

Notice 2015-16

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Via the Internet at Notice.comments@irs.counsel.treas.gov

Ms. Karen Levin
CC: PA: LPD: PR (Notice 2015-16)
Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

RE: Notice 2015-16 and Section 49801 - Excise Tax on High Cost Employer-Sponsored Health Coverage

Dear Ms. Levin:

This is in response to the invitation in Notice 2015-16 (the "Notice") to provide comments regarding issues that should be addressed in proposed regulations under Section 49801 of the Internal Revenue Code (the "Code") regarding the excise tax on high cost employer-sponsored health coverage. We appreciate the opportunity to submit comments at this stage of rule-making on this important topic. We are providing these comments on behalf of the School Employees Retirement System of Ohio ("SERS"), but believe these comments provide insight regarding issues relating to many plans other than SERS, including retiree health plans offered by other state and local government retirement systems ("Retirement Systems") as well as private employer plans offering employer-sponsored retiree health coverage that should be addressed in the proposed regulations.

Brief Summary

Many Retirement Systems provide health coverage to retirees of participating employers under the Retirement System ("Retiree Health Coverage"). Because such Retiree Health Coverage provides benefits to a population that is by its nature older and/or disabled, providing coverage to such individuals who are not yet eligible for Medicare can be significantly more expensive than coverage provided to a population of active employees that more closely reflects the national workforce. Chronic health conditions and other ailments can result in early retirement, so that a retiree plan covering individuals not eligible for Medicare is likely to have higher claims experience than one covering individuals with similar age and gender characteristics who are in the national workforce. As a result, Retiree Health Coverage that provides only modest coverage may well be on track to trigger an excise tax as early as 2018.

Currently, SERS's actuary projects that in 2018 each person with self-only coverage in SERS's non-Medicare group is projected to trigger an excise tax of approximately \$160 per month. The amount is projected to increase each succeeding year. There will be a disproportionately greater impact on Retiree Health Coverage than on plans covering active populations if regulations do not clearly accommodate the relief for such plans. Imposing the heavy burden of an immediate excise tax on low-benefit group health plans that use concerted efforts to provide affordable coverage to deserving individuals will only result in a decrease in the level of benefits or ultimately in the entire burden of those higher costs being shifted to a Health Insurance Marketplace ("Marketplace") or Medicaid as the struggling plans are unable to shoulder the added financial burdens. Given the subsidies provided for Marketplace coverage, any revenue to the federal government from the excise tax quite possibly will be outweighed by the cost of the subsidies provided.

We believe Code Section 4980I has provisions that reduce or eliminate the unintended consequences of the excise tax. For example, the statute allows plans providing coverage to retired employees who have not attained the age of 65 and who have attained the age of 65 to be treated as one group when determining cost for purposes of the statute. In addition, provisions of the statute permit retiree plans to use rules that eliminate cost enhancing factors having no relationship to the level of benefit coverage provided. We ask that future guidance reflect these provisions.

Background of Public Retirement System Plans

Prior to the Social Security Act, many state and local governments created Retirement Systems to administer pension benefits for individuals who retired from public employers. The Retirement Systems were initially or eventually established by state or local statute and, in most cases, are themselves considered to be governmental entities that are separate and distinct from their retirees' public employers. State or local governments also established the legal framework for the Retirement Systems through statutes and regulations.

In addition to pension benefits, many Retirement Systems provide Retiree Health Coverage to eligible retirees. Retirement System plans cover only retirees of specified government employers and their eligible dependents. Retiree Health Coverage generally covers both Medicare-eligible and non-Medicare-eligible retirees through options or benefit packages under the same plan. It is worth noting that a meaningful percentage of governmental retirees who are not yet eligible for Medicare have not retired due to having sufficient funds to maintain retirement but rather have retired due to a disability or chronic disease that prevents continued employment.

Retiree Health Coverage is not funded by the Retirement System but is funded by public employers and the retirees, as well as investment returns on the funds received from the employers and retirees. For example, local governments that employ firemen will make contributions to a Retirement System for the firemen's retiree health coverage. Local school systems, colleges and universities will make contributions to a Retirement System for the retiree health coverage of teachers and school employees. In some cases, funding from retirees is adjusted based upon need. For example SERS subsidizes the premium cost for low income individuals, a class that frequently

has high claims experience. Getting additional funding from either source is a difficult and complicated process, since the employer contributions are set by statute. As a result, additional expenses of the Retiree Health Coverage generally result in reduced benefits for the retirees; the significantly increased expenses that likely would result from imposition of the excise tax could lead to a termination of the Retiree Health Coverage. Once a retiree reaches age 65, the cost of medical coverage is helped tremendously by Medicare funding, but until then the Retirement System (i.e., the employers and the retirees) must cover all expenses.

Comments in Response to Notice 2015-16

Regulations Should Provide that Code Section 4980I(d)(2)(A) Permits Applicable Employer-Sponsored Coverage to Aggregate Pre-65 Retirees with Post-65 Retirees for Purposes of Determining Cost as Set Forth in the Statute.

Code Section 4980I(d)(2)(A) states that “[i]n the case of applicable employer-sponsored coverage which provides coverage to retired employees, the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries.” Consistent with this, the Technical Explanation of the Patient Protection and Affordable Care Act prepared by the Joint Committee on Taxation (March 10, 2010, JCX-18-10) notes that “In determining the coverage value for retirees, employers may elect to treat pre-65 retirees together with post-65 retirees.” (Emphasis added.) The Notice specifically references Code Section 4980I(d)(2)(A) as a “Specific Rule.” However, it later states that under a potential approach being considered for purposes of determining costs for groups of similarly situated employees, the initial groups of similarly situated employees would be determined by aggregating all employees covered by a particular benefit package and makes no reference to the permissive aggregation permitted by this Code Section.

Retiree Health Coverage typically coordinates with Medicare coverage for those individuals who are entitled to Medicare. Thus, if an individual has attained age 65, the retiree coverage provided by a Retirement System typically takes the form of a Medicare supplement. Medicare Advantage coverage may be available as well. Since Medicare pays the majority of the costs for an individual who is entitled to Medicare, a Medicare supplement or Medicare Advantage policy or coverage generally costs a plan much less than health coverage for an individual who has not yet attained age 65 and become eligible for Medicare.

For individuals who are not entitled to Medicare, the Retirement System will offer coverage that provides benefits similar, but not necessarily identical, to the coverage provided by the combination of Medicare and the employer sponsored coverage that coordinates with Medicare. Because Medicare does not buffer any of the costs to the Retirement System, however, the cost of the coverage is much greater. As noted above, many pre-65 retirees have disabilities and chronic conditions. Due to the adverse claims experience resulting from such individuals, the cost of the coverage for those not eligible for Medicare is high and, if considered as a separate benefit package, likely will exceed the thresholds to determine an excess benefit. On the other hand, if the coverage for Medicare eligible retirees is aggregated or put together with coverage for those individuals not eligible for Medicare, the lower cost of Medicare-eligible retirees will help balance the higher cost of the non-Medicare eligible retirees, with the result that the average aggregate cost of the coverage for the retirees will likely be below the thresholds to determine an excess benefit.

Retirement Systems often have plans that provide benefit packages to retirees who have attained age 65 as well as those who have not attained age 65. As recognized in the Notice, “there may be more than one benefit package provided under a group health plan.” As discussed more fully below, cost for purposes of Section 4980I is to be determined by reference to rules similar to COBRA. Accordingly, the definition of a “plan” should also be made by reference to existing regulations that define the term “group health plan” for purposes of COBRA. Q&A-6 at Treas. Reg. Section 54.4980B-2 provides that “all health care benefits, other than benefits for qualified long-term care services (as defined in section 7702B(c)), provided by a corporation, partnership, or other entity or trade or business, or by an employee organization, constitute one group health plan, unless” the instruments governing the arrangement or arrangements to provide health care benefits clearly provide otherwise and the arrangements are operated as separate plans. (Emphasis added.) Thus in a typical wrap plan arrangement, a plan with multiple benefit packages including separate benefit packages that are insured and self-insured, and that are for Medicare eligible individuals and for non-Medicare eligible individuals, is one plan for purposes of Code Section 4980I.

Congress was well aware of the potential impact on plans that provide coverage to retirees and particularly to retiree plans that provide coverage to pre-65 individuals not eligible for Medicare. In Code Section 4980I(b)(3)(C)(iv) it provided for an increase in the threshold for “qualified retirees.” More importantly, as evidenced by Code Section 4980I(d)(2)(A), Congress deemed it appropriate to make it clear that when determining the cost of coverage “under rules similar to the rules of section 4980B(f)(4),” coverage for pre- and post-65 retirees may be aggregated at the election of the plan. As discussed in the Notice, Code Section 4980B(f)(4) provides that the cost of coverage for “similarly situated beneficiaries” is to be used in determining COBRA premiums. Immediately following that language, Congress added a rule that where a plan provides coverage to retired employees, any pre-65 retiree and any retiree who has attained age 65 may be treated as “similarly situated beneficiaries.” By using the same term (i.e., “similarly situated beneficiary”), Congress clearly sought to overrule any interpretation of Code Section 4980B(f)(4) that may provide otherwise.

Code Section 4980I(d)(2)(A) does not refer to “benefit packages.” Although the use of benefit packages as a means to identify similarly situated beneficiaries may be consistent with the rules of Code Section 4980B(f)(4) in other situations, it clearly is not consistent with the statutory provision allowing a plan with different benefit options to treat retirees under age 65 and retirees who have attained age 65 as “similarly situated.” Applying a “benefit package” rule in the case of retiree medical coverage would eviscerate Code Section 4980I(d)(2)(A). In light of the way post-65 coverage is designed, it is unlikely that any post-65 coverage that is coordinated with Medicare in some fashion and pre-65 coverage that cannot be so coordinated would be deemed a single “benefit package.” Much of the coverage offered to pre-65 individuals takes the form of PPO, HMO, or other narrow-network coverage; there may be no comparable coverage for individuals eligible for Medicare, due in part to restrictions on such coverage imposed by Medicare. For example, in any given geographic area, there may be an HMO offering coverage to individuals under age 65, but not to post-65 individuals.

Thus, we ask for confirmation that, for purposes of Code Section 4980I(d)(2)(A), in the case of a plan that offers multiple retiree benefit packages, the plan may elect to determine the cost of coverage by treating retired employees who have not attained age 65 and retired employees who have attained age 65 as “similarly situated beneficiaries” who may, at the discretion of the plan, be

permissively aggregated for purposes of determining cost under Code Section 4980I regardless of the type of coverage or benefit package in which they are enrolled under the plan.

Alternative Methods of Determining Cost Should be Available under Regulations

Code Section 4980I(d)(2)(A) provides that cost shall be determined under rules similar to the rules of Code Section 4980B(f)(4). (Emphasis added.) The Notice recognizes that some commenters suggested that cost could be determined by reference to the cost of similar coverage available elsewhere, such as through a Marketplace. Treasury and the IRS expressed certain concerns regarding the use of such an approach, including that it might not fully account for all benefits and features of a plan. Notwithstanding those concerns, comments were solicited as to whether any alternative approaches would be consistent with the statutory requirements of Code Section 4980I, and if such alternative approaches would be useful.

We believe that the use of alternative methods would be both useful and consistent with the statutory requirements. Allowing a plan to obtain the cost of coverage based on the cost of similar coverage from a Marketplace, the Blue Cross/Blue Shield standard benefit option available under the Federal Employee Health Benefits Plan, or other metrics based on actuarial values is an appropriate method of obtaining cost and consistent with the Affordable Care Act (the “ACA”). For example, in Code Section 36B, the premium assistance amount to which a taxpayer is entitled may be determined by reference to the “applicable second lowest cost silver plan.” Code Section 36B(b)(2)(B). If a premium assistance amount may be determined by reference to the premium cost of a level of coverage as determined under actuarial value rules developed by the Department of Health and Human Services (“HHS”) and available at a Marketplace, it appears reasonable that the cost amount for determining an excess benefit under Code Section 4980I may also be determined by reference to the cost of a level of coverage available at a Marketplace. Thus, if the actuarial value determined by HHS rules at 45 CFR Part 156 results in a benefit package being at the silver level of coverage, the cost of the coverage for purposes of Code Section 4980I could be established by reference to the cost of a silver level product available at a Marketplace.

We further suggest that any plan offering coverage that is at the silver level should not be subject to the excise tax. In other words, silver level coverage should be a safe harbor and a plan offering silver or a lesser level of coverage should not trigger the excise tax. The second lowest cost silver plan is the “applicable benchmark plan” for purposes of determining the premium assistance amount under Code Section 36B. Treasury Regulation Section 1.36B-3(f). Using a silver plan as a standard for determining a federal subsidy on one hand and then assessing an excise tax on a plan that offers the same level of coverage is inconsistent. Clearly Congress saw the silver level plan as a preferred level of coverage and regulations under Code Section 4980I should not permit an anomaly that triggers the taxation of such coverage.

Moreover, an alternative method based on actuarial value would more accurately reflect the value of the benefit package provided to individuals. Such a method of cost determination identifies a cost of the coverage provided to individuals without the influence of adverse claims experience that is unique to a particular group’s demographic. The cost of similar coverage from a Marketplace reflects a larger population, and would be more reflective of the cost of the benefit package than the

adverse claims experience of a particular group. Retiree Health Coverage tends to incur higher costs not due to richer coverage, but rather as a result of the much higher claims experience of a covered population that (i) is markedly older than the active workforce, (ii) generally includes disabled individuals who, by reason of their disabled status, tend to incur higher medical claims, and (iii) may be predominantly female. The use of readily available alternative methods would eliminate those factors derived from plan-specific data that may cause one group of individuals to trigger an excise tax, even though their coverage is no better than that provided to a group whose coverage does not trigger the excise tax. This use of an alternative method would avoid the inequitable result of penalizing a plan with an ordinary design that simply has adverse claims experience and more reasonably identify a cost for the benefits provided through the coverage.

Although the Notice notes that the use of an alternative method may not be appropriate because the metric may be based on essential health benefits, we believe that Retiree Health Coverage has very few benefits that are not essential health benefits. Options to eliminate this issue could be to make the alternative method available only where the benefit package provides no benefits in addition to essential health benefits, or to provide factors to adjust the cost for plans with additional benefits.

The Notice states the concern that two self-insured plans “that have different costs of applicable coverage might nonetheless have equal actuarial values.” It is for precisely this reason that we believe it is more appropriate that different plans having the same actuarial value should have the same cost for purposes of calculating the excise tax. The use of an alternative method will help ensure that benefit packages with similar benefits are taxed at a similar level.

Regulations defining the Actuarial Cost Method Should Permit Adjustments to Eliminate Above-Average Claims Experience

The Notice indicates that Code Section 4980B(f)(4) provides self-insured plans the choice of two methods of determining cost: the past cost method and the actuarial basis method. The actuarial basis method, which is the default method to be used by plans, is to take into account such factors as the Secretary may prescribe in regulations. Such factors have not yet been identified, but Treasury and IRS have requested input on whether the regulations should identify specific factors that must be satisfied in making an actuarial determination of the cost of coverage. In line with the above discussion regarding the influence of adverse claims experience that are unique to a particular benefit package, we believe one such factor should be an adjustment to eliminate plan-specific, above-average claims experience. In order to develop a more accurate estimate of cost, actuaries will frequently weight claims experience by giving greater weight to the most recent claims experience but also using adjustments based on prior years experience of a plan so as to lessen the impact of the most recent claims experience. As an additional option, an actuary should be permitted to use claims experience factors of plans with standard populations so as to develop a cost that is not increased due to the high claims experience of a non-standard population. Such an actuarial factor and permitted adjustment would allow a determination of cost that is not above the cost used for similarly situated beneficiaries in a plan not having the unique adverse claims experience of a retiree plan.

Age and Gender Adjustments Should be Based on a Retiree Plan and Safe Harbors Should be Developed

As noted above, the population of a retiree medical plan consists of individuals who generally are older and have greater medical needs due to disabilities and chronic conditions than does a plan that includes active employees. We believe that an adjusted limit based on a plan with both active and retired employees would not fully adjust to the costs for a plan with only retirees. Thus, when adjustments are made under the authority of Code Section 4980I(b)(3)(C)(iii), the premium cost of the Blue Cross/Blue Shield standard benefit option under the Federal Employee Health Benefits Plan should reflect a price based on the cost of such coverage for only retirees. As provided by the statute, the cost of this coverage would then be divided by the premium cost for such coverage for the age and gender characteristics of the national workforce. If the cost of coverage for those individuals who are active employees is included with those individuals who have the same age and gender characteristics but who are retirees, the adjustment for a retiree plan will likely be diluted to the detriment of the retiree plan. By having a separate calculation for retiree coverage, the adjustment would then reflect a more accurate cost adjustment of a retiree plan.

The Notice solicits comments on whether it would be desirable and possible to develop safe harbors that would adjust the dollar limit thresholds for employee populations with different age and gender characteristics. Because threshold amounts are needed by plan sponsors at a significant period of time before the beginning of the calendar year to which the threshold relates, we believe that some type of safe harbor is needed that gives adequate notice and allows plan sponsors to prepare plan designs. We also believe that a retiree population would be an ideal category for which to develop a safe harbor adjustment, since in general it can be designed to cover a population that shares certain basic characteristics, namely, an age above a certain threshold, a higher percentage of disabled individuals, and in SERS's case, a higher percentage of women than the national workforce, which factors should permit the relevant population to be readily segregated for cost analysis. Certainly these age and gender characteristics are different from those of the national workforce. To fail to recognize this distinction would not reflect the true relative cost of a retiree plan and would penalize those entities that offer such plans, which in some cases could have the undesirable effect of causing the sponsors of such plans to determine that they cannot continue to offer such coverage.

One potential safe harbor for Retiree Health Coverage of a Retirement System would be to treat any coverage provided under a retiree medical plan as "coverage other than self-only coverage" as is already permitted in the case of multiemployer plan coverage pursuant to Code Section 4980I(b)(3)(B)(ii). Retirement Systems are similar to multiemployer plans in many respects and such treatment under a safe harbor for a plan that receives contributions from many employers would be consistent with the statute. Another option would be to establish an adjustment based on an appropriate index as was done in developing the 55% factor in Code Section 4980I(b)(3)(C)(ii)(II) to cover the years from 2010 through 2017. Although such an adjustment factor may not be completely accurate, it can be reasonable for purposes of the statute. Instead of one adjustment factor there would be multiple factors for age and gender characteristics dependent upon representative plans. For example, a safe harbor adjustment factor could be based on experience of the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan.

Conclusion/Summary

We appreciate this opportunity to provide these comments and hope they are helpful in preparing future guidance regarding Code Section 4980I and the excise tax imposed by the ACA. Retiree Health Coverage for Non-Medicare eligible individuals is very expensive. This group includes many individuals who are disabled or who suffer from chronic conditions. Plans for Retirement Systems often subsidize coverage for such individuals and provide an incentive for the individuals to remain under the coverage. The cost of coverage for this group will ordinarily exceed the threshold amounts in Code Section 4980I. As noted, SERS's actuary projects that unless the relief suggested above is granted, each member of this group with retiree-only coverage will trigger an excise tax of \$160 per month or nearly \$2,000 per year. If SERS passes this cost on to the retiree, in many cases it will increase the retiree's premium by approximately sixty percent (60%) or more.

Although Code Section 4980I(b)(3)(C)(iv), provides a modest adjustment in the dollar threshold for retirees who are at least age 55 but not yet eligible for Medicare, further adjustment is permitted and is needed to prevent inappropriate taxation of Retiree Health Coverage. As an additional rule for the calculation of the cost of coverage used for determining whether the threshold has been exceeded, Congress included in the statute Code Section 4980I(d)(2), which clearly provides that a plan with multiple benefit packages may aggregate all benefit options for all individuals who are receiving coverage by reason of being a retiree when the cost of coverage is determined. By permitting aggregation with retirees who are eligible for Medicare, Congress provided a rule which will allow retiree plans providing ordinary benefits to avoid the excise tax. Regulations should clearly provide for this rule and allow such permissive aggregation.

Other Code Sections also permit rules to make allowance for adverse claims experience of high cost populations to avoid the excise tax and the regulations should reflect such rules. Code Section 4980I does not prohibit an alternative method for the determination of cost. An alternative method which permits a plan to use cost data of similar coverage from a Marketplace where the high claims experience of early retiree groups is blended with other individuals to reflect a more reasonable cost for the coverage should be permitted. Regulations for the actuarial cost method should permit adjustments for high claims experience unique to a plan. Lastly, age and gender adjustments should reflect retiree plans so as to adjust the threshold amounts to reflect the actual cost of coverage for such populations. Failure to provide for such rules in the regulations will cause an excise tax to be imposed on plans only because they provide reasonable coverage to a high claims experience group and not because the benefits provided exceed those typically provided.

If the excise tax is triggered for Retiree Health Coverage, many Retirement Systems will either need to pass costs on to the retirees or curtail benefits for such coverage. As a result, thousands of retirees will be faced with higher costs and/or may receive less coverage

Calfee, Halter & Griswold LLP

In the event you have any questions or comments regarding these comments, please do not hesitate to contact the undersigned.

Very truly yours,

A handwritten signature in black ink that reads "Wade D. Clark". The signature is written in a cursive style with a large, prominent "W" and "C".

Wade D. Clark

A handwritten signature in black ink that reads "Claudia Brobst". The signature is written in a cursive style with a large, prominent "C" and "B".

Claudia Brobst