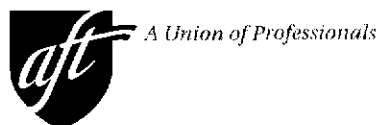


Notice 2015-16

MAY 19 2015



May 15, 2015

CC: PA: LPD: PR (Notice 2015-16)
Internal Revenue Service
P.O. Box 7604, Ben Franklin Station
Washington, DC 20044

Notice.comments@irs.counsel.treas.gov

Dear Ladies and Gentlemen:

On behalf of our 1.6 million members, the American Federation of Teachers (AFT) welcomes the opportunity to comment on several approaches under consideration for the development of regulatory guidance regarding the excise tax on high-cost employer-sponsored health plans under Code Section 4980I. The AFT is a union of professionals that champions fairness; democracy; economic opportunity; and high-quality public education, healthcare and public services for our students, their families and our communities. Virtually all our members are covered by locally negotiated health insurance programs that could be subject to this tax, and therefore have a vital interest in how the various approaches might be incorporated in future proposed regulations.

The excise tax on high-cost plans, or "Cadillac tax," is one of the revenue-raising provisions in the 2010 Affordable Care Act. The tax is determined by comparing the cost of an employer-sponsored plan to a benchmark of \$10,200 for self-only coverage and \$27,500 for other-than-self-only coverage. Costs include premiums paid by the employer and/or the employee, as well as any contributions to health savings accounts, health reimbursement accounts and flexible spending accounts. Any amount above the benchmark is taxed at 40 percent. While this tax will be levied on insurance companies where the plan is fully insured and on employers where the plan is self-funded, the tax will likely be passed on to consumers, who are unable to shift costs.

The above-cited benchmark amounts are to be determined under rules similar to those in place for determining COBRA premiums. In 2018, the benchmarks will be adjusted upward based on several different factors, including one for high-risk

The American Federation of Teachers is a union of professionals that champions fairness; democracy; economic opportunity; and high-quality public education, healthcare and public services for our students, their families and our communities. We are committed to advancing these principles through community engagement, organizing, collective bargaining and political activism, and especially through the work our members do.

American Federation
of Teachers, AFL-CIO

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AFT Higher Education
AFT Public Employees
AFT Nurses and Health
Professionals

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professions (\$1,650 for self-only and \$3,450 for other-than-self-only coverage) and another for gender and age differences between the sponsored plan and the national workforce. The benchmarks will also be increased if the Blue Cross Blue Shield standard plan for federal employees under the Federal Employees Health Benefits Program grows faster than 55 percent between 2010 and 2018. Going forward, there will be an annual inflation adjustment in the threshold amounts based on the rise in the Consumer Price Index for Urban Consumers (CPI-U), beginning in 2019. For 2019 only, an extra 1 percent will be added to the inflation adjustment.

Reasons for the Tax

It is our understanding that the purpose of the tax is twofold: (1) to offset the tax-free status of employer-sponsored health insurance, which is seen as a drain on the U.S. Treasury, while increasing federal revenues to pay for subsidized care, and (2) to bend the healthcare cost curve by suppressing moral hazard—the incentive for consumers to overuse healthcare because they do not bear its full cost. Some analysts argue that this tax will lead employers and employees to seek out more efficient plans and perhaps an increase in wages. However, we believe that workers will be forced to consider high-deductible health plans, and any savings from the switch will stay with the employer. This outcome will not lower the cost curve but shift more costs to workers, who will likely forgo necessary care or go into debt to pay for the high out-of-pocket costs associated with high-deductible health plans. This shift will be especially felt by those with a chronic condition in need of care and prescription drugs.

Our concern about the design of the tax to curtail unnecessary utilization is based on our view of the demand and supply currents that exist in the employer marketplace for healthcare. Providers of care have consolidated over the last 20 years and now hold monopoly pricing advantages in many parts of the country. Consumers have not consolidated, so even a large school district or state government has very little say over the prices of care that are negotiated between insurers and healthcare providers. Employers and union-represented employees are left to negotiate over utilization and plan design, which only impacts one part of the total cost. Therefore, while employers and unions are doing everything possible to control unnecessary utilization, they have no input or control in price negotiations that occur between insurers and providers.

On top of this negotiating imbalance sits a number of well-known structural reasons why American healthcare costs are higher than those in any other industrialized nation. Among the most notable problems are:

- Fee-for-service medicine contains incentives for overuse, underuse and misuse, by paying providers who cause complications or are slow to diagnose problems.
- A 2-to-1 ratio of specialists to primary care physicians. Specialists spend more money, use more technology and complicated interventions, and get paid more per hour of work.
- More technology than any other country (e.g., about four times more MRIs are performed in the United States than in Canada).
- Higher prescription drug prices than other industrialized countries.
- A complicated billing system, which adds to administrative costs.

The employer-sponsored health insurance model has assigned employers the responsibility to manage healthcare purchasing for most workers. Unfortunately, employers have weak incentives to act collectively to increase the efficiency of the healthcare delivery system. Employers use healthcare as a tool to attract and retain a high-quality workforce, not as a coordinated strategy to produce an efficient healthcare system. As a result, corporate and public treasurers concentrate on containing their specific short-term healthcare costs, rather than creating a long-term efficient healthcare system.

Moral Hazard

While a number of analysts have opined that workers overuse healthcare services, the root cause of this assertion is based on a RAND Corporation study that was conducted about 40 years ago. RAND researchers compared health plan utilization among participants in different cost-sharing groups to a theoretical plan that required no premium sharing, no deductible, no copayments and no coinsurance. As predicted, participants in the "no-cost plan" used more services than those in the various cost-sharing plans, who pared back both outpatient care and inpatient admissions by about one-third. However, once they entered the healthcare system, patients in all cost-sharing plans spent about the same amount per episode as those in the no-cost plan. Moreover, the analysts found that consumers were just as likely to forgo necessary care as unnecessary care.

While moral hazard may be a convenient way for analysts to justify passing on increased healthcare expenses to employees, cost sharing will do very little to address the underlying causes of the rising costs. The imposition of the excise tax will shift more costs to patients, decrease the demand for some necessary services and likely force consumers to make medical decisions based on cost. Making consumers responsible for controlling healthcare cost trends is a flawed proposition for several reasons:

- Consumers do not have the necessary information or knowledge to confirm a diagnosis or value the worth of alternative treatments. Consumers rely on medical professionals for guidance on both points. Even if the information were available, consumers would still rely on provider advice and recommendations.
- Consumers are involved emotionally in medical decisions for themselves and their families, and often make quick medical decisions to lower emotional stress. Again, they need a competent guide to show them the path to high-quality care and outcomes.
- Even when the employer offers to offset some or all of the deductible through a tax-advantaged account, employees are reluctant to use these funds for routine or chronic care. Due to uncertainty of future healthcare needs, consumers will keep allocated funds in reserve, especially if they can take them into retirement.

On Feb. 23, 2015, the Treasury released pre-rulemaking notice 2015-16, in which it raised a number of specific questions regarding how the tax might be implemented and requested comments on these issues. Our comments on specific issues raised in this notice follow below.

Extension of the Excise Tax to Supplemental Welfare Funds

It is our understanding that once the sponsoring employer determines the amount of the excise tax, it may allocate a portion of the tax to "benefit administrators" who provide other self-funded "applicable employer-sponsored coverage." We urge the Treasury and IRS to exempt self-insured collectively bargained supplemental benefit funds from any potential high-cost plan excise tax liability **by excluding any**

supplemental coverage provided from such funds in future regulations and with respect to this tax.

Over the years, hundreds of thousands of New York City rank-and-file employees, and many New York state employees, have been covered by two sources of health benefits:

- Major medical coverage provided under group plans administered by the city of New York, the state, counties, towns and school districts (i.e., the employer); and
- Supplemental plan coverage provided by separate self-insured, self-administered welfare benefit funds sponsored by various local unions, including the United Federation of Teachers.

The costs of both sources are funded by the employer as a result of collective bargaining and are included in the employer's overall budget for employee benefits. These negotiated supplemental employee welfare benefit plans provide supplemental benefits that are not otherwise covered by New York state, county, town or city plans. Specifically, the basic health plans provided by New York City to large categories of employees do not include prescription drug coverage, some prescription appliances and hearing aids. Some of the covered drugs are very expensive. For example, the welfare fund covers hepatitis C drugs for more than 100 members at a cost of \$85,000 per person.

Based on collective bargaining agreements with the unions, New York City contributes contractually specified fixed amounts, ranging from \$1,215 to \$1,780 per member per year, to cover all of the benefits offered by the plans. Many unions have not been able to increase employer contributions to these funds for many years, and they would be forced to stop providing certain benefits if they were required to pay any part of the excise tax on high-cost plans. As the excise tax on major medical plans alone would limit health coverage for employees, any extra tax applied to supplemental benefit funds would further restrict the funding for employee benefits.

Also, expanding the definition of "applicable employer-sponsored coverage" to supplemental benefit funds would create a rule that would be difficult to administer. For example, some of these benefit funds may be solely devoted to providing dental and vision programs, while others may offer programs and services that are not

directly health related, such as disability and life insurance, legal services and burial benefits. Asking plan administrators to determine which part of an employer's welfare fund contribution is subject to the excise tax would be complicated, time-consuming and costly.

We are asking the Treasury to treat the benefits provided by these unique supplemental welfare funds as "supplemental excepted benefits," and not subject them to the Affordable Care Act requirements that apply to group health plans. Benefits provided by these funds are supplemental to major medical coverage, and are provided separately by union-administered welfare funds. The easiest way to meet this goal is by excluding such funds from the definitions of "applicable employer-sponsored coverage" and "person who administers the plan of benefits" in future regulations as well as guidance with respect to this tax. If, however, it is determined that any portion of the excise tax is attributable to the contribution made to the supplemental benefit fund, that portion should be the responsibility of the employer, which has negotiated and budgeted for the expenses. After all, the excise tax is directed at the employer and not supplemental union benefit funds.

On-Site Medical Clinics

Both the Treasury and IRS anticipate that future proposed regulations will exclude de minimis medical coverage provided by on-site medical clinics from being counted toward the applicable premium dollar limits upon which the excise tax is based. This convention is consistent with longstanding COBRA regulations excluding on-site medical clinics from the definition of group health plan if the care is primarily first aid, provided during working hours and only available to active employees who are not charged for the care. In instances where these clinics provide other services beyond first aid, such care should be excluded from the cost of employer-sponsored care as well.

Since 2012, the state of Montana has created five healthcare clinics—in Helena, Billings, Missoula, Miles City and Butte—that offer free primary care, including flu shots and lab services, to any of its 32,000 state employees, their dependents, and retirees covered by the state employee health plan. These services are offered on top of the typical state employer-sponsored health insurance coverage.

The Montana Unified School Trust (MUST) has recently entered into an agreement with the Montana Health Centers to permit about 1,200 educators in the general vicinity of the clinics to have access to them as well. MUST pays \$18 per member per month to access the clinics. Meanwhile, the Billings public school district has established two of its own clinics for the primary care of its employees, with no copay for primary care visits and no copay on generic prescription drugs ordered through the clinics. One clinic is located in a school administration building and the other is in an office building that is close to several schools.

The state contracts with a private company to run the facilities for the state employees and pays for everything. Program managers report that the per-visit cost in these state-sponsored clinics is lower than in the private fee-for-service sector. As a result, the cost for a patient to visit one of these health clinics is about half what it would cost to see a private physician. Because it's free to patients, hundreds of people who had not seen a doctor in years have entered the system.

A recent review of the first year's operation of the clinic in Helena showed some promising results for 2013:

- The center had more than 25,000 primary care visits and operated at 95 percent of capacity.
- More than 1,800 patients were identified with previously undiagnosed chronic health conditions, and high cholesterol and high blood pressure were the most common new diagnoses, followed by asthma/COPD and diabetes.
- Savings came from paying physicians an hourly rate instead of a fee-for-service rate, and from the state's ability to buy supplies at lower prices.

It is our understanding that once the employer determines that the excise tax threshold has been surpassed, and the amount of the tax is calculated, the employer may allocate a portion of the tax to any entity considered as a plan administrator. As these clinics are relatively new, it is unclear if these promising results are sustainable over time. Forcing these clinics to report out and pay a portion of the excise tax for the necessary services they provide could cause them to go out of business. Requiring the state or school district to include the cost of this innovative initiative as part of its 2018 premium costs would chill employer and union interest in this potentially cost-containing initiative.

We are asking the Treasury to consider these health clinic services as “supplemental excepted benefits” and not make them subject to the excise tax on high-cost plans.

Determining the Cost of Applicable Coverage

The Affordable Care Act specifies two methods for self-funded plans to determine the applicable premiums: the actuarial basis method and the past cost method. The typical collectively bargained plan negotiated by our locals uses the past cost method to determine premium costs. These amounts are regularly calculated for employer budgeting purposes and are readily available from third-party administrators. The use of incurred claims over a fixed time period is preferable to using submitted claims to align utilization and costs.

We are more likely to see the actuarial calculation employed in groups with no claims history. However, the plan sponsor should be given the flexibility to employ either approach. The regulations should require that the method that results in the lowest claim cost for the given period be adopted by the employer.

Because of the uncertainty of high-cost claims from year to year, it would be unfair to charge an excise tax on employer-sponsored health plans in a year where the plan experienced a high number of catastrophic claims due to a natural disaster or just bad luck. We therefore recommend that the tax trigger be based on the average claim costs over a five-year rolling period, which would smooth out catastrophic spikes and provide employers and union-represented employees time to develop alternative plan designs to lower costs, without shifting them to workers.

In determining cost of coverage under the past cost method, the costs that the Treasury suggests be considered include claims, premiums for stop-loss insurance, administrative expenses and reasonable overhead expenses for salaries, rents, supplies, etc. The cost of claims could include either claims incurred during the measurement period or claims submitted during the measurement period. Reserves for future claims, claims incurred above the stop-loss policy's threshold, or any previously determined excise tax would not be taken into account.

In our view, including anything other than incurred claims costs in the calculation is solely aimed at increasing federal revenues to pay for subsidized care, and not at bending the healthcare curve. Both efficient and inefficient health plans experience

administrative claims expenses for enrollment, claims adjudication and dispute resolution. In addition, many administrative fees, such as reinsurance for self-funding, coordination of benefits, subrogation, high-cost claims management, and development and maintenance of high-quality/low-cost provider networks, are focused on improved efficiency and cost containment. Charging plan sponsors administrative fees for cost containment is contrary to the stated goal of controlling healthcare costs. If such fees are included in the cost of care, it will have a chilling effect on employer interest in managing costs.

Aggregation by Benefit Package, Disaggregation by Family Size

The Treasury is considering asking plan sponsors to aggregate workers, eligible retirees, surviving spouses and dependents by plan design (e.g., HMO, PPO, POS, Indemnity, etc.), and requiring them to calculate the cost of coverage of each plan type, instead of grouping all employees together to calculate an average cost. After participants are grouped by plan design, the employer would then disaggregate these groups based on self-only coverage and other-than-self-only coverage in order to calculate the cost of each coverage tier. The cost of each tier would then be compared to the self-only and other-than-self-only thresholds of \$10,200 and \$27,500 to determine if an excise tax had been triggered. The Treasury is considering further disaggregating the other-than-self-only group into subgroups based on family composition (e.g., two adults, one adult and dependent children, etc.). Our comments on these approaches follow below.

The typical local union collective bargaining agreement provides for multiple plan designs with varying degrees of premium and out-of-pocket cost sharing. Active employees, early retirees and normal retirees (in non-Social Security states) may participate in these plans. Coverage for early retirees and normal retirees is provided either by a local school district, a consortium of school districts or, in some cases, the state teachers' or public employees' retirement plan. When the plan is statewide as in Texas and Ohio, plan benefits for retirees age 65 and over are coordinated with Medicare.

While plan design and member cost sharing are major discussion points in collective bargaining, the contract settlement is charged an average cost (either positive or negative) for the overall cost changes in the health plan. Changes in plan design, wellness, cost sharing and wage reduction tradeoffs during contract negotiations

permit employers and union-represented employees to decide the best ways to divide total compensation between wages and benefits, based on current economic conditions and the value placed on each component of total compensation.

Implementation of the suggested aggregation and disaggregation rules contained in the notice will distort the collective bargaining process by imposing an enormous outside pressure on both parties, and will lead to results that work against local employer workforce policies and distort employer and member values. Most public employers use healthcare and other benefits to attract and retain a high-quality workforce. However, this workforce strategy will likely be negated by the threatened imposition of the tax. Rather than fight over which part of the tax the employer and employees will pay, the parties will likely consider adopting high-deductible health plans. This plan design will likely lower health plan costs below the 2018 thresholds, while shifting more out-of-pocket costs to workers. As a result, the cost curve won't be bent but instead shifted over to workers, who will either forgo necessary care or go into debt to pay for high unreimbursed deductibles.

It is therefore recommended that plan sponsors be asked to calculate the average cost of incurred claims for the entire covered population to determine the cost of coverage, without regard to plan type or family size. This calculation could be performed at least 12 months before the threshold date (i.e., compare the average cost of coverage in 2017 to the 2018 threshold) to give employers and employees time to negotiate over how best to address the potential tax.

Should the law constrain the Treasury's ability to adopt the average cost method endorsed above, we recommend two other ways to aggregate employer-sponsored plans. First, it is common for large public employers to offer multiple health plans with different levels of premium sharing for employee election. It is not unusual to learn that the value of the various plan designs is similar. For example, Boston's public school system offered five plan designs for educator selection in the 2014-15 school year: two HMOs, two PPOs and one POS. Second, if the actuarial value of different plan designs is similar, the employer should be permitted to aggregate the plans for determining the cost of care. For example, the American Red Cross, another contracted employer, has reported that the actuarial value of its four offered plans in 2015 vary from 63 percent for an equivalent bronze level plan to 88 percent for an equivalent gold level plan. As a practical matter and to ease administrative compliance, plan sponsors should be permitted to aggregate similar plan designs

when determining self-only and other-than-self-only costs. Additionally, plan sponsors should be given the flexibility to combine different plan designs when their actuarial value is about the same.

Dollar Limit Adjustments

The Affordable Care Act provides for several adjustments that will raise the dollar thresholds of \$10,200 for self-only coverage and \$27,500 for other-than-self-only coverage in 2018. There is a health cost adjustment percentage, adjustments for age and gender, adjustments for qualified retirees, and adjustments for inflation and high-risk professions. Since the AFT represents more than 100,000 healthcare workers and school nurses, and because many put their lives at risk every day, we will address our concerns for this group separately. Our comments on the other adjustments are presented below.

By including these adjustments, there was at least a tacit acknowledgement that health plan premiums are not driven by overutilization of generous health benefits but impacted by many different factors, including group demographics and inflation. The most obvious adjustment—where a health plan member lives—was curiously omitted from this list. This omission will likely lead to the imposition of the excise tax on health plans in northeast cities and towns. Other high cost-of-living areas will likely trip over the thresholds as well.

The typical educator's health plan features premium cost sharing, deductibles, coinsurance and copays—hardly the kind of “Cadillac” plan reported in the press. The following chart illustrates cost-sharing features for a Blue Cross Blue Shield PPO offered in school districts in Albuquerque, Pittsburgh and Boston. It shows that Boston educators have already exceeded the family cost threshold as a result of their monthly premiums (\$2,693 a month x 12 months = \$32,316), despite agreeing to a significant amount of cost sharing.

In addition to the various premium and out-of-pocket cost-sharing costs shown in this chart, thousands of members have given up wage increases to maintain coverage for themselves and their families. Our members trade off earned wage increases for financial protection against the uncertainty of a future catastrophic accident or illness for themselves and their families.

**Comparison of In-Network Family Coverage
in the Albuquerque, Pittsburgh and Boston Public School Districts
Blue Cross Blue Shield PPO, 2014-15**

Plan Feature	Albuquerque	Pittsburgh	Boston
Monthly Premium	\$1,212*	\$1,466	\$2,693
Employee Share of Monthly Premium	\$485**	\$208	\$730
Annual Premium	\$14,544	\$17,592	\$32,316
Deductible	\$750	\$500	\$0
Out-of-Pocket Maximum	\$6,750	\$0, but deductible, copays, Rx drug expenses, balanced billing and non-covered expenses are not included in the out-of-pocket limit	\$9,000
Office Visits: Primary Care/Specialist	\$25/\$40 per visit	\$20/\$30 per visit	\$20/\$30 per visit
Emergency Room	\$150 copay per visit, plus deductible and 20% coinsurance	\$75 copay per visit	\$100 copay, waived if admitted
Prescription Drugs Retail Member Copay: Generic/Formulary Brand/Non-Formulary Brand	20% (min. \$8, max. \$20)/30% (min. \$25, max. \$55)/40% (min. \$45, max. \$105) for a 34-day supply	\$10/\$30/\$50 for a 31-day supply	\$10/\$25/\$45

*Reflects Albuquerque Public Schools (APS) Family Monthly Premium Rate. APS collects 12 months of premiums (24 bimonthly payroll deductions).

**For employees who earn \$30,000 or more annually and when both employee and spouse/domestic partner participate in the APS Employee Wellness Incentive Program (annual biometric screening required). This represents the majority of APS employees enrolled in the medical plans. Employees earning \$30,000 or more who do not participate in the Employee Wellness Incentive Program pay \$509.72 monthly. Employees earning less than \$30,000 who participate in the Employee Wellness Incentive Program pay \$242.36 monthly. Employees earning less than \$30,000 who do not participate in the Employee Wellness Incentive Program pay \$267.36 monthly.

Section 4980I calls for the annual premium benchmarks to 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 age and gender differences between the two groups.¹ Specifically, the adjustment is equal to the excess of the premium cost for the standard Blue Cross Blue Shield plan offered under the Federal Employees Health Benefits Program for age and gender characteristics of the national workforce as compared to the premium cost for the same plan substituting the employer's workforce.²

Approximately 7 in 10 K-12 teachers and 9 in 10 nurses are female. It's important to recognize the higher cost of insuring workers in these professions. Many school districts gladly employ educators in their 50s and 60s who by many measures are at the top of their profession. Likewise, colleges and universities employ many professors over the age of 55 who have become experts in their field after years of study, teaching and writing. However, it would be a complicated, expensive and time-consuming proposition for plan sponsors to determine the appropriate adjustment to the cost thresholds based on the above-cited comparison. We are therefore requesting that the Treasury and IRS develop a formula or matrix that can be easily applied by plan sponsors for this adjustment.

After the 2018 adjustments are determined, future adjustments are tied to the CPI-U. However, Department of Commerce data show that medical inflation exceeds the CPI-U by about 3 percent per year. If this trend continues, more and more health plan sponsors will be forced to pay the high-cost plan excise tax. The future of employer-sponsored health insurance will be jeopardized by limiting the inflation adjustment to the CPI-U. We understand that the Treasury may not have the authority to replace the CPI-U with the medical CPI after 2018, but we want to make clear that threshold adjustments based on the CPI-U will be very harmful to our members.

High-Risk Professions

If a majority of a plan sponsor's employees are engaged in a high-risk profession, there will be another adjustment to the thresholds. There are several problems with this adjustment as it is currently proposed. First, the definition only includes

¹26 USC § 4980I (f)(2)

²26 USC § 4980I (b)(3)(C)(iii)(II)

individuals who provide out-of-hospital emergency medical care, including paramedics, emergency medical technicians and first responders. It needs to be expanded to specifically include school nurses, coaches, teachers, paraprofessionals and bus drivers, as many of these workers are required by state and/or local law to be proficient in first aid and CPR as part of their job. Second, emergency medical care extends beyond out-of-hospital care and includes emergency room care, surgical care, intensive care and, in some cases, care during recovery from a life-threatening disease. Third, in many instances, teachers, school nurses, hospital nurses, lab technicians and other at-risk employees may be excluded from an adjustment because they do not constitute a majority of the plan sponsor's employees. Should these individuals drive up the cost of their health plan because they were injured or contracted a disease as part of their job, the plan should not be penalized.

Four states—Virginia, New York, Indiana and Oregon—now require teachers to become certified in CPR, and Hawaii (HB 76, SB 43) and Massachusetts (HB 484) were considering bills in 2014. The 2013 Virginia law requires all teachers to complete training or become certified in emergency first aid, CPR and automated external defibrillator (AED) use before their licenses can be renewed. Section 917 of the New York State Education Law requires public school administrators to ensure the presence of at least one operable AED at each school building, as well as appropriately trained and certified staff who can respond to medical emergencies that require CPR/AED. The Texas Education Code does not require that all teachers become certified in emergency first aid, but section 22.902 requires that athletic coaches and sponsors, school nurses, physical education teachers and marching band directors have a current certification in AED filed with the district. California law requires that child care providers maintain current certification in pediatric first aid and CPR (Emergency Medical Services Authority law 100000.17), and that all school bus drivers demonstrate proficiency in first-aid practices by successfully completing a competency-based written examination administered by the California Highway Patrol, in addition to any other requirement for a school bus driver's certificate (Emergency Medical Services Authority law 100003).

Other states consider educators, nurses and healthcare personnel as first responders in law. For example, in Colorado, "first responder" is defined as an individual who responds in a professional capacity to an emergency, including those

that occur in a school building, and includes school administrators and teachers.³ Florida's definition includes physicians, advanced registered nurse practitioners, physician assistants and workers employed by public or private hospitals in the state.⁴ Missouri classifies first responder as any person trained and authorized by law or rule to render emergency medical assistance or treatment, including registered nurses and physicians.⁵ Texas first responders include emergency medical services personnel, including hospital emergency facility staff.⁶

The National Academy of Sciences Transportation Research Board commissioned a study in 2013 to determine if there was a definition of the term first responder in federal law,⁷ and concluded that there was no such definition. The term has been used in the popular press to refer to law enforcement and fire and emergency medical personnel, especially since the events of 9/11. However, a broad interpretation of first responder should include teachers, school nurses, and healthcare workers in hospitals and urgent care centers who provide urgent and emergency care services.

Unknown hazards associated with an emergency are often not known until the patient has been diagnosed and treated by medical professionals in the hospital. In addressing workplace hazards, the Occupational Safety and Health Administration promulgated extensive standards applicable to healthcare employers.⁸ An example of this type of emergency is the June 2, 2006, explosion at a manufacturing plant in Pandora, Ohio, where serious injury from exposure to chemical materials affected not only the emergency medical technicians who transported patients but also the hospital staff who cared for them.

Homeland Security Presidential Directive 8 (HSPD-8) initially defined first responder in part as "individuals who, in the early stages of an incident, are responsible for the protection and preservation of life, property, evidence, and the environment, including emergency response providers ... as well as emergency management, public health, clinical care, public works, and other skilled support personnel ... who

³See CRS 24-33.5-1802

⁴Fla. Stat. 252.515(3)(a)

⁵192.800 R.S. Mo.

⁶Texas Government Code 161.0001

⁷National Cooperative Highway Research Program, NCHRP Project 20-59(41), "Legal Definition of 'First Responder'"

⁸See 29CFR 1910.1200; 29CFR 1910.1030

provide immediate support services during prevention, response, and recovery operations.”⁹ While HSPD-8 was subsequently rescinded, the replacement policy statement did not contradict this definition. The new directive refers to first responders through the National Security Strategy of May 2010¹⁰ without providing a definition. Since this new directive does not offer an alternative definition of first responder, the Treasury could develop its own definition.

We are urging the Treasury to include in the definition of first responder bus drivers, school nurses, teachers, school staff, and healthcare workers inside and outside of a hospital setting. As a practical matter, educators, bus drivers, school nurses, and other school staff members and healthcare workers act as first responders in urgent and emergency situations. Moreover, they are considered first responders by the public. Extending the definition to these workers will help offset the unexpected healthcare costs they may experience as part of their job.

Delay the Implementation of the Tax

During this period of outreach for input on regulatory guidance and subsequent development of proposed regulations, thousands of labor union contracts will be renegotiated. Many of these agreements will be in place before any guidance is provided on the application of this tax. We therefore recommend the implementation of any excise tax be delayed until the later of either the date that the final rules are put in place or the end of an existing collective bargaining agreement in effect on the date the final regulations are adopted.

We appreciate your consideration of these concerns to our members.

Sincerely,

John D. Abraham
Manager, Research and Strategic Initiatives Department

JDA : mb opeiu#2 afl-cio

⁹§(2)(d)

¹⁰http://osce.usmission.gov/national_security_strategy_2010.html

