

Notice 2015-16

MAY 19 2015



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CC:PA:LPD:PR (Notice 2015-16)
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Internal Revenue Service
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Washington, DC 20044

Submitted electronically via Notice.comments@irs.counsel.treas.gov

Re: Notice 2015-16

Ladies and Gentlemen:

On behalf of the 1.6 million active members and retirees of the American Federation of State, County & Municipal Employees (AFSCME), AFL-CIO, I am submitting comments on Notice 2015-16 concerning Section 4980I and the Excise Tax on High Cost Employer-Sponsored Health Coverage under the Affordable Care Act (ACA). The bulk of AFSCME's membership is in the public sector where a large number of health plans will likely be impacted by this tax in 2018 or soon thereafter.

Beginning in 2018, a tax will be imposed on all employer-sponsored health coverage costing more than \$10,200 for self-only coverage and \$27,500 for all other coverage. The costs in excess of these thresholds will be subject to the 40 percent tax, payable by the insurer for fully-insured plans or the plan sponsor or employer for self-funded plans. While the liability is not directly payable by employees covered by the plans that will be taxed, there is no doubt that it will ultimately be the employees that will be impacted by the tax, either through reduced benefits or significantly increased out-of-pocket health care costs.

While AFSCME continues to support the ACA and its overarching goal of expanding access to high-quality, affordable health care coverage, we have, from the beginning, been deeply troubled about the impact of this law's excise tax on high-cost plans. Many factors influence the cost of health care, some within a covered individual's control but many are not. The Milliman actuarial firm recently analyzed this tax established in Section 4980I of the ACA, focusing on the factors that drive premium growth and its impact on high cost plans. Contrary to the belief that the tax will target overly rich health benefits, their analysis found that "it is likely to be a tax based on factors other than benefit richness and beyond the control of health plan members" such as geography, age and gender. While the 4980I provision attempts to adjust the thresholds to correct for the impact of age and gender on premiums, the analysis found it did not fully realize this goal and could unduly affect women and older employees. Further, outside of benefit level, the premium cost-driving factor found to have the greatest level of variability – geography – is not addressed in the law at all.

American Federation of State, County and Municipal Employees, AFL-CIO

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Although we question the policy rationale for the tax and fear the negative effects it will have on the health care coverage of middle-class families, we submit these comments with the intention of minimizing the potentially harmful and uneven impact on workers and their families.

Notice 2015-16 was issued by Treasury and the IRS in order to gather feedback on potential approaches to implementing various issues under Section 4980I. The Notice focuses on three broad aspects of the excise tax: (1) what counts toward the cost of coverage for tax purposes; (2) how the cost of this coverage is determined; and (3) how to apply the called for adjustments to the baseline dollar thresholds.

Section III. Definition of Applicable Coverage

Section 4980I includes a fairly expansive definition of “applicable employer-sponsored coverage” consisting of coverage under any “group health plan” paid with pre-tax dollars with exclusions for certain “excepted benefits” included in Section 9832(c) such as accident and disability insurance, workers’ compensation, long-term care and insured limited scope dental and vision coverage. The Notice describes potential approaches for determining when/if several types of coverage will be treated as applicable coverage. AFSCME supports some of the approaches but suggests changes in others:

Health Savings Accounts (HSAs)

With respect to HSAs, the Notice proposes to include both employer contributions and employee contributions through salary reduction as applicable coverage. We find two problems with this approach. First, it assumes that all HSAs are automatically considered to be “applicable employer-sponsored coverage” and second, we disagree that the statute intended to treat employee salary reduction contributions to these accounts as employer contributions.

While the language in 4980I includes a section on HSA (and MSA) contributions in determining the liability to pay the tax, this is predicated on the assumption that such coverage is determined to be “applicable employer-sponsored coverage” which is defined as “coverage under any group health plan.” Therefore, an arrangement or coverage that is not a “group health plan” is not subject to the tax. As indicated in Field Assistance Bulletin 2004-1 and 2006-2, the Department of Labor (DOL) considers HSAs to be group health plans only to the extent that they fail to satisfy the five-step safe harbor set out in the bulletin (e.g. if employer imposes conditions on the utilization of HSA funds beyond those permitted by the Code, employer influences investment decisions relating to the account, etc.). And while not technically considered formal guidance, Treasury, DOL and Department of Health and Human Services did include a statement in the preamble of previous ACA regulations asserting that both MSAs and HSAs generally are not treated as group health plans. Any future guidance should clarify that contributions to an HSA are only included in the excise tax calculation if the HSA is a group health plan.

Beyond the determination of whether or not an HSA is a group health plan, there is uncertainty over whether or not “employer contributions” specified in Sections 49801(c)(2)(B) and 49801(d)(2)(B) should include salary reduction contributions made by employees. Based upon a straightforward reading of the provision, we believe that if the intent was to also include pre-tax employee contributions, direct reference to this type of contribution would have been made, as was done in Section 49801(d)(2)(B)(i) concerning the determination of costs for health FSAs: “the amount of employer contributions under any salary reduction election under the arrangement.” We recommend that salary reduction contributions to HSAs that are determined to be “group health plans” should be excluded from the tax.

Limited Scope Dental and Vision Benefits and Employee Assistance Programs

The Notice proposes that Treasury and IRS exercise their authority under Section 49801(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, thereby excluding them from applicable coverage for purposes of the tax. We support this approach.

In addition, the excepted benefit coverage exclusion from applicable coverage should be expanded to include the limited wraparound coverage finalized in the recently issued Amendments to Excepted Benefits rule. This rule states that this limited coverage, offered by employers to certain employees and retirees enrolling in individual or Multi-State Plan coverage, will be treated as excepted benefits. To be consistent with the treatment of other excepted benefits, Treasury and IRS should consider this limited wraparound coverage outside the scope of applicable coverage.

IV. Determination of Cost of Applicable Coverage

The Notice proposes potential approaches for determining the cost of the applicable coverage, focusing on three specific areas – similarly situated individuals, self-insured methods and HRAs.

Similarly Situated Individuals

For what constitutes similarly situated employees, Treasury and IRS propose that each group would be determined by first aggregating all employees covered by a particular benefit package provided by the employer (e.g. HMO option enrollees, PPO option enrollees), then disaggregating employees based on whether they are enrolled in self-only coverage or other than self-only coverage. We support this treatment. Comments were requested on the extent to which benefit packages must be identical to be considered the same for aggregation purposes. We endorse the view summarized in the AFL-CIO comments:

The AFL-CIO agrees the Department should permit the grouping of similar but not identical benefit packages. Doing so could address some of the inequities that would otherwise result under this law 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 the Department 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 so long as the actuarial value of each benefit package within the grouping is within an acceptable corridor, such as a five-percentage point corridor. Employees could be grouped together without regard to the benefit type. 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 located at the employer's East Coast facility were covered by PPO with an 84 percent actuarial value, these 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. The party responsible for determining the cost of applicable coverage could then work with benefit professionals to determine the most appropriate grouping based on all of the facts and circumstances.

Once these first two mandatory steps have been completed, the Notice suggests that employers be given the option of further aggregation within the other than self-only coverage as well as further optional disaggregation based on either a broad standard (such as specified job categories or collective bargaining status) or a more specific standard (such as a specified list of limited specific categories – e.g. current and former employees, bona fide geographic distinctions). We support the proposed permissive aggregation approach of *not requiring* employers to determine the cost of coverage for employees enrolled in other than self-only coverage based on the coverage tier or the number of individuals covered (e.g. employee plus one, employee plus two or family coverage). With regard to the proposed optional disaggregation approaches, we too have concerns such an option may result in potential abuses and urge caution. We further suggest that, if any such option is provided, no more than one layer of permissive disaggregation should be permitted.

Self-Insured Methods

The Notice proposes giving employers of self-insured plans the option of the two methods set out in COBRA Section 4980B(f)(4)(B) – actuarial basis method and past cost method – for determining the cost of applicable coverage under Section 4980I. We support this proposal, but suggest that Treasury and IRS allow changes between methods more frequently than the suggested five years. We do agree, however, that there be a limitation on using the past cost method in any year where significant changes in coverage or employees covered occur. Further, we recommend that regardless of method chosen by the employer, Treasury and IRS should detail exclusions from the costs to be taken into account. Specifically, all federal, state and local taxes and fees should be excluded, including but not limited to those imposed under the ACA, such as the Patient Centered Outcomes Research Institute fee, the Transitional Reinsurance Program fee and the Health Insurance Providers fee. And for insured plans, any broker fees or commissions should be excluded.

Health Reimbursement Arrangements

Treasury and IRS are proposing various different methods for determining the cost of coverage under an HRA: 1) based on the amounts made newly available to the employee each year (excluding any carryover amounts or amounts available prior to 2018), 2) adding together all claims and administrative expenses attributable to HRAs and dividing that sum by the number of employees covered, 3) permitting or requiring employers to value HRAs using the actuarial basis method.

We recommend providing plan sponsors flexibility in choosing any of these methods to determine costs. However, under all methods, certain amounts should be disregarded when determining the cost of coverage: amounts contributed or credited to an HRA before 2018; amounts related to investment earnings; amounts contributed during a worker's career if they may only be used during retirement; amounts used to reimburse expenses for excepted benefits; and in order to prevent double counting, amounts used to fund the worker's/retiree's contribution for coverage.

V. Applicable Dollar Limit

Adjustments for High-Risk Professions

Section 4980I includes upward adjustments to the baseline dollar thresholds for "employees engaged in a high-risk profession or employed to repair or install electrical or telecommunication lines" if the majority in the plan are in such positions. Feedback is requested on whether further guidance should be provided on the definition of "employees engaged in a high risk profession." We agree with the AFL-CIO view that additional guidance and clarification is needed as summarized in their comments:

With respect to "individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders)," we suggest providing 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 Standards' (BLS's) Standard Occupational Classification (SOC) definition for "Emergency Medical Technicians and Paramedics;"
- 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" 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.

With respect to determining who qualifies as “individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries,” we suggest providing 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, and 45-0000—Farming, Fishing and Forestry), as being engaged in the enumerated industries; or
- Treat any individual employed by an employer the primary activity of which falls within one of the enumerated industries, following commonly used industry codes such as those under the North American Industry Classification System (NAICS) (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.

Two additional areas mentioned in the Notice needing further guidance in order to implement this adjustment are how employers should determine if the majority of employees covered by a plan are engaged in a high risk profession and what exactly the term “covered by the plan” means in this context. Because the employer aggregation rules may come into play in determination of this “majority,” we recommend that Treasury and IRS issue guidance permitting government entities to apply a reasonable, good faith interpretation of Code Section 414 (b), (c), (m) and (o) when determining if they should be treated as a single employer for these purposes. This would be consistent with guidance issued for such employers under the employer shared responsibility regulations. As for the definition of “covered by the plan,” it should take into account the risk pool used to calculate the cost of applicable coverage. We recommend achieving this by basing eligibility for this adjustment on the employees enrolled in a benefit package.

Age and Gender Adjustments

Although this Notice focuses only on the possibility of developing safe harbors that would appropriately adjust the dollar thresholds for employee populations with age and gender characteristics that are different from those of the national workforce, there are many important implementation issues that will need to be considered. Some of them, as summarized by comments submitted by the AFL-CIO, are:

- 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 and that allows for easy access to data already collected on a regular basis by the federal government. 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 liabilities are calculated on a monthly or annual basis) will be important factors that influence our views on this matter.
- 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 the Department 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 in doing 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. We urge the Department 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 the Department requires aggregation by benefit package when calculating the cost of applicable coverage, it would be the group of employees enrolled in that benefit package. If permissive disaggregation is used to create smaller risk pools to determine the cost of coverage, then the Department should allow the age and gender adjustment to be based on the group of enrolled employees in that smaller group. We also urge the Department to clarify that the age and gender adjustment applies to all retirees, as well as non-retired employees.

AFSCME appreciates this opportunity to provide input at the initial stages of the rulemaking process relating to these provisions.

Sincerely,


Steven Kreisberg
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