plan year (often referred to as a run-out period).

With respect to reasonable overhead expenses, Treasury and IRS invite comments as to whether additional guidance on what constitutes reasonable overhead expenses 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.

Treasury and IRS anticipate that the costs taken into account under the past cost method under the proposed regulations would not take into account reserves for potential future costs, claims incurred to the extent subject to reimbursement under a stop-loss or reinsurance policy, or any portion of the cost of coverage which is attributable to the excise tax.[10] Treasury and IRS invite comments on all aspects of this potential approach, including whether a similar standard should apply for purposes of determination of the COBRA applicable premium.

3. HRAs

Treasury and IRS anticipate that future guidance will provide that an HRA is applicable coverage under § 4980I. Section 4980I does not include special rules for determining the cost of coverage under an HRA. Therefore, the cost of coverage under an HRA is determined under the general § 4980I valuation rules.

Notice 2002-45, 2002-28 I.R.B. 93, contains guidance on a number of issues relating to HRAs, provides that HRAs are subject to COBRA, and states that the COBRA applicable premium under an HRA may not be based on a qualified beneficiary's reimbursement amounts available from the HRA. Treasury and IRS have not provided further guidance on the calculation of the COBRA applicable premium for an HRA.

Treasury and IRS are considering various methods that future guidance might permit for use in determining the cost of applicable coverage under an HRA, including determining the cost of applicable coverage under an HRA based on the amounts made newly available to a participant each year. This potential approach would not take into account carry-over amounts or amounts made newly available before 2018 (except potentially amounts made available for non-calendar plan years beginning in 2017 and ending in 2018). This approach might provide employers with greater certainty as to the cost of applicable coverage under an HRA from year to year.

[10] Section 4980I(d)(2)(A) provides that, for purposes of determining the cost of applicable coverage "any portion of the cost of such coverage which is attributable to the tax imposed under this section shall not be taken into account[.]"

In certain circumstances, however, such an approach could overvalue an HRA because the total contributions might not be spent in the current period (for example, because the employer provides large HRA contributions that go unused in a given year). Accordingly, Treasury and IRS are also considering a rule, either instead of or in addition to the potential approach described above, that would permit employers to determine the cost of coverage by adding together all claims and administrative expenses attributable to HRAs for a particular period (separately for each level of coverage if the employer allocation differs by employee election, such as allocating $1,000 to the accounts of employees electing self-only coverage and allocating $2,000 to the accounts of employees electing family coverage) and dividing that sum by the number of employees covered for that period (at that level of coverage). Under this potential approach, reasonable overhead expenses would be determined in a manner similar to that described in section IV.C.2.c.ii of this notice (Costs Taken into Account under Past Cost Method). Treasury and IRS are also considering whether to permit or require employers to use the actuarial basis method to determine the cost of coverage under an HRA.

Some stakeholders 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. This suggestion is based on the position that the other coverage purchased with HRA proceeds would be applicable coverage and that including the value of both the HRA and the other coverage would constitute double counting. Comments are requested on the frequency with which HRAs allow reimbursement only for employee contributions toward coverage, on how the cost of an HRA should be determined if the HRA can be used by employees to fund employee contributions toward coverage and can be used for other medical expenses, and, specifically in that circumstance, on whether the standard should depend on how employees choose to use the HRA (that is, for employee contributions toward coverage or for other expenses), and on the administrability of such an approach.

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 the frequency with which HRAs allow reimbursement only for types of coverage that are not applicable coverage, on how the cost of an HRA should be determined if employees can use it both for coverage that is and for coverage that is not applicable coverage, and, in that circumstance, on whether the standard should depend on how employees choose to use the HRA (that is, for applicable coverage or for a benefit that is not applicable coverage), and on the administrability of such an approach.

Treasury and IRS are concerned that making available multiple methods for determining the cost of applicable coverage under an HRA could increase administrative complexity materially. Providing only one method to determine the cost of applicable coverage would minimize these concerns. Treasury and IRS ask stakeholders to take this issue into account in commenting on methods to determine the

cost of applicable coverage for HRAs. Treasury and IRS also invite comments on each of the potential approaches described above, in addition to suggestions for other approaches that could be used in determining the cost of applicable coverage under an HRA. Comments are invited also on whether specific rules are needed for HRAs with no carry-over feature and on whether the potential approaches described in this section for purposes of determining the cost of applicable coverage under § 4980I should apply for purposes of determining the COBRA applicable premium.

D. Determination Period

Section 4980B(f)(4)(C) provides that the determination of any COBRA applicable premium is to be made in advance for a 12-month period. Thus, for COBRA continuation coverage the method for calculating the applicable premium must be elected prior to the determination period for which the applicable premium applies. As applied for purposes of § 4980I, it is contemplated that under similar rules 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 liability under § 4980I would generally be known at the beginning of the taxable year generating the liability.

Treasury and IRS invite comments on whether these COBRA rules should apply for purposes of § 4980I and on whether additional guidance would be beneficial with respect to the determination period for purposes of COBRA and for purposes of § 4980I. In addition, Treasury and IRS request 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. This method would not be available for determining COBRA applicable premiums because COBRA requires the applicable premium to be determined prior to the period of coverage. The feasibility of this method may depend upon the timing for the filing of a return and payment of the tax because under this proposed approach the plan will need to collect information after the end of the plan year about claims incurred but paid after the end of the calendar year. Treasury and IRS anticipate addressing these procedural timing issues and requesting comments on possible approaches as part of a subsequent notice devoted largely to procedural issues under § 4980I.

V. APPLICABLE DOLLAR LIMIT

A. In General

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. See § 4980I(b)(3)(B)(i).

Section 4980I(f)(1) provides that an employee is treated as having self-only coverage with respect to any applicable coverage of an employer, except that an employee "shall be treated as having coverage other than self-only coverage only if the employee is enrolled in coverage other than self-only coverage in a group health plan which provides minimum essential coverage (as defined in section 5000A(f)) to the employee and at least one other beneficiary, and the benefits provided under such minimum essential coverage do not vary based on whether any individual covered under such coverage is the employee or another beneficiary."

Various types of applicable coverage are not MEC. Examples include (to the extent they are excepted benefits) the following: (1) health FSAs; (2) coverage for on-site medical clinics; (3) coverage only for a specified disease or illness, offered as independent non-coordinated benefits (if payment for coverage is excluded from gross income or for which a deduction under § 162(l) is allowed); and (4) hospital indemnity or other fixed indemnity insurance, offered as independent non-coordinated benefits (if payment for coverage is excluded from gross income or for which a deduction under § 162(l) is allowed). See § 5000A(f)(3); Treas. Reg. § 1.5000A-2(g). HSAs are also applicable coverage that do not constitute MEC. See 78 FR 54986, 54990 (Sept. 9, 2013).

B. 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.

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

Treasury and IRS 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. For example, if an employee has applicable coverage with an aggregate cost of $12,000 of which $3,000 is self-only major medical coverage and $9,000 is other-than-self-only coverage, the composite dollar limit for the employee to determine excess benefits would be the sum of (1) 25% ($3,000/($3,000 + $9,000)) of the self-only coverage dollar limit and 75% ($9,000)/($3,000 + $9,000) of the other-than-self-only coverage dollar limit.

Other categorization rules under § 4980I would continue to apply (so, for example, self-only coverage under a multiemployer plan would be treated as other-than-self-only coverage). Treasury and IRS invite comments on these potential approaches, including any potential administrative difficulties in applying them, as well as any other approaches that might address this issue.

C. 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, noted earlier in section II.A., will apply to increase these amounts. Treasury and IRS intend to include rules regarding these adjustments in proposed regulations and invite comments on the application and adjustment of the dollar limits.

Specifically, as described earlier in section II.A., § 4980I(b)(3)(C)(ii) provides that a "health cost adjustment percentage" will be applied to the baseline per-employee dollar limits for 2018 to determine the actual applicable dollar limits for that year, and § 4980I(b)(3)(C)(v) provides that, for taxable years after 2018, a cost-of-living adjustment will be applied to determine the applicable dollar limits .

1. 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, § 4980I(f)(2) defines a "qualified retiree" as "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." Treasury and IRS request comments on how an employer determines that an employee is not eligible for enrollment under the Medicare program.

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." Section 4980I(f)(3) provides that "employees engaged in a high-risk profession" means "law enforcement officers (as such term is defined in section 1204 of the Omnibus Crime Control and Safe Streets Act of 1968), employees in fire protection activities (as such term is defined in section 3(y) of the Fair Labor Standards Act of 1938), individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders), individuals whose primary work is longshore work (as defined in section 258(b) of the Immigration and Nationality Act (8 U.S.C. 1288(b)), determined without regard to paragraph (2) thereof), and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. Such term includes an employee who is retired from a high-risk profession described in the preceding sentence, if such employee satisfied the requirements of such sentence for a period of not less than 20 years during the employee's employment."

Treasury and IRS 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. Comments are also requested on whether further guidance on the definition of "employees engaged in a high risk profession" would be beneficial, taking into consideration that various categories set forth in § 4980I(f)(3) are determined by laws not under the jurisdiction of Treasury or IRS.

3. 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.

VI. POSSIBILITY OF OTHER METHODS OF DETERMINING COST OF APPLICABLE COVERAGE

As noted previously, § 4980I provides that the cost of applicable coverage is determined under rules that are similar to the rules for determining the COBRA applicable premium, which is based on the cost of applicable coverage provided to similarly situated employees of the employer. Some stakeholders have suggested that the cost of applicable coverage for an employee could be determined by reference to the cost of similar coverage available elsewhere (for example, through an Affordable Insurance Exchange, also known as a Health Insurance Marketplace). Some have also raised the question whether the cost of applicable coverage for an employee could be determined by reference to coverage available elsewhere based on actuarial values, metal levels (bronze, silver, etc.), or other metrics. However, such metrics might be

based only on essential health benefits (defined in 45 CFR § 156.110) and may not fully account for other features and benefits. In addition, in the case of self-insured or large group plans, two such plans that have different costs of applicable coverage might nonetheless have equal actuarial values. Treasury and IRS invite comments on whether any alternative approaches to determining the cost of applicable coverage would be consistent with the statutory requirements of § 4980I and, if so, would be useful.

VII. REQUEST FOR COMMENTS

Treasury and IRS invite comments on the issues addressed in this notice and on any other issues under § 4980I. As noted earlier, Treasury and IRS intend to issue another notice inviting comments on certain additional issues not addressed in this notice. It is expected that the comments responding to the notices will be used to inform proposed regulations that will be issued in the future for further public notice and comment.

Public comments should be submitted no later than May 15, 2015. Comments should include a reference to Notice 2015-16. Send submissions to CC:PA:LPD:PR (Notice 2015-16), Room 5203, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (Notice 2015-16), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC 20044, or sent electronically, via the following e-mail address: Notice.comments@irscounsel.treas.gov. Please include "Notice 2015-16" in the subject line of any electronic communication. All material submitted will be available for public inspection and copying.

VIII. RELIANCE

This notice does not provide guidance under § 4980I upon which taxpayers may rely.

IX. NO INFERENCE

No inference should be drawn from any provision of this notice concerning any provision of § 4980I other than those addressed in this notice or concerning any other section of the Affordable Care Act or COBRA.

X. DRAFTING INFORMATION

The principal author of this notice is Karen Levin of the Office of Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this notice contact Ms. Levin at (202) 317-5500 (not a toll-free call).