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Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
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Subject: Notice 2015-16

Cavanaugh Macdonald Consulting, LLC (CMC) thanks the Department of the Treasury (Treasury) and the Internal Revenue Service (IRS) for this opportunity to comment on Section 4980I of the Internal Revenue Code (Code) and Notice 2015-16. As a leader in providing actuarial consulting services to the other postemployment benefits (OPEB) plans of state and local governments, we have been engaged with various organizations in discussions regarding specific technical issues with §4980I. We are satisfied that the comments to be made by those organizations will provide Treasury and IRS the detailed concerns of the various professionals serving plans providing employer-sponsored health coverage. We therefore focus our firm's comments on a broader perspective of §4980I and discuss the implications of §4980I on the public sector OPEB environment.

We believe the OPEBs of state and local governments, including health care coverage, provide meaningful benefits to eligible disableds and retirees in exchange for their prior service. As postemployment health care benefits are provided to a population that is aged and/or may be of an impaired health status, the definition of "excess benefit" using an annual limitation based upon seemingly arbitrary, dollar-based thresholds, including the pre-Medicare retiree/high-risk adjustments prescribed by §4980I(b)(3)(C)(iv), may increase the cost of postemployment health care benefits that are not overly generous or rich, but reflect the higher cost of health care due to characteristics such as age, health status, and/or geographical location. Additionally, many postemployment health care plans provide coverage to a membership that straddles eligibility for Medicare. As such, a postemployment health care plan may be the primary payer for a portion of the covered population and secondary to Medicare for the remainder. Here, coverage mechanics (e.g., subsidy requirements, provider availability) often result in the coverage between two population segments that are otherwise "similarly situated beneficiaries" being split into separate "benefit packages". In short, the delivery of health care is not a "one size fits all" proposition, and we believe some accommodation should be made for plans whose focus may not be purely on participants whose coverage is based upon active employment.

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§4980I(f)(2) – Definition of “Qualified Retiree”

This section defines a “qualified retiree” as an individual who:

- Is receiving coverage by reason of being a retiree;
- Has attained age 55; and
- Is not entitled to benefits or eligible for enrollment under the Medicare program under title XVIII of the Social Security Act.

Health care benefits provided through postemployment benefit plans may include participants who are disabled, surviving spouses, and/or other eligible dependents. From a definitional perspective, under the terms of the plan, these participants may not be classified as a “retiree”. Regulatory guidance should clarify the definition of “by reason of being a retiree”, and it is our opinion that this definition should include those receiving benefits under a postemployment health care plan as the result of disablement, survivorship, or other means of qualification (e.g., eligible, non-spouse dependent). Additionally, many disabled participants receiving health care coverage through postemployment benefit plans may no longer be actively employed (i.e., “retired”), not by the traditional reason of age, but due to a substantial impairment to their health. As such, we believe some consideration should be made for these individuals who are below the age of 55 and likely to have health care costs that are higher than those of actively employed individuals. If changing the age limit of §4980I(f)(2)(B) is beyond the scope and authority of the regulatory guidance to be provided, accommodation may be provided via adjustments to the applicable dollar limit using actuarial techniques. Last, we believe regulatory guidance should specifically address the definition of “similar insurance” provided by §9832(c)(1)(D) as it relates to §4980I(d)(1)(B)(i). If postemployment health care coverage provided due to work-related disabilities is included in this definition, and the costs associated with this population can be excluded from the cost of applicable employer-sponsored coverage, some relief may be provided to plans providing health care benefits to the disabled.

In regards to entitlement to benefits or eligibility for enrollment under the Medicare program under title XVIII of the Social Security Act, regulatory guidance may want to consider those state and local government employees who have been or who were in continuous employment with their employer since March 31, 1986, who are not or who were not covered under a Section 218 Agreement nor subject to the mandatory Social Security and Medicare provisions, and remain or remained exempt from both Social Security and Medicare taxes, provided they are or were members of a public retirement system. These current and future “qualified retirees” of public sector postemployment health care plans are entitled to or eligible for benefits under the Medicare program, but may not be eligible for “premium-free” Medicare Part A benefits (i.e., may be required to contribute towards or replace Medicare Part A coverage). As such, we believe regulatory guidance should recognize the resulting additional cost of applicable employer-sponsored coverage in determining the applicable dollar limit.

§4980I(d)(1)(B)(ii) - Definition of Applicable Coverage for Self-Insured Dental & Vision Benefits

This section includes dental and vision coverage provided under a separate insurance policy (i.e., fully-insured) as “excepted benefits”, but it is unclear if self-insured dental and vision benefits that



are separately elected are to be considered “excepted benefits”. Regulatory guidance should provide clarification on this topic. It is our opinion that benefit financing mechanics (i.e., self-insured vs. fully-insured) should not be an element of the definition for “excepted benefits” and, in general, the application of §4980I. The similar treatment of self-insured benefits with fully-insured benefits is consistent with other applicable elements of the Code [§4980I(f)(4), §5000(b)(1)].

§4980I(d)(2)(A) – Definition of “Retired Employee”

This section allows for the aggregation of 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. As the term “retired employee” is not defined and may, in of itself, be contradictory, regulatory guidance should provide clarification. Here, we believe language to provide for the inclusion of, “any former employee, surviving spouse, or other primary insured individual”, as specified in §4980I(d)(3), would promote consistency in the application of §4980I. Additionally, regulatory guidance may want to modify, if possible, “age 65” to refer to the age of eligibility under the Medicare program as defined by title XVIII of the Social Security Act, in the event subsequent legislation modifies the general age in which individuals are defined to be Medicare-eligible.

§4980I(d)(2)(A) - Aggregation by Benefit Package in the Determination of Cost of Applicable Coverage

As noted in our introduction, a postemployment health care plan may be the primary payer for a portion of the covered population and secondary to Medicare for the remainder. As such, coverage mechanics (e.g., subsidy requirements, provider availability) often result in the coverage between two population segments that are otherwise “similarly situated beneficiaries” being split into separate “benefit packages” that are mutually exclusive based upon a plan’s payer status (primary or secondary to Medicare). We believe regulatory guidance should provide for the aggregation of all “retired employees” covered under applicable employer-sponsored coverage, regardless of the specific “benefit packages” in which “retired employees” are enrolled (no further grouping beyond “self-only” and “other-than-self-only” mandatory disaggregation), as, in our opinion, the true intent of §4980I(d)(2)(A) was to provide for the aggregation of costs of all “retired employees” in a way that accounts for the unique primary/secondary payer status of a plan sponsor offering postemployment health care benefits. In the event it felt that further grouping per §4980B(f)(4) is required, a “mapping” process could be used to appropriately allocate the cost of benefits where the payer is secondary to Medicare to the cost of benefits where the payer is primary based upon historical enrollment migration patterns.

§4980I(b)(3)(C)(iii) - Age and Gender Adjustments to the Applicable Dollar Limit

§4980I(b)(3)(C)(iii) provides for the adjustment of the dollar limits provided by §4980I(b)(3)(C)(i) to reflect the age and gender characteristics of all employees of the individual’s employer as compared to the age and gender characteristics of the national workforce. First, regulatory guidance should indicate if these adjustments are permissive or mandatory. Next, regulatory



guidance should describe the acceptable methods to be used to perform the adjustment calculation. Such guidance could parallel the rules established for the determination of minimum value (MV) in accordance with the Affordable Care Act. Here, MV may be determined using the Minimum Value Calculator, design-based safe harbors, or actuarial certification. Embedded in the detail of the regulatory guidance describing the acceptable methods to be used to perform the adjustment calculation, it is hoped that the needed data, such as the age and gender distribution data for the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan, as well as the age and gender characteristics of the national workforce are indicated. Last, regulatory guidance may want to provide for an additional adjustment that would allow factors such as a plan's overall health status and/or geographical location to be incorporated into the adjustment. As noted in our introduction, the cost of applicable employer-sponsored coverage may not reflect overly generous or rich benefits, but, instead, reflect the covered group's characteristics such as health status and/or geographical location. Using actuarial techniques, the cost of applicable employer-sponsored coverage for essential health benefits (EHB), normalized for age and gender, could be adjusted to the actuarial value (AV) of the EHB of the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan. The excess, if any, of the cost of applicable employer-sponsored coverage for EHB over the EHB cost for the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan could then be used to increase the limits of provided by §4980I(b)(3)(C)(i).

In closing, we thank Treasury and IRS for this opportunity to comment on §4980I. If you have questions regarding this letter, please do not hesitate to contact us.

Sincerely,

A handwritten signature in black ink, appearing to read 'Eric Gary'.

Eric Gary, FSA, FCA, MAAA
Chief Health Actuary

A handwritten signature in black ink, appearing to read 'Alisa Bennett'.

Alisa Bennett, FSA, EA, FCA, MAAA
Principal and Consulting Actuary