Notice 2015-16

American Federation of Labor and Congress of Industrial Organizations

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Submitted by e-mail to Notice.comments@irscounsel.treas.gov

May 15, 2015

CC:PA:LPD:PR (Notice 2015-16)
Room 5203
Internal Revenue Service
PO Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Notice 2015-16

Ladies and Gentlemen:

These comments on Notice 2015-16 ("Notice"), issued by the Department of the Treasury and the Internal Revenue Service ("Treasury and IRS"),[1] are submitted by the American Federation of Labor and Congress of Industrial Organizations ("AFL-CIO") and its 56 affiliated unions. The AFL-CIO represents more than 12.5 million workers across the country in all sectors of our economy, including those working in manufacturing, construction, transportation, grocery and retail stores, food processing and meatpacking, health care, education, hospitality, entertainment and state and local governments. Our affiliated unions negotiate or otherwise advocate for health care benefits for tens of millions of workers, retirees, and their family members. These benefits are provided through a variety of plan types, including but not limited to, single employer and multiemployer plans, both insured and self-funded.

It is especially important that Treasury and IRS act quickly to issue rules for implementing the 40 percent excise tax on high-cost health plans. The excise tax is already having an impact on workers' health plans. Employers have indicated they are now making

[1] The Notice was published on February 23, 2015 and is available at http://www.irs.gov/pub/irs-drop/n-15-16.pdf.

changes in benefit packages to cut back and shift costs to employees and retirees.[2] In workplaces where workers bargain collectively with their employers, our affiliated unions know first-hand that employers are raising the excise tax at the bargaining table as a reason to cut health benefits in contracts that are being negotiated (and they have been doing this for several years). The absence of any regulatory guidance for applying the excise tax has greatly complicated efforts for workers and employers, especially as they negotiate collective bargaining agreements with terms that extend beyond the effective date of Section 4980I.

Overview of the 40% Excise Tax on High Cost Health Plans and Notice 2015-16

Section 4980I of the Internal Revenue Code ("Code"), added by the Affordable Care Act,[3] imposes an excise tax equal to 40 percent of the cost of employer-sponsored health coverage provided to an employee or retiree that exceeds certain dollar thresholds (the "excess benefit") in taxable years beginning after December 31, 2017. Liability for the excise tax falls directly on a "coverage provider," which could be a health insurer, the employer, or a health plan administrator, depending on the particular circumstances. Each employer, however, is responsible for calculating the amount of any excess benefit subject to the tax and notifying each coverage provider of its share of the excess benefit.[4]

The baseline dollar thresholds above which the cost of coverage will be taxed for the 2018 taxable year are $10,200 for self-only coverage and $27,500 for other-than-self-only coverage. For multiemployer plans, the threshold is $27,500 regardless of coverage type. The amounts for 2018 might be adjusted upward if health care costs have increased above certain amounts between 2010 and 2018. The amounts will be adjusted upward in 2019 using a measure of overall price inflation in the economy plus one percentage point. In all subsequent years, an adjustment will be made just for overall price inflation. Additional upward adjustments in the amounts might be made in the case of certain retirees, certain plans that cover workers and retirees who are or were employed in specified high-risk professions, and certain plans for which a participating employer has an employee population with age and gender characteristics that are more costly to cover than a population with the age and gender characteristics of the national workforce.

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[2] *See*, e.g., International Foundation of Employee Benefit Plans, *2015 Employer-Sponsored Health Care: ACA's Impact* (2015) exh. 34 (finding that among organizations currently on pace to trigger the excise tax, 13.2% have already taken action to avoid the tax and 20.8% are currently working on changes to avoid it).

[3] The "Affordable Care Act" or "Act" refers to the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152.

[4] In the case of applicable coverage provided through a multiemployer plan (as defined in Section 414(f)), the plan sponsor, not the employer, is responsible. Section 4980I(c)(4)(B).

Section 4980I includes parameters for determining the coverage to which the 40 percent excise tax applies and calculating the cost of that coverage. Coverage that counts generally encompasses any employment-based group health coverage, including health FSAs, HSAs, and Archer MSAs[5] under certain conditions. There are several significant exceptions, such as certain dental and vision benefits and most other health coverage that qualifies as "excepted benefits." This calculation includes both the employer and the employee shares of the cost of the coverage and is to be done using rules similar to those used to determine COBRA premium amounts.

Treasury and IRS issued Notice 2015-16 to solicit feedback from stakeholders on potential approaches to implementation and other issues related to Section 4980I. The Notice focuses on three broad aspects of the excise tax: (1) which health care coverage counts under the tax; (2) how the cost of coverage is determined; and (3) how the dollar limits are determined, including application of the law's various upward adjustments to the dollar limits. Treasury and IRS expect to issue a second notice soliciting feedback on issues not addressed in the Notice, including issues related to the calculation and assessment of the tax. Feedback provided in response to the notices will help inform development of proposed rules for implementing Section 4980I.

Impact of the Excise Tax on Workers' Health Benefits

The AFL-CIO strongly supports the coverage expansions provided by the Affordable Care Act but continues to reject the policy rationale for an excise tax on high cost employer-based health plans.[6]

Employment-based health coverage is an essential component of our patchwork health insurance system and a critical source of health and financial security for Americans. More than 160 million people are covered by employment-based coverage, including 58 percent of Americans under the age of 65.[7] We remain deeply concerned about the impact of the 40 percent

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[5] While Section 4980I and the Notice reference Archer MSAs, our comments do not address these medical savings accounts because they ceased to be generally available in 2007. *See* Section 200(i). In addition, Archer MSAs were not a typical feature of collectively bargained plans as they had to be paired with a high deductible health plan and were limited to small employers.

[6] In light of significant concerns about the negative impact the excise tax on high cost health plans will have on workers, retirees and their families, delegates to the AFL-CIO's 2013 Convention adopted a resolution calling for the repeal of the excise tax on high-cost health plans. *Resolution 54: AFL-CIO Convention Resolution on the Affordable Care Act, available at* http://www.aflcio.org/About/Exec-Council/Conventions/2013/Resolutions-and-Amendments/Resolution-54-AFL-CIO-Convention-Resolution-on-the-Affordable-Care-Act

[7] U.S. Census Bureau, Current Population Survey, 2014 Annual Social and Economic Supplement, t. HI01, *available at* http://www.census.gov/hhes/www/cpstables/032014/health/h01_000.htm (last accessed May 14, 2015).

excise tax on high-cost health plans on the adequacy and availability of employment-based coverage.

The tax is premised on the notion that shifting more health care costs onto individual patients will lead them to control health care costs and expenditures in a way that insurance companies, health plans, and health systems experts have been unable to do. During the congressional debate on the Act, proponents of the tax theorized that having *too much* insurance creates a moral hazard that leads individuals to get *too much* health care and/or not shop around to find low-cost health care providers. In their view, forcing individual patients to have more "skin in the game" in the form of higher out-of-pocket expenses for the health care services that they use would address this problem. This tax was created, therefore, as an incentive for plan sponsors to increase the out-of-pocket costs of workers and/or reduce coverage in other ways.[8]

While employers may, indeed, be preparing to cut benefits and shift costs to workers or already doing so, much of the available evidence suggests it also will result in poorer health outcomes, increased use of services at higher levels of care, and financial strain for many households —while not unquestionably controlling costs.

This is not a tax on so-called "Cadillac plans" or "excess insurance." As health care actuaries at the benefits consulting firm Milliman recently concluded, "Although the excise tax is often referred to as a tax on overgenerous health benefits, it is likely to be a tax based on factors other than benefit richness and beyond the control of health plan members."[9] Looking at what would happen in the very first year the tax goes into effect, Milliman's extensive analysis found that the tax will be applied unevenly across the country because geography (e.g., the way prices demanded by health providers vary from region to region) will have the largest impact on premium costs, while benefit levels will have a relatively small impact. In some areas of the country, an average "Chevy" level of coverage will be taxed, while in others a "Cadillac,"

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[8] Jost, T. and White, T., *Cutting Health Care Spending: What Is the Cost of an Excise Tax that Keeps People from Going to the Doctor* (2009) Accessed at http://www.ourfuture.org/files/Jost-White_Excise_Tax.pdf on May 12, 2015.

Congressional Budget Office estimates of early versions of the ACA legislation substantiated that the effect of the tax would be to push people to choose plans with lower premiums, by "choosing health plans that either pay a smaller share of covered health care costs (which would reduce premiums directly as well as indirectly by leading to less use of covered medical services), manage benefits more tightly, or cover fewer services." Congressional Budget Office, Letter to Sen. Evan Bayh from Douglas Elmendorf (Nov. 30, 2009) p. 8. http://www.cbo.gov/sites/default/files/11-30-premiums.pdf

[9] Robert H. Dobson and Stuart D. Rachlin, Milliman, *What Does the ACA Excise Tax on High-Cost Plans Actually Tax?* (Dec. 9, 2014) p. 3 available at https://www.nea.org/assets/docs/Milliman--What_Does_the_Excise_Tax_Actually_Tax.pdf. ("Milliman")

platinum level of benefits will not be taxed. Furthermore, some plans will be subject to the tax because they cover higher numbers of women or older adults.[10]

By reducing the affordability of care, the cost shifting and other benefit cuts likely to result from the tax will have negative consequences for Americans' overall health. That is, the tax is likely to increase underinsurance among Americans and discourage the use of necessary medical services, not just unnecessary care, as out-of-pocket costs (not counting premiums paid by the individual) are already high. According to a 2014 Commonwealth Fund survey, "More than one of five 19-to-64-year-old adults who were insured all year spent 5 percent or more of their income on out-of-pocket costs, not including premiums, and 13 percent spent 10 percent or more."[11]

Decades of research have shown that increased cost-sharing will decrease the use of essential and non-essential services in equal amounts. More recent studies have shown that increased cost-sharing has led to increased use of emergency department and hospital care by people with chronic illnesses, resulting in greater overall expenditures for a significant number of people. The literature also shows that elderly individuals, low income people, and those with chronic illnesses are particularly vulnerable to negative health and financial outcomes as a result of these policies.[12, 13] The comprehensive and often cited 2006 RAND healthcare investigation found that the poorest and sickest of those studied had better health outcomes before cost-sharing.[14] Similarly, the 2014 Commonwealth Fund survey found that "[t]wo of five (40%) [privately insured] adults with deductibles of 5 percent of income reported that because of their deductible, they had not gone to the doctor when sick, did not get a preventive care test, skipped a recommended follow-up test or did not get needed specialist care."[15] This finding was broadly consistent with an earlier analysis of existing literature focusing solely on chronically ill patients and cost sharing, which concluded that those findings are unambiguous, "[F]or patients with congestive heart failure, lipid disorders, diabetes, and schizophrenia, greater use of inpatient and

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10 Milliman.

11 Collins, Sara R. et. al, The Commonwealth Fund, *Too High a Price: Out-of-Pocket Health Care Costs in the United States: Findings from the Commonwealth Fund Health Care Affordability Tracking Survey, September-October 2014* (Nov. 2014) p. 1.

12 Swartz, K. Cost-sharing: Effects on spending and outcomes. Robert Wood Johnson Foundation (2010), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1.

13 Remler, D. and Greene, J., "Cost-sharing: A blunt instrument," *American Review of Public Health* (2009).

14 Brook, Robert H. et. al, *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate*. (2006), *available at* http://www.rand.org/pubs/research_briefs/RB9174.

15 Collins, Sara R. et. al, p. 4.

emergency medical services are associated with higher co-payments or cost sharing for prescription drugs or benefit caps."[16] (Citations omitted)

Over time, an increasing number of workers will feel the tax's impact—including those with average benefits or lower—having their health coverage taxed or cut to avoid the tax.[17] This is inevitable unless health care cost growth slows to a rate that is at or below overall inflation in the economy, breaking completely with our long historical experience. That is because the dollar thresholds used to determine the taxable premium amounts subject to the excise tax will grow only at the rate of inflation and therefore are expected to decrease in real value over time.

Our labor union affiliates report that already in contract negotiations, employers have cited the impending tax in demanding health benefit concessions from workers. In recent contracts, deductibles have doubled, out-of-pocket maximums have increased 100 percent, and copayments have increased substantially. Most of these concessions have been made without a corresponding increase in wages. We expect that employees in nonunionized workplaces are even more likely to see their benefits decreased without any corresponding increases in their earnings.[18]

It is against this backdrop that Treasury and IRS will create rules for implementing the excise tax. While the statutory language of Section 49801 lays down parameters for how the excise tax is to be applied, Treasury and IRS will necessarily need to make many decisions as part of the rulemaking process about which coverage counts, how the cost of that coverage is to be calculated, and how the dollar limits and upward adjustments to them are to be determined. Given the questionable policy rationale for the tax and the risks it poses to the health and financial security of working families, we urge Treasury and IRS to take every opportunity in the

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16 Goldman, Dana P., et. al, "Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health," JAMA, Vol. 298: pp. 61-69, No. 1 (July 4, 2007) at pp. 64-65.

17 *See*, e.g., Herring, Bradley and Lisa K. Lentz, "How Can We Bend the Cost Curve? What Can We Expect from the "Cadillac Tax" in 2018 and Beyond?," *Inquiry*, vol 48: 322-337 (Winter 2011/2012) p. 334 ("While relatively few people with private insurance are likely to be affected by the Cadillac tax when it is implemented in 2018, the number of affected people is projected to grow rapidly over time."); Troy, Tevi D. and D. Mark Wilson, American Health Policy Institute, *The Impact of the Health Care Excise Tax on U.S. Employees and Employers* (2014) ("In 2018, the excise tax is anticipated to hit 17 percent of all American businesses, and 38 percent of large employers.")

18 One analysis of the excise tax on high-cost health plans found that employees hit by the tax from 2018 to 2014 could see an average after-tax decline in their compensation of $1,050 due to the shift to taxable wages if their employers increased their wages to offsets cuts in their health benefits. The same study concluded that these impacted employees could alternatively see a $6,150 cut in their health benefits but no increase in their pay. Troy and Wilson, p. 1.

regulatory process to minimize the uneven and inappropriate impact of the tax and its detrimental effects on workers and their families.

Section III. Definition of Applicable Coverage

The definition of "applicable employer-sponsored coverage" ("applicable coverage") in Section 4980I(d)(1) sweeps broadly, seeking to cover virtually any tax-favored means for workers to obtain and pay for health care benefits through employment. The exclusions from applicable coverage in Section 4980I(d)(1)(B) and listed in the Notice are essentially limited to certain excepted benefits included in Section 9832(c).[19]

In Section III of the Notice, Treasury and IRS outline possible approaches for addressing whether or when several types of coverage will be treated as applicable coverage. As detailed below, the AFL-CIO supports some of the approaches, but in other instances, suggests that future proposed regulations include a different treatment for some arrangements as well as expand the excepted benefits exclusions from applicable coverage.

HSAs (Section III-D)

The Notice proposes to treat all employer contributions to HSAs, including worker salary deferral contributions, as applicable coverage while excluding worker after-tax contributions.[20] In our view, this proposed treatment is too expansive, covering all HSAs whether or not they are, in fact, applicable coverage, and any future guidance regarding the treatment of HSAs under Section 4980I must recognize that most HSAs are not part of a group health plan.

First, "applicable employer-sponsored coverage," as defined in Section 4980I(d)(1)(A), is

> 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). (*emphasis added*)

In turn, Section 4980I(f)(4) incorporates the following definition of "group health plan" from Section 5000(b)(1):

> a plan (including a self-insured plan) of, or contributed to by, an employer … to

[19] Notice, pp. 7-8.

[20] Notice, p. 8. The Notice also includes Archer MSAs in this discussion, but as we noted previously (fn. 5 supra), our comments will not address these accounts.

provide health care (directly or otherwise) to the employee, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

But, HSAs are not necessarily "group health plans" even if an employer makes contributions. Indeed, Treasury, together with the Department of Labor and Department of Health and Human Services, in addressing the impact of other provisions of the Affordable Care Act, stated that HSAs "... generally are not treated as group health plans because the amounts are available for both medical and nonmedical expenses."[21]

Under Department of Labor guidance,[22] HSAs might be treated as an "employee welfare benefit plan" as defined in Section 3(2) of the Employee Retirement Income Security Act, as amended ("ERISA"), and thus be part of a group health plan. But, those circumstances are limited, requiring an employer to do more than contribute to the HSA voluntarily established by the worker. As indicated in FAB 2004-1, the employer must impose limitations and restrictions on the HSA beyond those specified in Section 223, such as limits on utilization or investment of funds or represent the HSAs are a plan established or maintained by the employer.

In light of the long-standing recognition by Treasury, IRS and the Department of Labor that HSAs are not generally considered group health plans, the proposed treatment of them as applicable coverage is surprising. But even more, it is not warranted under the statutory language on which the Notice expressly relies.

The Notice cites Sections 4980I(c)(2)(B) and (d)(2)(C) as the basis for including employer and pre-tax worker contributions to HSAs as applicable coverage.[23] Because each subparagraph, one addressing the entity liable for any tax due and the other specifying the calculation of the cost of coverage, states it applies if the applicable employer-sponsored coverage includes an HSA, neither subparagraph overrides the clear statutory directive that "applicable employer-sponsored coverage" is limited to group health plans.

There is some ambiguity as to whether the "employer contributions" referenced in Section 4980I(d)(2)(C) should include workers' salary deferral contributions to an HSA

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21 Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections; Final Rule and Proposed Rule, 75 Fed. Reg. 37188, 37190 (June 28, 2010) *available at* http://www.gpo.gov/fdsys/pkg/FR-2010-06-28/pdf/2010-15278.pdf.

22 Field Assistance Bulletin 2004-1 (April 7, 2004) *available at* http://www.dol.gov/ebsa/regs/fab2004-1.html; Field Assistance Bulletin No. 2006-02 (October 27, 2006) *available at* http://www.dol.gov/ebsa/pdf/fab2006-2.pdf.

23 Notice, p. 8.

(assuming the HSA is a group health plan). We recommend the exclusion of these salary reduction contributions from the cost of applicable coverage. While references to "employer contributions" in the Code generally include pre-tax salary reduction contributions based on the income exclusion in Section 106, the text of Section 4980I(d)(2) suggests Congress intended to exclude such contributions to HSAs.

Section 4980I(d)(2)(B) addresses the cost of coverage when applicable coverage includes an FSA, another arrangement that often includes both employer and worker salary deferral contributions, and it clearly distinguishes between employer contributions and worker salary deferral contributions. The absence of a similar reference Section 4980I(b)(2)(C) indicates that Congress did not intend to include salary reduction contributions to HSAs.

Further, if salary reduction HSA contributions are included in the excise tax calculation, a similar tax benefit could be obtained, as the Notice recognizes, by direct worker contributions to the HSA on an after-tax basis, and a deduction under Section 223. Workers should not be required to go through additional administrative hoops to obtain similar tax benefits.

On-site Medical Clinics (Section III-E)

With respect to on-site medical clinics, the Notice proposes to exclude from the definition of applicable coverage those clinics offering "only de minimis medical care to employees." The Notice specifically asks whether on-site clinics that satisfy the criteria in the current COBRA regulations[24] and offer additional services such as immunizations, injections of antigens provided by workers, the provision of aspirin and other nonprescription pain relievers and the treatment of injuries due to accidents at work should be excluded. In addition, Treasury and IRS seek comments on the standard for determining whether the medical care provided is de minimis as well as the method for determining cost under Section 4980I should the clinic be considered applicable coverage.

The AFL-CIO supports the proposed exclusion of on-site medical clinics from the definition of applicable coverage, and we urge Treasury and IRS to expand it by broadening the services a clinic may offer, the individuals eligible for those services and the location of excludable clinics.

The services available should be expanded beyond the proposed additions to include, at a minimum, prescriptions for acute minor conditions, any assessments or screenings related to wellness programs, primary care, and coordination of care for individuals with chronic conditions. All clinic services should be available to workers' dependents, including spouses and children, as well as retired workers and their dependents. The excluded clinics should not be limited to those located in worksites. The suggested expansion of the clinic exclusion accurately

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[24] *See* 26 CFR § 54.4980B-2, Q&A-1(d).

and appropriately reflects the changing nature and use of clinics by employers and some multiemployer plans. In many instances, clinics are being expanded or introduced in order to coordinate care better, offer convenient, trusted care facilities to workers, and reduce health spending. These efforts should be encouraged, and excluding clinics offering these services from the scope of applicable coverage will send that signal.

If Treasury and IRS do not adopt the broad exclusion of clinics from applicable coverage, the AFL-CIO recommends that plan sponsors have the option to determine whether a clinic is applicable coverage based on the nature of the services provided or the cost of those services. The determination of costs raises issues which deserve further consideration, but at a minimum, costs should not include capital or start-up costs for clinics or costs not directly related to the health care services provided.

Limited Scope Dental and Vision Benefits and Employee Assistance Programs
(Sections III-F and III-G)

The Notice proposes that Treasury and IRS exercise their authority under Section 4980I(g) and treat self-insured limited scope dental and vision benefits and employee assistance programs ("EAPs") satisfying the requirements of the recently amended regulations as excepted benefits[25] excluded from applicable coverage.

The AFL-CIO supports the proposed exclusion from applicable coverage of self-insured limited scope dental and vision benefits and EAPs as excepted benefits.

Limited Wraparound Coverage as an Excepted Benefit

After the Notice was published, the final rule treating certain limited wraparound coverage benefits as excepted benefits was issued by Treasury and IRS, the Department of Labor and the Department of Health and Human Services.[26] The rule establishes a pilot program permitting employers and plans to offer limited wraparound coverage to certain workers and retirees who obtain individual coverage or Multi-State Plan coverage through a marketplace.

To be consistent with the proposed treatment of other newly recognized excepted benefits, Treasury and IRS should consider any limited wraparound coverage benefits as excepted benefits outside the scope of applicable coverage.

Exclude Telehealth Benefits Coverage from Applicable Coverage

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[25] The final rule on Amendments to Excepted Benefits was issued on October 1, 2014 (79 Fed. Reg. 59130).

[26] Amendments to Excepted Benefits, 80 Fed. Reg. 13995 (March 18, 2015).

As unions and multiemployer plans continue to address rising health care costs, benefits may be added or modified and new approaches to delivering health care may also be considered. Medical clinics are one such development and another is the inclusion of telehealth benefits. These benefits, often limited in scope, provide an alternative to more expensive care delivery sites, such as emergency rooms or urgent care centers. Like clinics, they offer a convenient way for workers to access care and like EAPs, they can provide counseling and direction in cases where additional medical care is needed. Since this benefit is targeted, as is the excise tax itself, at reducing health care costs and encouraging the use of less expensive care, it would be appropriate to exclude telehealth benefits from applicable coverage.[27]

IV. Determination of Cost of Applicable Coverage

As the Notice indicates, the general rule in Section 4980I(d)(2)(A) is that the cost of applicable coverage is to be determined using rules similar to those used to calculate the applicable COBRA premium under Section 4980B(f)(4).[28] Section 4980I(d)(2)(A) also includes three other rules governing the cost determination:

- Any cost attributable to the tax under Section 4980I is to be excluded;
- The amount of any cost shall be calculated separately for self-only and other coverage;[29] and
- If coverage for retired employees is provided, the plan may elect to treat retired employees who are not yet age 65 and those that are entitled to Medicare as similarly situated beneficiaries.

In addition, Section 4980I(d)(2) includes specific rules for health FSAs and HSAs.

Potential Approaches for Determining Cost of Applicable Coverage (Section IV-C)

Treasury and IRS outline potential approaches for determining the cost of applicable coverage while noting that no guidance on these issues under COBRA has been provided. Treasury and IRS alert commenters that future guidance for determining the COBRA applicable premium likely will attempt to harmonize the COBRA rules with the rules for determining the

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[27] Alternatively, as discussed later in these comments, telehealth benefits could be excluded from costs as part of a plan's programs to manage care efficiently.

[28] Notice, pp. 10-11.

[29] As discussed at p. 13, the separate calculations do not apply to coverage offered under multiemployer plans.

cost of applicable coverage. The Notice addresses three areas related to determining cost—similarly situated individuals, self-insured methods and HRAs—and our comments on each area are detailed below.

As a general matter, the AFL-CIO suggests that the rules for determining the cost of applicable coverage under Section 4980I do not need to be identical to those used to calculate COBRA premiums. The statutory directive is for the rules to be "similar to" those under COBRA, but in light of the very different purposes of the two statutory provisions, we urge consideration of where the rules might vary.

Similarly Situated Individuals. (Section IV-C-1) Treasury and IRS describe a potential approach to determining each group of employees who are similarly situated for purposes of determining the applicable cost, starting with mandatory aggregation of all employees covered by a particular benefit package and followed by mandatory disaggregation of each of those groups according to specified characteristics and then by permissive disaggregation based on specified characteristics. "[F]or 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."[30]

Aggregation by Benefit Package. Treasury and IRS are considering requiring employees to be grouped together first according to the benefit package in which they are enrolled and provide examples of benefit packages of different values and different types (e.g., high option vs. standard option, HMO vs. PPO, and HMO vs. HMO). Feedback is requested on whether and to what extent benefit packages that are not identical should be considered the same and therefore allowed to be grouped together for this purpose.

The AFL-CIO agrees Treasury and IRS should permit the grouping of similar but not identical benefit packages. Doing so could address some of the inequities that would otherwise result due to variations in the cost of coverage that result from differences in the pricing power of health care providers in local health care markets and from differences in the demographics of the covered population for each similar but non-identical health benefit package.

We recommend Treasury and IRS consider two approaches to permitting the aggregation of non-identical but similar benefit packages given the dearth of specific measures for comparing benefit packages. Under the first approach, employees covered by non-identical benefit packages could be grouped together, without regard to benefit type, so long as the actuarial value of each benefit package within the grouping is within an acceptable corridor, such as a 5-percentage point corridor. For example, if employees located at an employer's West Coast facility were covered by an HMO with an 88 percent actuarial value and the employees at the employer's East Cost facility were covered by PPO with an 84 percent actuarial value, these

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30 Notice, p. 13.

employees could be grouped together. Under the second approach, a reasonable, good faith interpretation of what constitutes the same or substantially similar benefit packages could be employed. A determination of the most appropriate grouping would be based on all of the facts and circumstances.

Mandatory Disaggregation (Self-Only Coverage and Other-than-Self-Only Coverage). Treasury and IRS are considering requiring disaggregation of a group of employees covered within a benefit package (who have been aggregated under the approach described above) based on whether an employee had enrolled in self-only coverage or other-than-self-only coverage. We suggest Treasury and IRS provide explicit guidance clarifying that this disaggregation is not required for any coverage provided under a multiemployer plan. Treasury and IRS already have acknowledged in their discussion of Section 4980I(d)(2)(A)'s requirements related to the calculation of the cost of applicable coverage for self-only and other-than-self-only coverage that this is the proper approach to multiemployer plans, stating, "Section 4980I(b)(3)(B)(iii) [sic] 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."[31] An explicit statement to this effect in the forthcoming regulatory guidance would avoid any confusion.

Permissive Aggregation within Other-than-Self-Only Coverage. Treasury and IRS acknowledge that Section 4980I(d)(2)(A) does not require further disaggregation of employees enrolled in other-than-self-only coverage into sub-groups based on the number of individuals who are receiving coverage in addition to the employee for purposes of determining the cost of applicable coverage. Accordingly, Treasury and IRS are considering permitting an employer to "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."[32] We recommend Treasury and IRS adopt this approach and allow it to be used to determine the cost of applicable coverage regardless of whether the costs of coverage vary by the number of individuals covered in addition to the employee for purposes of determining the premium amount charged to the employee.

We note that this is an area where the different underlying purposes of COBRA and the 40 percent excise tax on high-cost health plans point to the need for separate rules. Requiring further disaggregation by the number of individuals covered in addition to the employee appears to increase the likelihood that there will be an excess benefit subject to the 40 percent excise tax, compared to simply determining the cost of applicable coverage as an average of all employees with other-than-self-only coverage. In practice, requiring this kind of further disaggregation would lead to unequal treatment of plans with the same average cost of applicable cost for other-

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31 Notice, p. 11.

32 Notice, p. 14.

than-self-only coverage as a whole if one plan covered large enough families to push the costs specific to them over the applicable limit. We do not believe this is the kind of outcome that Congress intended.

Permissive Disaggregation. Treasury and IRS are considering whether to permit for COBRA purposes further disaggregation "based on distinctions that have traditionally been made in the group insurance market" and also whether to permit this further disaggregation under Section 4980I. Treasury and IRS indicate they are considering two approaches to permitting permissive disaggregation: 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 any criterion related to a participant's health; or a more specific standard (such as a specified list of limited specific categories for which permissive disaggregation is allowed). Feedback is solicited on this approach.

The AFL-CIO shares the concern expressed by Treasury and IRS about potential abuses that may result from permissive disaggregation. Our concern extends to disaggregation for purposes of determining both the applicable COBRA premium and the cost of applicable coverage for the 40 percent excise tax on high-cost health plans. Treasury and IRS should be skeptical of any approach to disaggregation that results in small groups that bear no resemblance to reasonable risk pools, have noticeably dissimilar demographic profiles or trends, and that appear to serve no legitimate policy objectives. Further, we urge Treasury and IRS to be mindful of the need to align the groups of employees used to determine the cost of applicable coverage with the groups used to determine the applicability of the high-risk profession adjustment and the amount, if any, of the age and gender adjustment to the applicable dollar limit. Last, regardless of the approach taken, no more than one layer of permissive disaggregation should be permitted.

Aggregation of Retirees. With respect to retired employees, Section 4980I includes explicit direction that "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 employees,"[33] thus overriding the more general directive that the cost of applicable coverage is to be determined under rules similar to the COBRA rules. This statutory language provides broad discretion to aggregate retirees, especially given that many retirees 65 and older enrolled in employer-sponsored coverage are likely covered under a Medicare supplemental benefit and those under age 65 are likely enrolled in a comprehensive benefit package that is quite different. Consistent with this, we recommend that Treasury and IRS provide additional guidance describing the manner and circumstances in which plans may choose to aggregate pre-65 and 65-and-older retirees. In particular, we ask that Treasury and IRS provide guidance clarifying that all pre-65 and 65-and-older retirees enrolled in applicable coverage through a plan may be

[33] Section 4980I(d)(2)(A).

aggregated, regardless of the specific benefit package or benefit type (e.g. PPO, HMO, Medicare Advantage, etc.) in which they are enrolled. In addition, aggregation of pre-65 retirees and active workers should also be permitted, particularly when applicable coverage for both groups is substantially similar. Further, Treasury and IRS should affirm that even when pre-65 retirees are aggregated with any other group (non-retired employees or retirees 65 and older), the qualified retiree adjustment will apply.

Self-Insured Methods. (Section IV-C-2) The Notice proposes to apply the two methods that self-insured plans may use to calculate the COBRA applicable premium[34]—the actuarial basis method and the past cost method—to cost determinations under Section 4980I. In addition, the Notice indicates Treasury and IRS are considering whether to require a plan to use the selected valuation method for at least five years[35] unless the past cost method is not available due to any significant change within the meaning of Section 4980B(f)(4)(B)(ii).[36]

In order to allow plan sponsor flexibility in making determinations under Section 4980I, the AFL-CIO suggests that Treasury and IRS permit the use of both valuation methods and allow changes in methods more frequently than the proposed five years. The only exception would be the limitation on utilization of the past cost method in any year if there is any significant change in coverage or workers covered.

With respect to the actuarial basis method, Treasury and IRS note they are considering a broad standard where the cost of applicable coverage would equal a reasonable estimate of the cost of providing coverage for the determination period using reasonable actuarial principles and practices. The estimate would be of the actual cost the plan is expected to incur, not the minimum or maximum exposure. In addition, comments on all aspects of the approach are sought, including whether some accreditation of individuals making actuarial estimates should be required.

The AFL-CIO agrees that any estimate under the actuarial basis method made in advance of a particular determination period should be based on the expected actual cost to the plan, but we also note, as discussed in connection with the determination period, that actual costs would be available if cost determinations were made after the end of the year. In our view, a broad standard, rather than a list of factors to be satisfied, is more appropriate.

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[34] Section 4980B(f)(4)(B).

[35] As indicated in the Notice, this standard is under consideration with respect to COBRA premium calculations as Treasury and IRS are concerned about possible abuse if plans frequently change between the two methods. Notice, p. 16.

[36] Under that section, the past cost method cannot be used if there is "any significant difference … in coverage under, or in employees covered by, the plan" between the two determination periods.

The proposed regulations should require that the individuals making actuarial estimates have the appropriate skills, credentials and experience to perform the work, though membership in the American Academy of Actuaries should not be required.

While a list of factors to be satisfied should not be required, we recommend that Treasury and IRS specify exclusions from the costs to be taken into account, whether the actuarial basis or past cost method is used to determine the cost of coverage. All federal, state, and local taxes and assessments, and regulatory licenses and fees should be excluded, including but not limited to those enacted as part of the Affordable Care Act, such as the Patient Centered Outcomes Research Institute fee[37] and the Health Insurance Providers fee.[38] Additional exclusions should include any expenses incurred in connection with the determination and reporting of any excludable taxes, assessments and fees, as well as, for insured plans, any broker's commissions or fees.

The AFL-CIO also suggests that costs associated with the provision of certain benefits and certain costs of administration be excluded from the costs taken into account under either the actuarial basis or the past cost method. Certain modes of delivering benefits, such as the clinics and telehealth benefits previously described in these comments, the management of high cost claims, adoption of medical homes and the development of maintenance of high quality and low cost provider networks are all efforts undertaken by plans to improve the delivery of health care benefits and control the costs of those benefits. Discouraging the adoption and use of these mechanisms is contrary to one of the stated goals of the excise tax—the reduction of health care spending. These methods and benefits should be encouraged as they are targeted towards the continued provision of adequate, appropriate and affordable quality health care benefits to America's workers.

Health Reimbursement Arrangements (Section IV-C-3)

According to Notice 2015-16, future guidance will provide that health reimbursement arrangements (HRAs) are applicable coverage. In keeping with that treatment, Treasury and IRS describe various methods under consideration for determining the cost of applicable coverage under an HRA. One approach would look at the amounts newly available to the worker each year and would not take into account carry-over amounts or amounts newly available before 2018. Another approach, described as an alternative, or addition to, the "amounts newly available" approach, would determine the cost of coverage by adding all claims and administrative expenses attributable to HRAs and dividing the sum by the number of covered

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[37] Sections 4375 and 4376. These sections currently provide that the PCORI fee does not apply for plan or policy years ending after September 30, 2019.

[38] Affordable Care Act, Section 9010.

employees. Lastly, Treasury and IRS are also considering whether to permit or require the use of the actuarial basis method to value HRAs.[39]

Over the years, HRAs have been used in different ways. As Treasury and IRS and the Departments of Labor and Health and Human Services have recognized,[40] HRAs can be integrated with other coverage and for retirees, HRAs can be either integrated or stand-alone. In some instances, the amounts credited to HRAs are notional and in others, actual dollars are contributed and invested. For some retiree HRAs, contributions are credited during the worker's career while in others, contributions are not made until retirement.

In light of the wide variety of HRAs, the AFL-CIO suggests the following principles to guide Treasury and IRS as they consider the possible methods for determining the cost of coverage:

- Any amounts contributed or credited to an HRA before 2018, as well as any related investment earnings, should be disregarded;
- Any amounts that may be used only during retirement, even if contributed or credited during a worker's career, should be disregarded in determining the cost of coverage while the worker is employed;
- Any amounts used to reimburse expenses for excepted benefits should be disregarded;
- Any amounts used to fund the worker's contribution for coverage, including retiree coverage, should be disregarded;[41] and
- Any amounts attributable to investment earnings or credits should be disregarded unless and until they are used to reimburse worker or retiree expenses.[42]

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39 Notice, pp. 18-20.

40 IRS Notice 2013-54 (September 13, 2013) *available at* http://www.irs.gov/pub/irs-drop/n-13-54.pdf; EBSA Technical Release 2013-03(September 13, 2013) *available at* http://www.dol.gov/ebsa/pdf/tr13-03.pdf and Insurance Standards Bulletin, Application of Affordable Care Act Provisions to Certain Healthcare Arrangements, September 16, 2013, *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cms-hra-notice-9-16-2013.pdf.

41 Failure to exclude these amounts will lead to double counting as the cost of coverage already takes into account the expected contribution.

42 These same principles should apply to HRA contributions made when workers elect coverage under the employer plan covering their spouse. In these instances, the HRA would be included as part of the cost of coverage of the worker's employer plan.

While the "amounts newly available" approach is simple and direct, it may, as Treasury and IRS note, lead to overvaluing an HRA if those amounts are not used in full during the year they become available. The other approaches under consideration address this potential problem, and we suggest that plan sponsors be able to select any method to determine the cost of coverage.

If HRA reimbursements are available for multiple purposes, such as worker or retiree contributions to the cost of coverage, excepted benefits or other benefits, the cost of the HRA should be allocated among the different uses. In our view, establishing rules distinguishing among different uses of HRA amounts is neither burdensome nor overly complex, and any perceived burdens should be weighed against the risk that workers and retirees will bear additional costs if coverage is reduced in order to avoid a taxable excess benefit.

Determination Periods (Section IV-D)

Under Section 4980B(f)(4)(C), the COBRA applicable premium is determined in advance for a 12-month period. Treasury and IRS are considering adopting a similar rule under Section 4980I so the potential excise tax liability, likewise, would be known in advance. Comments are also sought on the feasibility of using actual costs and determining the cost of coverage after the end of the year.[43]

The AFL-CIO suggests that both methods be available, affording the most flexibility to plan sponsors and permitting any potential excise tax liability to be based on the lower of the two costs. It is possible that even reasonable actuarial estimates of annual costs may turn out to be too high and assessing a penalty based on those estimates—when the actual costs of coverage for the year are lower--would not be appropriate.

By contrast, it would also not be appropriate to assess an excess benefit tax when costs exceed reasonable projections. While certain increases in costs can be moderated through plan design, even well designed plans may have higher costs when workers or their dependents have serious health problems.

Other Issues

While the Notice addresses methods for calculating the cost of applicable coverage for self-insured plans, we also note that certain plans operate under fully insured contracts with participating arrangements. In these funding arrangements, the ultimate premium paid for a contract year is not determined until after the end of the contract year and is based on the Plan's actual experience (i.e., a reflection of the plan's actual cost). For example, a plan with positive claims experience during a year would receive a return of premium after the end of the year,

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[43] Notice, p. 20.

resulting in a lower effective premium amount than was initially paid during the year. The reverse of that example also exists where the premium paid during the contract is artificially lowered with a determination after the end of that contract of whether and how much additional premium is due. We urge Treasury and IRS to consider providing guidance on the appropriate treatment of these kinds of insured arrangements. Ideally, the same cost determination provisions ultimately available for use by self-funded plans would be extended to apply to these special fully insured arrangements.

V. Applicable Dollar Limit

Employees with Self-Only and Other-than-Self-Only Applicable Coverage (Section V-B)

In some instances an employee simultaneously has coverage to which the self-only dollar limit applies and coverage to which the other-than-self-only dollar limit applies. Treasury and IRS intend to promulgate a rule that clarifies how the dollar limit is to be applied in this event.

The Notice suggests two alternative approaches to applying the dollar limitation: (1) the applicable dollar limitation would be determined by the type of coverage (self-only or other-than-self-only) that accounts for the majority of the aggregate cost of the applicable coverage for the employee (which would be deemed to be other-than-self-only coverage if self-only coverage and other-than-self-only coverage make up equal amounts of the aggregate cost of applicable coverage); or (2) a composite dollar limit would be applied by pro-rating 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. The Notice also acknowledges that for applicable coverage provided through a multiemployer plan, the annual limitation for other-than-self-only coverage applies for all employees, regardless of whether the employee is enrolled in self-only or other-than-self-only coverage.

Both of the suggested approaches are reasonable. We recommend Treasury and IRS permit plan sponsors to choose either approach to determine the dollar limit when an employee has both coverage to which the self-only dollar limit applies and coverage to which the other-than-self-only dollar limit applies.

Adjustments for Qualified Retirees (Section V-C-1)

Section 4980I(b)(3)(C)(iv) provides an adjustment to the otherwise applicable annual limit for "an individual who is a qualified retiree."[44] In turn, Section 4980I(f)(2) defines a "qualified retiree" as "any individual who (A) is receiving coverage by reason of being a retiree,

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[44] In 2018, the adjustment will be $1,650 for those with self-only coverage and $3,450 for those with other than self-only coverage. These adjustments will be increased each year under Section 4980I(b)(3)(v).

(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 statute is clear that the annual limit will be increased for any retired worker who is at least age 55 and not yet entitled to coverage under Medicare. As previously noted in these comments, Treasury and IRS should affirm that the qualified retiree adjustment will apply even when pre-65 retirees are aggregated with any other group (non-retired employees or retirees 65 and older).

The upward adjustment also should apply to the retiree's surviving spouse who, after the death of the qualified retiree, satisfies the age requirement and is not entitled to Medicare coverage. Section 4980I(d)(3) defines an employee to include "any former employee, surviving spouse, or other primary insured individual." Any surviving spouse of a retiree eligible for applicable coverage under the terms of the plan will thus be considered in determining the cost of coverage and any potential excess benefit. Because the surviving spouse becomes the "primary insured individual" following the qualified retiree's death, the adjustment should continue for the surviving spouse.

Adjustments for High-Risk Professions (Section V-C-2)

Section 4980I provides that 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 telecommunications lines," the applicable annual limit shall be adjusted upward by specified dollar amounts.[45] The term "employees engaged in a high-risk profession" is defined in the statute as including specific categories of individuals and certain employees who are retired from a high-risk profession.[46]

Inclusion of an upward adjustment in the annual limitation for high-risk professions is consistent with health insurers' historical use of industry and/or occupation as factors in setting premiums because of the correlation between these characteristics and claims costs.[47] Therefore,

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[45] Section 4980I(b)(3)(C)(iv). Note that in its summary of the 40% excise tax on high-cost health plans, the Joint Committee on Taxation stated that an individual's annual limit "cannot be increased by more than $1,650 for individual coverage or $3,450 for family coverage ([as indexed]) and the age and gender adjusted excess premium amount, even if the individual would qualify for an increased threshold both on account of his or her status as a retiree over age 55 and as a participant in a plan that covers employees in a high-risk profession." Joint Committee on Taxation, U.S. Congress, *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as Amended, in Combination with the "Patient Protection and Affordable Care Act," JCX-18-10* (March 21, 2010) p. 66.

[46] Section 4980I(f)(3).

[47] *See*, e.g., National Association of Insurance Commissioners and Center for Insurance Policy Research, *Rate Regulation*, available at http://www.naic.org/documents/topics_health_insurance_rate_regulation_brief.pdf (last

this adjustment potentially addresses some of the higher health care costs expected to be incurred by employees engaged in certain professions and industries.

We note, however, that the list of high-risk professions and industries mentioned in the statute does not include some industries and occupations that by objective measures are high risk. As a result, industries and occupations that face higher health care costs because of the work performed are unlikely to be eligible for upward adjustments in their applicable dollar limits. For example, the following partial list of industries not mentioned in Section 4980I as high-risk professions had *employer-reported* incidence rates of nonfatal occupational injuries and illnesses that were more than one-and-a-half times the rate for all workers in 2013: air transportation, hospitals, nursing and residential care facilities, accommodation, transit and ground passenger transportation (local government), utilities (local government), beverage and tobacco product manufacturing, leather and allied product manufacturing, wood product manufacturing, couriers and messengers, and performing arts, spectator sports, and related industries.[48] A look at incidence rates of nonfatal occupational injury and illness cases with days away from work, restricted work activity, or job transfer reveals 25 industry sectors with rates 2.6 or more times the rate for all industries.[49] This includes numerous additional industries not listed in the statute, such as workers engaged in food processing. A similar examination of workplace fatality rates would highlight additional high-risk industries not listed in Section 4980I's definition of high-risk professions, such as the transportation and warehousing industry sector with a 2013 workplace fatality rate more than four times the national rate.[50]

Individuals Defined as Engaged in a High-Risk Profession. Treasury and IRS ask for input on whether they should provide further guidance on the definition of "employees engaged in a high-risk profession." We recommend Treasury and IRS provide guidance for determining whether an employee satisfies this definition with respect to the categories of individuals for which no specific definition is provided by reference to another statutory provision: "individuals

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accessed 5/11/15). In a report for the National Education Association, actuarial consultants at Milliman also identified industry as a premium-driving factor. As an example, the Milliman analysis showed that health insurance premiums for an employer-sponsored group health plan in the mining industry would be priced 20% higher than for a baseline plan using Milliman's pricing model. Milliman, p. 3.

48 Bureau of Labor Statistics, US Dept. of Labor, "Employer-Reported Workplace Injuries and Illnesses—2013," *News Release, USDL-14-2183* (Dec. 4, 2014) t. 1.

49 Bureau of Labor Statistics, US Dept. of Labor, "Employer-Reported Workplace Injuries and Illnesses—2013," *News Release, USDL-14-2183* (Dec. 4, 2014), "Supplemental Tables," t. SNRO2 *available at* http://www.bls.gov/iif/oshwc/osh/os/ostb3963.pdf

50 Calculated from AFL-CIO, *Death on the Job: The Toll of Neglect: A National and State-by-State Profile of Worker Safety and Health, 24th ed.* (Apr. 2015) p. 57, *available at* http://www.aflcio.org/content/download/154671/3868441/DOTJ2015Finalnobug.pdf Statistics cited are for hours-based fatality rates (3.3 for all in industries and 14.0 for transportation and warehousing in 2013).

who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders)" and "individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries."

With respect to "individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders)," we suggest Treasury and IRS provide guidance clarifying that:

- With respect to "emergency medical technicians" and "paramedics," those responsible for calculating any excess amount may rely on commonly used occupation categories that align with each of these, such as the Bureau of Labor Statistics (BLS's) Standard Occupational Classification (SOC) definition for "Emergency Medical Technicians and Paramedics;"[51]

- The broad category of "individuals who provide out-of-hospital emergency care" includes any individual who has been trained in her job to provide emergency medical care or basic life support; or, in the alternative

- Given the lack of any federal legal definition of "first-responders"[52] or any formal occupational category used by BLS related to this term, "first-responders" includes (but is not limited to) individuals trained in their jobs to provide emergency medical care or basic life support in response to a disaster or emergency situation, including individual health emergencies.[53]

We note that individuals in some occupations are required, by law or their employer, to be trained to provide emergency medical care when medical professionals are unavailable to provide emergency care. For example, regulations promulgated by the Federal Aviation Administration require commercial passenger airline carriers to train their flight attendants in the proper use of automated external defibrillators and in the performance of cardiopulmonary

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[51] Bureau of Labor Statistics, U.S. Dept. of Labor, *Occupational Employment Statistics: Occupational Employment and Wages, May 2014: 29-2041 Emergency Medical Technicians and Paramedics, available at* http://www.bls.gov/oes/current/oes292041.htm (Mar. 25, 2015), last accessed May 7, 2015.

[52] *See* National Cooperative Highway Research Program, "The Legal Definitions of First Responder," *Research Results Digest 385* (Nov. 2013), downloaded from http://onlinepubs.trb.org/onlinepubs/nchrp/nchrp_rrd_385.pdf .

[53] A broad definition of "first responders" is necessary if this term is to be given real meaning, especially since professions usually considered to be "first responders" are called out separately in the statute. The parenthetical illustrating the meaning of "individuals who provide out-of-hospital emergency care" already includes separate mention of medical technicians and paramedics. Further, law enforcement officers and employees in fire protection activities are enumerated separately as distinct high-risk professions.

resuscitation, as well as to equip their airplanes with certain emergency medical equipment (including such defibrillators in some cases).[54]

With respect to determining who qualifies as "individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries," we would support guidance permitting the use of either of two alternative approaches:

- Treat any individual employed in an occupation that falls within well-known occupation major groups that align with these categories, such as those established by BLS under the SOC system (e.g., 47-0000—Construction and Extraction and 49-0000 Installation, Maintenance, and Repair Occupations; and 45-0000—Farming, Fishing, and Forestry), as being engaged in the enumerated industries; or

- Treat any individual whose employer's primary activity falls within one of the enumerated industries, following commonly used industry definitions or codes such those under the North American Industry Classification System (NAICS)[55] (e.g., the major groups for Sector 23—Construction; Sector 21—Mining, Quarrying, and Oil and Gas Extraction; and Sector 11—Agriculture, Forestry, Fishing and Hunting) or the related Principal Activity Codes used by the IRS, as being engaged in a high-risk industry.

Permitting those responsible for calculating the excess amount to choose between the two approaches would mitigate any administrative complexity associated with determining whether the majority test is satisfied. In the case of multiemployer plan participants who typically work for multiple employers during a single taxable year, the first approach would be more feasible to administer. Instead of having to engage in a complex determination of whether an individual was employed by an employer engaged in one of the specified high-risk industries during any given month, the party responsible for calculating an excess benefit amount could look to the individual's job classification, information a multiemployer plan may already have or could easily obtain from the collective bargaining agreement and which very likely will remain unchanged during a taxable year. The latter method would apply more easily in circumstances in which an individual is unlikely to change jobs while covered under the plan.

We are mindful, however, that the kinds of governmental classification systems cited above vary in scope and each serves its own purpose within the specific context in which it was created. These systems do not necessarily align completely with common understandings of which businesses and occupations are engaged in an industry. Further, each classification system tends to lag real world developments as industries and jobs evolve. Therefore, it will be

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[54] 14 CFR §§ 121.803, 121.805.

[55] U.S. Census Bureau, U.S. Dept. of Commerce, "North American Industry Classification System: 2012 NAICS," *available at* http://www.census.gov/cgi-bin/sssd/naics/naicsrch?chart=2012, last accessed May 13, 2015.

important to delegate reasonable, good faith discretion to the parties responsible for determining whether certain employees are engaged in a particular industry.

Government Entity Employers. The upward adjustment to the applicable dollar limit relating to employees engaged in a high-risk profession or employed to repair or install electrical or telecommunication lines is applicable only if a majority of a participating employer's employees qualify as such individuals. Therefore, the employer aggregation rules that apply to this section[56] may come into play in determining whether the majority test is satisfied. Consistent with the guidance provided for applying the employer aggregation rules under the employer shared responsibility requirements of Section 4980H[57], we recommend that Treasury and IRS issue guidance permitting government entities to apply a reasonable, good faith interpretation of Section 414 (b), (c), (m) and (o) in determining whether government entity employers shall be treated as a single employer for purposes of Section 4980I.

"Covered by the Plan." Section 4980I's majority test requires calculation of a ratio of the number of employees of an employer engaged in a high-risk profession or employed to repair or install electrical or telecommunication lines covered by the plan over the total number of that employer's employees covered by the plan. Section 4980I does not include a definition of "covered by the plan" for purposes of this determination, and Treasury and IRS request feedback on how "plan" should be defined for this purpose. Given the upward adjustment in the annual limitation reflects Congress's determination that the enumerated professions' health-related risks are an important factor driving higher costs for their health coverage, it is important to align the definition of plan for purposes of the majority test with the risk pool used to calculate the cost of applicable coverage. In particular, we recommend permitting the determination of whether a group is eligible for this adjustment to be based on the employees enrolled in a benefit package, especially if Treasury and IRS issue rules mandating aggregation of individuals covered by benefit package for the purpose of calculating the cost of applicable coverage. To the extent Treasury and IRS permit or require further disaggregation of enrolled employees for purposes of determining the cost of applicable coverage, consideration should be given to permitting alignment between the group used to determine whether the majority test is satisfied for the high-risk adjustment with the group used to determine cost.

Multiemployer Plans. In the case of multiemployer health plans, we recommend that Treasury and IRS permit determination of whether the majority test is satisfied and application of the upward adjustment in the annual limitation to be done on an aggregate basis, across the entire covered population of employees in the plan (or benefit package), not separately for each employer. Therefore, if a majority of all of the employees covered under the plan, irrespective of

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56 Section 4980I(f)(9).

57 79 Fed. Reg. 8548 (Feb. 12, 2014).

their respective employer(s), are individuals engaged in high-risk professions or employed to repair or install electrical or telecommunication lines, then the upward adjustment in the annual limitation should apply. This approach should be available to be used by a multiemployer plan sponsor at its election.

Retirees. Section 4980I provides that the term "employees engaged in a high-risk profession" "includes an employee who is retired from a high-risk profession...if such employee satisfied the requirements [described in this section to be considered an employee engaged in a high-risk profession] for a period of not less than 20 years during the employee's employment."[58] Unlike the definition of a "qualified retiree,"[59] the statute includes no limitations on who qualifies as a retiree under this provision based on the individual's age or entitlement to benefits or eligibility for enrollment under the Medicare program. This section does not include a definition of an individual "employed to repair or install electrical or telecommunications lines" and therefore does not address whether retirees who were "employed to repair or install electrical or telecommunications lines" during their period of employment count in determining eligibility for this upward adjustment. We recommend Treasury and IRS provide guidance clarifying that individuals "employed to repair or install electrical or telecommunications lines" include retirees, using the same formulation as Congress used for "employees engaged in a high-risk profession." For both categories of retirees, we recommend Treasury and IRS permit the party responsible for calculating any excess amount to adopt any method that is expected to provide a reasonable basis for determining whether a retiree satisfies the 20-year requirement.

Age and Gender Adjustments (Section V-C-3)

Section 4980I provides that the applicable annual dollar limitation shall be increased if the cost of providing coverage under a standard benefit package is higher for the employees of an employer than for the national workforce as a whole because of differences in the age and gender characteristics between the two groups.[60] In particular, the amount of the adjustment is equal to the "excess (if any) of—

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

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58 Section 4980I(f)(3).

59 Section 4980I(f)(2).

60 Section 4980I(b)(3)(C)(iii).

> (bb) that premium cost for the provision of such coverage under such option in such taxable period if priced for the age and gender characteristics of the national workforce."[61]

The statutory language of this provision clearly provides that adjustments occur only if the cost of the baseline FEHBP benefit package for the employees of the employer is greater than it would be for employees who are representative of the age and gender composition of the national workforce. That is, no downward adjustments in the annual dollar limitations can occur. Inclusion of an upward adjustment in the annual limitation based on the age and gender characteristics of the employees compared to the national workforce is consistent with health insurers' use of age and gender as factors in setting premiums because of the correlation between each of these characteristics and claims costs.[62]

Treasury and IRS ask for feedback 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" but raise no other issues about how this provision should be implemented. We encourage Treasury and IRS to explore the development of specific tools (such as calculators or tables) that simplify the calculation of the adjustment amount. The age and gender adjustment, if implemented by Treasury and IRS appropriately, can have a meaningful impact on whether there is any excess benefit subject to the 40 percent excise tax. For example, one analysis estimates that the age and gender adjustment for an employer whose employees have the age and gender characteristics of the national education workforce would be $1,253 for self-only coverage in 2018, increasing the applicable annual dollar limit from $10,200 to $11,453.[63] Treasury and IRS can greatly facilitate access to this adjustment and help minimize the administrative costs of determining its amount by providing access to tools.

Any such tools or similar safe harbors should satisfy two related criteria: they should (1) lead to reasonable approximations of the adjustment; and (2) not systematically undervalue the adjustment. We note that with respect to pricing premiums, age and gender interact with each other differently at each combination of age and gender, and that the distribution of individuals by age and gender also affects estimated future health care costs. That is, mere averages do not provide accurate approximations of cost and therefore do not provide accurate estimates of the appropriate age and gender adjustment for a particular population.[64] Any tools or safe harbors

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61 Section 4980I(b)(3)(C)(iii)(II).

62 *See*, e.g., National Association of Insurance Commissioners and Center for Insurance Policy Research, *Rate Regulation*, *available at* http://www.naic.org/documents/topics_health_insurance_rate_regulation_brief.pdf (last accessed 5/11/15).

63 Milliman, fig. 6.

will have to incorporate accurately both the interrelationship of age and gender and the impact on premiums of the distribution of employees by age and gender. A calculator would be more likely to capture accurately the complexities of the age and gender adjustment, but a table that achieved the same goal would be acceptable. To the extent that Treasury and IRS develop a table for determining the age and gender adjustment, the table must not undervalue the adjustment.

Last, we urge Treasury and IRS to provide that the use of any tools will be at the election of the party responsible for calculating any excess benefit amount, with other appropriate methods for determining the adjustment made available.

Although the discussion of the age and gender adjustment provision in Notice 2015-16 is limited to soliciting feedback on whether safe harbors can and should be developed, Treasury and IRS will face several other important implementation issues. These include, but are not limited to, the following:

- Treasury and IRS will need to establish guidelines for the development of acceptable premium pricing models, as well as develop its own premium pricing model if it chooses to provide tools, such as a calculator. There are a number of important issues that would need to be addressed in doing so, but those are largely beyond the scope of these comments.

- Section 4980I does not define "national workforce," and there does not appear to be a definition of that precise term elsewhere in federal law. Since Congress provided no specific definition and placed no specific limitations on its meaning, we suggest Treasury and IRS adopt a definition that is consistent with a broad, common sense understanding of this term, one that allows for easy access to data the federal government already collects. We recommend Treasury and IRS look to the definition of the labor force used by BLS, including employed and unemployed workers and without regard to an individual worker's insured status.

- Guidance will be required regarding the timing and related methods for determining the age and gender composition of the national workforce and the applicable group of employees. We expect that the permitted cost calculation methods, determination periods, and other rules governing the calculation of the tax (such as whether tax

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[64] The National Education Association, in its comment letter on Notice 2015-16, provides a specific illustration of how two populations, with the same average age and the same gender ratio but very different age/gender distributions, would have markedly different premiums and estimated age and gender adjustments. In its example of two different populations, each with the average age of 45 and a male/female split of 33.3% and 66.6%, one group's estimated age and gender adjustment is nearly 2.9 times that of the other's. National Education Association, Letter to the Internal Revenue Service on Notice 2015-16, May 15, 2015.

liabilities are calculated on a monthly or annual basis) will be important factors that influence our views on this matter.

- Although the statute identifies the plan to be used for pricing the premiums that are to be compared to determine any adjustment, it does not indicate an "as of" date for that plan's design. The benchmark plan design—the Blue Cross/Blue Shield standard benefit plan option under the Federal Employees Health Benefits Plan—could change from year to year. The only reference to a timeframe in this subsection of the law is to the type of benefits received by an individual during the tax year; for example, the dollar limit for the self-only coverage is to be used if the individual was provided self-only coverage during the tax year. For purposes of determining adjustments, rules will be needed for identifying which year's plan design can or must be used, and in what circumstances it can or must be used.[65]

- Any pricing model must establish the appropriate relationship between the premium prices for self-only and other-than-self-only coverage. For this purpose, we urge Treasury and IRS to adopt the ratio of the other-than-self-only coverage annual dollar limit over the self-only coverage annual dollar limit ($27,500/$10,200)—2.7—to define the appropriate relationship between the premium amounts for both categories of coverage.

- Treasury and IRS must define the relevant pool of employees for determining the age and gender characteristics used for the premium cost calculation. How this group is defined will determine whether the age and gender adjustment provides a meaningful adjustment to the annual limitation for a particular pool of employees. As we have elsewhere in these comments, we urge Treasury and IRS to align the adjustments to the applicable annual limits with the pool of employees who have been grouped together for purposes of calculating the cost of applicable coverage. Here, this means determining the age and gender adjustment amount using the age and gender characteristics for the employee group used to calculate the cost of coverage. If Treasury and IRS require aggregation by benefit package when calculating the cost of applicable coverage, it would be the group of employees enrolled[66] in that benefit package. If permissive disaggregation is used to

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[65] Staff of the Joint Committee on Taxation appear to suggest that if the standard Blue Cross/Blue Shield option is not available under the Federal Employees Health Benefit Plan for any year, the Secretary will identify an option available under the Federal Employees Health Benefit Plan for that year that is substantially similar to the standard Blue Cross/Blue Shield option. They do not discuss, however, the possibility of changes to the standard Blue Cross/Blue Shield option itself. Joint Committee on Taxation, U.S. Congress, *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as Amended, in Combination with the "Patient Protection and Affordable Care Act," JCX-18-10* (March 21, 2010) p. 61, fn. 137.

[66] Section 4980I(b)(3)(C)(iii)(II)(aa) provides that the premium cost for an individual be determined "if priced for the age and gender characteristics of all employees of the individual's employer." Section 4980I(d)(3) provides

create smaller risk pools to determine the cost of coverage, then Treasury and IRS should allow the age and gender adjustment to be based on the group of enrolled employees in that smaller group. We also urge Treasury and IRS to clarify that the age and gender adjustment applies to all retirees, as well as non-retired employees.

The AFL-CIO appreciates the opportunity to comment on the Notice, and we look forward to the prompt release of proposed and final rules governing the 40 percent excise tax on high-cost health plans. If you have any questions about these comments or need any additional information, please do not hesitate to contact me.

Very truly yours,

/s/ Shaun C. O'Brien

Shaun C. O'Brien
Assistant Policy Director for Health & Retirement

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for purposes of § 4980I, "The term 'employee' includes any former employee, surviving spouse, or other primary insured individual." Section 4980I(b)(3)(C)(iii)(II)(aa) is properly interpreted in light of this definition. In particular, use of the phrase "other primary insured individual" makes it clear that the class of employees relevant to the calculation of the age and gender adjustment only includes those employees (active employees, former employees, surviving spouses, and other primary insured individuals) who are in fact enrolled in applicable coverage sponsored by the employer (or the sponsors of a multiemployer plan in the case of coverage provided under a multiemployer plan).