Notice 2015-16

MAY 19 2015

GEHRING GROUP
INSURANCE BROKERS & CONSULTANTS

CC:PA:LPD:PR (Notice 2015-16)
Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station, Washington, DC 20044
VIA E-MAIL: Notice.comments@irscounsel.treas.gov

RE: IRS NOTICE 2015-16

Ladies & Gentlemen:

As employee benefits consultant to a large number of public sector employers in a state in which retirees are allowed by Statute to remain on the employer's medical plan; and where public sector employers have a considerable early retiree population whose higher healthcare costs impact employer plans claims costs and as a result – premium costs that will be a factor in the calculation of the Cadillac Tax; and where state and local governments largely have collectively bargained and unionized employees; and where a large aged and uninsured population reside resulting in higher premiums for employer health plans; we respectfully submit the below comments and thoughts for your review and consideration in response to IRS Notice 2015-16:

1. Definition of Applicable Coverage, i.e. the specific types of coverage that will be subject to the excise tax;

We do not believe that employee contributions to health Flexible Spending Accounts (FSA) should be included in the definition of Applicable Coverage (AC). The inclusion of these accounts may encourage employers to cease offering these tax favored accounts that are necessary to promote well-being and assist employees in meeting out of pocket medical and dental costs. For example, dental care is essential to good health, particularly good heart health. Dental plans currently have limited coverage maximums, yet dental costs are increasing. Many employees are able to spread the cost of much needed services through payroll deductions throughout the year and reduce the effective cost due to the tax free contribution status, making these much needed services more affordable. Further, FSA accounts come in two types, employer funded and employee funded. A large majority in public sector are employee funded with a cap that has been lowered in recent years to $2,550. The employee election may vary and the employer has no control over these employee elections, so inclusion in the value of Applicable Coverage would be an uncertainty over which the employer has no control, (other than to not allow medical FSA election programs to employees), but could put them at risk for a penalty. Employer-funded FSA accounts utilized to fund wellness programs should also be excluded from the definition of Applicable Coverage especially when these accounts are used as an incentive for wellness programs. It has been a long term commitment of employers to achieve employee engagement and many have used employer funded FSA accounts as wellness program incentives to success. Including these Employer FSA funds, especially contributed toward wellness, would jeopardize the progress employers have made with their employee population toward a healthier lifestyle which is an important contributor in controlling costs.

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Employer-funded Health Reimbursement Account (HRA) contributions should be included at a predetermined charted safe harbor percentage rate. It would be burdensome to track per participant costs on an after the fact basis. It would be unfair to include potential contributions. It is important to note that HRA's promote consumerism and are necessary coupled with high deductible plans to offer affordable plan options. An example of how to handle HRA's might be to allow either an actuarial projection on the percentage of costs that will be utilized, or allow employees to use the prior year utilization rate percentage as a safe harbor. The preference of course would be to keep HRA accounts out of the definition for Applicable Coverage noting that employer funded HRA's, like FSA's often used for wellness incentives and adding these to the formula might discourage employers from encouraging, and employees from participating in wellness which has gained in momentum. Additionally, employer funded HRA accounts are paired with Consumer Driven Health Plans and the increase of consumerism should be encouraged not discouraged.

Similarly, contributions to health savings accounts should not be included in the valuation of Applicable Coverage if they are not treated as employer-sponsored plans. Employers have no control over individual bank accounts (which is what a non-employer-sponsored HSA is, for all intents and purposes). Moreover, health savings accounts serve an important function in encouraging employees to save for medical expenses in retirement.

Employer health centers should be excluded from Applicable Coverage. Services rendered at Employer-provided Clinics are often part of a comprehensive workforce wellness strategy and often see workers compensation injured employees. If an employee benefit plan percentage is necessary to be included-safe harbors must be selected for planning and administrative ease. At a minimum - administrative, facility operations, and start-up costs should be removed when calculating the value for AC. Only medical personnel and dispensary costs should be included as the other costs represent fixed costs and employers are not in the business of providing medical care; they are facilitating access.

Broker and consultant compensation should be able to be removed when calculating the employer and employee premium cost that is a part of Applicable Coverage. These costs represent service costs rather than medical expenditures. Brokers and consultants have become increasingly important to employers to control costs through plan negotiation and design, and to help navigate compliance as the provision of employer sponsored plans has resulted in 1) more available products in the (sophisticated) health insurance marketplace, 2) increased filing/payment/reporting requirements to the federal agencies for which education and assistance is necessary, 3) increased reporting requirements to include the W-2, PCORI, Transitional Reinsurance Fee, and 1094/1095 for example, 4) increased compliance requirements for employers with various mandates that continue to be released including for example: annual and lifetime maximums, women's wellness; out of pocket maximum definitions, maximum deductible, 5) assistance being needed for employees with regard to access to care and services, and claims as plan designs become more sophisticated in the goal of controlling costs, 6) employee education is necessary as consumer driven health care plan enrollment rises, new products and plan designs are implemented and reporting of health coverage and other legislative changes (cafeteria plan changes, FSA max changes, DOMA changes) need to be communicated effectively from knowledgeable professionals. Also, it should also be noted that in public sector, employers may not have the availability to add a separate budget line item to their approved budget, so by not allowing broker and consultant compensation to be removed from Applicable Coverage could unfairly penalize these employers.

The cost of Applicable Coverage (AC) should not include "workplace benefit" type plans such as hospital indemnity, critical illness for example that are tax free under IRC section 106, and are generally plans elected by, and paid for, by employees. These plans help employees to offset the risk of unexpected or extraordinary medical expenses and offer a buffer against the accumulation of medical debt. As deductibles and out of pocket maximums rise, employees need the availability of these products to meet their needs. Employers are unaware of the elections employees will make when designing their employer sponsored programs and working within cost guidelines, so adding these products to the value of AC is uncertain in indeterminable. Additionally, adding these to AC could result in the employer not offering these Workplace Benefit coverages which could place employers in an adversarial position with employees.

We agree with the agencies' expansion of the definition of "excepted benefits" to include various other forms of coverage, including separately administered dental and vision coverage, most employee assistance programs, and limited wraparound coverage. We recommend similarly excluding these types of coverage from the definition of Applicable Coverage, for purposes of administrative consistency.

2. Determination of Cost of Applicable Coverage, i.e. how to calculate the total cost of applicable coverage to determine whether or not it exceeds the cap and triggers the Cadillac tax;

The language of the Cadillac tax with regard to employer provided coverage should include:

a. Cost of employer-sponsored group medical and group prescription plan costs defined as cost to purchase/provide coverage that includes (a)Essential Health Benefit Plan, and/or (b) Minimum Value Coverage; or minimum essential coverage only when (a) or (b) not offered. "Group" worksite specific event or illness products (AFLAC, Colonial, and Allstate type plans) should be excluded when the employee purchases the coverage either through an individual or group product offering (note the offering of these coverages as "group product offerings" has become more popular and is important for guarantee issue purposes). Broker/consultant compensation should be specifically excludable when calculating the Applicable Cost as these fees/commissions are often in included in the premium paid to the insurance carrier and resulting insurance cost to the employer and employee. Health Industry Fee, Transitional reinsurance fee, PCORI fee, and any other state or local taxes and surcharges should also be excluded when determining the value of coverage.
b. Cost of employer-sponsored clinic medical care costs should not be included in the determination of Applicable Coverage. However, if determined to be includable the Applicable Coverage additional value should be calculated as including only direct medical care costs such physician costs, medical supply, and prescription drug supply costs. Admin, consulting, and occupancy costs of clinic should be specifically excluded, noting that employers are facilitating access to care.
c. Consumer Driven Health accounts (FSA, HRA, HSA) should only be included if the amounts to be provided are 1) employer paid 2) determinable in advance and 3) not earned through a wellness or health improvement incentive program.

3. Determining the Applicable Dollar Limit, i.e. how to apply the dollar limit to employees who have both self and other-than-self coverage (for example, an employee with self-only major medical coverage but an HRA that covers the employee and his/her family);

a. Application of a LOCAL COST FACTOR. Health coverage is priced based on many factors which includes employee population zip code. When calculating AC, there needs to be a STATE and a LOCAL adjustment factor. Insurance is regulated by state hence the state factor as the 1st adjustment factor. For example, Florida has a large Medicaid and Medicare population and has no expanded Medicaid. Additionally, there needs to be local cost adjustment factors within states. This results in higher cost of care in the state to insured individuals as transferred into higher health premiums. It is very unfair to have the same uniform limits apply to citizens of higher cost states, as to citizens living in lower cost states. Various areas, due to geography, limited access, low competition, high cost of living, or other factors have more costly medical care costs and resulting premium costs. An example is Key West in Florida. It's also important to note that medical inflation far exceeds COLA or other traditional inflation factors so any application of a "National" inflation factor would be unfair to residents of high cost states. A state, and local inflation rate are both necessary to create parity.
b. Exemption for governmental plans (notably where retiree coverage at same costs and plan design is mandated by governmental authority). In Florida, public sector entities are required by Statute to offer retiring employees enrollment at the same cost as employees in the employer sponsored group health plan. As such, plan costs are higher for employees due to the cost of 1) increased average age and 2) increased claims cost of older aged participants. Accordingly, state and local government plans should ideally be exempt from the Cadillac tax, and if not, be able to apply higher limits due to these aged individuals.
c. Application of an AGE FACTOR BASED ON AVERAGE POPULATION AGE. Health insurance rates are also calculated, and costs rise, with age. State and local governments have a disadvantage with regard to cost as they could have long term employees, resulting in a higher average age. The application of a factor for average population age (retirees have been proposed) to the Applicable Dollar Limit would provide more equity for employers with aging workforces and would mitigate the risk of age discrimination that may become an ancillary risk of this tax. So calculation of the AGE and GENDER Adjustment under Section 4980I9b)(3)(C) (iii) needs to include the entre risk pool (employees and retirees) and the factor should rise proportionately with average age. Example, a factor multiple for 45 should be much different than 35.
d. Allowance of High Risk higher limits to be applied to the applicable population in state and local governmental plans. The way the language is presently written, it appears that the plan would primarily have to cover high risk employees (such as fire and police) to be able to apply the higher ADL to these individuals. This is unfair to state and local governmental entities (and related entities such as special taxing districts) who provide coverage to these individuals as part of a greater population of employees. Removing these employees into a separate program or plan could have an adverse effect on some employers. <u>At a minimum, the state or local governmental entity should be allowed to benefit from the higher ADL for this population of employees by being able to proportionately increase the overall ADL for the group.</u> Example: 400 employees, 100 are fire and police. Assume all have single coverage. Calculation example is: ((300*10,200 + 100*11,850))/400=(3,060,000+1,185,000)/400=10,612.50 ADL per employee for this group.
e. We agree that EAP should be excepted benefits, like dental and vision benefits, and specifically not included in AC.

f. Extension of the use of the higher Family limit (Employee +1 rate) to all plans that have collectively bargained/unionized employees. The Cadillac Tax currently allows for multiemployer union Taft Hartley plans to utilize the higher family limit for all employees when calculating the Cadillac Tax owed. This means that participants who elect individual, employee only coverage are allowed the higher family limit before the Cadillac Tax is imposed. All collectively bargained and union employees should be treated similarly situated and therefore fairly. Not extending this higher limit to employers of union employees is inequitable with regard to hiring and labor relations, and may provide employers of unionized employees the inequitable imposition of the Cadillac Tax. The extension of this provision to state and local governments, especially in high insurance costs states, who similarly have union employees, and known to have a similarly aging and costly population, should be considered at a minimum. Please note that the non-application of the Cadillac Tax to State and Local Governmental Entities as per 3.b. is our preferred recommendation for the reasons outlined within these comments.

4. Other Methods of Determining Applicable Dollar Limit (ADL), i.e. if the commenter has thoughts on other ways not presented in the Notice to determine the applicable coverage.

We have presented our thoughts on the calculation in our comments above. We encourage the federal government to always remember that "insurance is local". Selling insurance across state lines will not change the cost of health insurance to individuals in those states as their coverage will still be priced the same as a house – by location, location, location. The IRS high-cost locality increases are not relatable to health care costs rates which vary widely by location. (For example, COBRA rates for some public employers in the Florida Keys are already in excess of the Cadillac thresholds due to various factors over which they have no control including lack of network discounts, competition, and their remote location). Additionally, the application of broad or federal level adjustments in determining the ADL, such as COLA, are not representative of inflation in health care or on a state or local level. It is important to find and provide equity and equality if this tax is going to be imposed nationally in an environment where insurance is priced locally.

Thank you for allowing us to submit our comments and thoughts for our consideration. If you would like to discuss anything in this letter further, please do not hesitate to contact us directly at (561) 626-6797.

Sincerely,

Kate Grangard

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Chief Operation & Financial Officer

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