

Notice 2015-16

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May 14, 2015

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

CC:PA:LPD:PR (Notice 2015-16)
Room 5203
Internal Revenue Service
PO Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Notice 2015-16

Ladies and Gentlemen:

We submit these comments on behalf of the International Longshore and Warehouse Union ("ILWU") in response to Notice 2015-16 issued by the Department of the Treasury and the Internal Revenue Service (the "Agencies") on February 23, 2015.

The ILWU represents longshore workers, marine clerks, warehouse workers, inland boatmen and other workers throughout the Pacific Coast of the United States, Alaska, Hawaii, Canada and Panama. The ILWU pioneered the establishment of collectively bargained group health plans, negotiating its first medical plan for longshore workers in 1949. In every west coast longshore contract ever since, as well as in the many other collective bargaining agreements the ILWU negotiates, one of the Union's principal objectives has been the maintenance and strengthening of the health and welfare benefits that improve the lives of its members and their families.

Before responding to the specific points addressed in Notice 2015-16 (the "Notice"), it is important to state at the outset that the ILWU opposes the excise tax (Internal Revenue Code § 4980I) in its entirety, and supports its repeal. Code §4980I threatens to erode the benefits that generations of ILWU members have fought so hard, and sacrificed so much, to obtain. For several decades, the ILWU and its signatory employers have relied upon the exclusion of most welfare benefits from income and business taxation. Code §4980I effectively eliminates a large, and ever growing, portion of that exclusion by taxing "excess benefits" at a rate that exceeds the top individual and corporate tax rates. Because the 'cost of coverage' grows with medical cost inflation, whereas the excise tax threshold is increased at a much lower cost-of-living rate (Code § 4980I(b)(3)(C)(v)), the excess benefit, which under Code §4980I(b)(2) is the difference between the cost of coverage and that threshold, will grow quickly over time. Thus, even plans that are now below the threshold are likely to soon exceed it.

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Ultimately, of course, this heavy burden on plans, employers and insurers will be borne by American workers. The excise tax will thus lead to increased instability in labor relations and collective bargaining, with a potentially destabilizing effect on key industries throughout the country. In the most recent west coast longshore negotiations between the ILWU and the Pacific Maritime Association covering all major west coast ports, the parties spent four months negotiating a variety of complex changes to the ILWU-PMA Welfare Plan: with the advent of the excise tax, future collective bargaining over health and welfare benefits can be expected to be even more difficult than in the past.

Although rulemaking cannot eliminate the serious problems that Code § 4980I will create, the ILWU submits these comments in the hope that the Secretary will exercise his authority under Code § 4980I(g) to ameliorate its impact. Below, we list the Union's comments under the sections of Notice 2015-16 (the "Notice") to which they pertain.

Section III: Exclusions from Applicable Coverage (Code § 4980I(d)(1)(B))

1. Dental, Vision and Employee Assistance Programs Should be Excluded from Applicable Coverage.

In sections III F and III G of the Notice, the Agencies propose to exclude limited scope dental and vision benefits and employee assistance programs from "applicable employer-sponsored coverage". The ILWU supports the proposed exclusions.

2. All other "Excepted Benefits" under Code § 9832 Should Also be Excluded from Applicable Coverage.

In addition to the foregoing benefits, the ILWU urges the Secretary to exercise his authority under section 4980I(g) to exclude from "applicable employer-sponsored coverage" all other "excepted benefits" listed in Code § 9832, including coverage that is supplemental to Medicare, subject to the criteria adopted in the recent final excepted benefits regulations (79 Fed. Reg. 59130, October 1, 2014). Given that the excise tax was adopted to help fund the government's expenses in implementing the Affordable Care Act (ACA), and given that all these benefits are excepted from the ACA, it would be inconsistent to impose the excise tax on their provision. Moreover, none of the excepted benefits in Code § 9832 represent 'high value employer-provided coverage': rather, they are ancillary benefits that help keep employees and their dependents healthy or help fixed income pensioners afford necessary supplemental health care.

Sections IV and VI: Determination of Cost (Code §§ 4980I(b)(2)(A), (d)(2)(A))

3. The Secretary Should Adopt a Variant of COBRA's Past Cost Method to Determine the Cost of Applicable Employer-Sponsored Coverage.

Section IV of the Notice invites comments on a variety of questions pertaining to how COBRA cost determination rules might apply to determining the cost of applicable coverage under Code § 4980I. Section VI of the Notice invites comments on "whether any alternative approaches

to determining the cost of applicable coverage would be consistent with the statutory requirements of § 4980I and, if so, would be useful.”

Taking the second question first, the ILWU notes that the statute does *not* require that a plan calculate the cost of applicable coverage in the *same* manner as it calculates COBRA premiums. Rather, it requires only that cost of coverage be determined in a manner that is *similar* to COBRA premium determination rules, regardless of how a plan calculates COBRA premiums. (Code § 4980I(d)(2)(A)) The statute’s choice of words is significant, and provides the Secretary with ample authority to fashion a cost method that is both feasible and consistent with the structure and purpose of the excise tax.

Although the Notice focuses more attention on the so-called ‘actuarial cost method’ under COBRA, the ILWU believes that a variant of the alternative ‘past cost method’ is more appropriate for purposes of calculating the excise tax. Code § 4980B(f)(4)(B)(i) (COBRA’s actuarial cost method) provides that premiums may be determined by “a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries which (I) is determined on an actuarial basis, and (II) takes into account such factors as the Secretary may prescribe in regulations.” Those “factors”, however, have never been prescribed in regulations. The resulting flexibility (and uncertainty) may be tolerable under COBRA, which simply imposes a ceiling on what plans may charge for continuation health coverage, but it is certainly not tolerable under Code § 4980I, where many millions of dollars that would otherwise be available to fund benefits are at stake. Indeed, plans that use the actuarial cost method vary widely in how they compute COBRA premiums, and such variability would make uniform assessment of an excise tax effectively impossible.

The past cost method (Code § 4980B(f)(4)(B)(ii)) permits self-insured plans to determine COBRA premiums on the basis of “the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period”, adjusted by an implicit price deflator of the gross national product. Using this approach promises greater uniformity, and far less administrative complexity, in the assessment of the excise tax. Moreover, applying a measure of general price inflation to adjust the tax is consistent with the use of the cost-of-living adjustment to increase the applicable dollar limits under Code § 4980I. Actuarial cost methods typically rely on short term projections of health care cost trends, and for many years the rate of health care cost inflation has been more than double that of general price inflation. To require plans to pay a tax on the basis of such historically high rates, when the statute only permits the threshold dollar limits to keep pace with cost-of-living increases, is inherently unfair and would make it even more difficult to meet the challenges of funding health benefits.

4. The Cost Method Adopted Under Code § 4980I(d)(2)(A) Must Compensate For Regional Variances in Health Care Costs.

It is well known that health care costs vary dramatically based on geographic area, far disproportionate to regional differences in standards of living. It is not unusual to find that the cost of a medical service in one area is more than 50% higher than its cost in another area. A majority of the longshore workers represented by the ILWU, for example, live and work in California, where

health care costs are higher than in many other parts of the country. It is because of these geographic variances, of course, that large databases of “usual, customary and reasonable” medical prices are broken down by region.

A self-only benefit package that costs, say, \$10,000 per year in one location will cost over \$15,000 per year in another. Ignoring such variances in medical costs would mean that the benefits provided to a worker living in one area remain tax free, while the exact same benefits provided to a worker in another area are subject to a significant excise tax. Without any cost factor reflecting geographic variances, Code § 4980I would become a tax on where workers and businesses are located rather than on what benefits they purchase. (See, Milliman, “What does the ACA excise tax on high-cost plans actually tax?” (December 9, 2014).)

Accordingly, the ILWU strongly urges the Secretary to consider the use of regional cost factors that plans can use for purposes of determining the cost of applicable employer-sponsored coverage under Code §§ 4980I for employees in high cost areas. To illustrate, there are several large industry databases that can be used to cost a reference standard plan of benefits in each metropolitan statistical area or other geographical area. (The benefits provided under the Blue Cross/Blue Shield standard benefit option of the Federal Employees Health Benefits Plan -- the reference standard adopted in Code § 4980I(b)(3)(C)(ii) -- may be used for this purpose.) Each of these area ‘standard costs’ can be compared to the national average ‘standard cost’, and their ratios (the national average standard cost over each area’s standard cost), or some correlated set of factors, could be used in determining the cost of applicable employer-sponsored coverage under Code § 4980I. In computing the aggregate cost of applicable employer-sponsored coverage for an employee in an above-average cost area, a plan should be permitted to multiply the actual cost by such a percentage factor to bring the cost closer in line with national averages.

Although the development and publication of regional cost factors may be a large undertaking, Code § 4980I initiates a new and very significant form of tax revenue that merits – and indeed demands – the effort. We know of no other way to address what would otherwise be a glaring inequity in the statute.

Section V: Adjustments to Dollar Limits (Code §§ 4980I(b)(3)(C)(iv) and (f)(2)-(3))

5. Any Retired Participant Who is Not Actually Enrolled in Medicare Should be Deemed a “Qualified Retiree”.

Section V.C.1 of the Notice solicits comments on how an employer (or plan) can determine that a participant is or is not “eligible for enrollment under the Medicare program” for purposes of determining whether the individual is a “qualified retiree” for whom an adjustment to the applicable dollar limit may be applied. The ILWU suggests that a retired participant should not fail to be a “qualified retiree” under Code § 4980I(f)(2)(C) unless that participant is *actually enrolled* in Medicare. There are many legitimate reasons that some retirees choose not to enroll in Medicare as soon as they reach Medicare age, and plans should not be deprived of the higher threshold just because such individuals *could* enroll. The reason for the adjustment to the dollar limit for qualified retirees under Code § 4980I(b)(3)(C)(iv) is the higher cost of covering pre-Medicare retirees, and

unless a retiree is actually enrolled in Medicare, the cost for his or her coverage remains high and the need for the adjustment is the same. This interpretation is, moreover, supported by the text of Code §4980I(f)(2)(C) itself, which defines “qualified retiree” to include a covered retiree at least age 55 who “*is not entitled to benefits or eligible for enrollment under the Medicare program*” (emphasis added). An individual who is not actually enrolled in Medicare would not appear to be “entitled to benefits”, and thus should be deemed a “qualified retiree” under this provision.

We note, finally, that requiring actual enrollment in Medicare before a plan loses the higher threshold for a retiree would not impose an undue burden on plan administrators, as information regarding a participant’s date of enrollment in Medicare is easily available through the normal electronic exchange of data with the Medicare program that plans use to determine when Medicare coverage is primary.

6. A Safe Harbor Should be Established for Determining Whether the Majority of Employees Covered by a Collectively Bargained Plan are Engaged in a High-Risk Profession.

Section V.C.2 of the Notice solicits comments on the interpretation of Code §§ 4980I(b)(3)(C)(iv) and (f)(3), namely “how an employer determines whether the majority of employees covered by a plan are engaged in a high-risk profession and what the term “plan” means in that context and how an employer determines that an employee was engaged in a high-risk profession for at least 20 years.” The ILWU suggests that the Agencies adopt a straightforward safe harbor rule to address these questions in the context of collectively bargained plans. Under the safe harbor rule, where a plan is established pursuant to a collective bargaining agreement which is principally limited to setting forth the terms and conditions of work in a high-risk profession, the majority of the employees of any employer signatory to that collective bargaining agreement who are covered under the plan would be deemed to be engaged in a high-risk profession, and a retired employee who had worked under that collective bargaining agreement or its predecessors for at least twenty years would be deemed to have been engaged in a high-risk profession for at least twenty years.

Section VII: Plan Year Implementation (Code §4980I(f)(8))

7. The Term “Taxable Period” Should be Interpreted to Refer to Plan Years, not Calendar Years, and Code § 4980I Should Not be Implemented With Respect to Any Plan Year Commencing Prior to 2018.

Section VII of the Notice invites comments on “any other issues under §4980I”. We believe that there is one such issue that is sufficiently related to the specific matters addressed in the Notice to merit comment here.

Code §4980I(f)(8) permits the Secretary to prescribe the meaning of the term “taxable period”. In cases where a plan administrator is responsible for payment of the excise tax under Code § 4980I(c)(2)(C), the ILWU urges the Agencies to conform the taxable period to the plan year rather than a calendar year. All plan financial transactions – the receipt of employer and employee

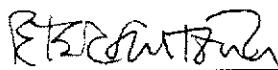
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contributions, benefit payments, provider renewals and setting of COBRA premium rates, the preparation of audited financial statements and the filing of Forms 5500 -- are handled on a plan year basis. It would be extremely inefficient and administratively burdensome to require plans to calculate and pay the excise tax on a calendar year basis.

Related to this suggestion, the ILWU also urges the Agencies not to implement the requirements of Code §4980I for any part of a plan year commencing prior to calendar year 2018. Plan administrators have never had to make tax payments of this nature or complexity before, and the rules and regulations they will have to comply with are far from final. Under the circumstances, it would be unreasonable to expect that plan administrators could budget and prepare for the new tax as early as 2017, as they would have to do if Code §4980I were applied to any part of a plan year commencing in that calendar year.

Sincerely,

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ILWU Coast Committee
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