Notice 2015-16

Massachusetts
Coalition of Taft-Hartley Trust Funds, Inc.

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Submitted by e-mail to Notice.comments@irscounsel.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:

The Massachusetts Coalition of Taft-Hartley Trust Funds, Inc. (the "Massachusetts Coalition") and the Massachusetts Building Trades Council (MBTC) are pleased to submit comments on Internal Revenue Service Notice 2015-16 ("Notice") with respect to the excise tax under Internal Revenue Code Section 4980I.

The Massachusetts Coalition is a voluntary association of over 20 multiemployer trust funds, each of which is governed by a joint board of management and labor trustees. Massachusetts Coalition members provide health and related benefits to over 150,000 lives primarily in Massachusetts and the New England area. The Massachusetts Coalition works to help its members access quality and innovative health care delivery systems for their participants and beneficiaries. Massachusetts Coalition member funds represent a variety of industries, including building and construction, building services, hotel and hospitality, and transportation and warehousing.

The Massachusetts Building Trades Council (MBTC) is a 95-year-old organization dedicated to helping working people improve their quality of life. The MBTC is comprised of 74 member locals representing over 75,000 working men and women in Massachusetts in the building and construction trades industry. Through collective bargaining, the member locals provide health benefits for their members and their families, typically through jointly trusteed Taft-Hartley health funds.

The Notice describes potential approaches to implementation of the excise tax on high cost employer-sponsored health coverage and invites comments. The Massachusetts Coalition and MBTC respectfully submit these comments on behalf of their multiemployer health fund members.

I. Background

Like other multiemployer funds, the multiemployer health fund members of the Massachusetts Coalition and MBTC provide comprehensive health benefits to employees and their families including medical, hospital, prescription drug, dental, and vision. Employers make contributions to the individual member funds based on the terms of the applicable collective bargaining agreement between the employer and the union that co-sponsors the multiemployer health fund. These collective bargaining agreements cover all terms and conditions of employment, such as wages, pensions, vacations, holidays, grievance procedures and much more. As a result, the negotiations inevitably represent give and take among labor and management over many issues, both economic and noneconomic. Benefits have long been a major part of the economic package, particularly in recent years as both health and pension costs have escalated. Workers have had to sacrifice in other parts of the economic package, such as wages, in order to continue to provide quality health coverage for themselves and their families. They have made these sacrifices over the years and are proud of what they have accomplished – with labor and management working together – to build strong health funds that provide quality and affordable care.

The Massachusetts Coalition and MBTC encourage Treasury and IRS to recognize that multiemployer plans are unique. They are unique not only because they are jointly managed by labor and management, but because multiemployer plans have a limited pool of resources that must be allocated among the entire group of plan participants and beneficiaries.

II. General Comments on Notice 2015-16

Congress itself recognized that multiemployer plans are unique. In enacting Code Section 4980I, Congress included Section 4980I(b)(3)(B)(ii), which states that "[a]ny coverage provided under a multiemployer plan (as defined in section 414(f)) shall be treated as coverage other than self-only coverage." Treasury and IRS should fully implement this provision in preparing guidance under Section 4980I. For example, based on this provision, there is no reason for a multiemployer plan to calculate the cost of self-only coverage because multiemployer plan coverage is always other than self-only coverage.

The Massachusetts Coalition and MBTC encourage the Treasury and IRS to provide maximum flexibility to multiemployer plans, within the confines of the statute. Flexibility should be tailored to ease of administration in order to lessen the impact on administrative costs and most importantly, to lessen the economic impact of the excise tax itself. The excise tax is either paid by the plan sponsor or coverage provider and charged back to the plan (for a self-insured plan) or by the health insurance issuer (for an insured plan) but in most instances the cost will ultimately be absorbed by the Plan.

Code Section 4980I(d)(2)(A) provides that the cost of applicable coverage is determined under rules "similar to" the rules used for determining the cost of COBRA coverage. We also encourage the Treasury and IRS to recognize that the excise tax rules and COBRA rules need not be identical or nearly the same, but merely similar. This provides flexibility in implementing the rules for determining the cost of applicable coverage for purposes of the excise tax in ways that do not affect COBRA considerations.

III. Specific Comments on Notice 2015-16

A. Definition of Applicable Coverage

The Notice identifies certain programs that Treasury and IRS anticipate will be excluded from the definition of applicable coverage in future regulations. We support the exclusion of these programs, particularly on-site medical clinics, limited scope dental and vision programs, and employee assistance programs. In addition, we encourage the Treasury and IRS to exclude all excepted benefits (as identified in other regulations) from the definition of applicable coverage, including wrap-around benefits most recently recognized as not group health plan coverage under the recently issued regulations. 79 Fed. Reg. 59130 (Oct. 1, 2014) and 80 Fed. Reg. 13995 (March 18, 2015).

With respect to on-site medical clinics, while the statute includes on-site medical clinics in the definition of applicable coverage, we support maximum flexibility to exclude certain types of clinics that provide limited care. The exclusion should apply to clinics that are both on-site at an employer's or union's own work site and those maintained by a multiemployer plan at another location. It should also apply to clinics that serve all participants and beneficiaries, including dependents and retirees. The exclusion should be broadened to include more services typically provided at these clinics, such as writing prescriptions, counseling, screenings, and annual physicals. Further, the exclusion for purposes of the excise tax need not be exactly the same as the exclusion for COBRA purposes because the two exclusions address different issues.

The Notice also requests comments on whether the standard for clinics that provide *de minimis* medical care should be based on the nature and scope of the benefits or a specific dollar limit on the cost of services, or a combination of both. We encourage allowing plans the flexibility to use either of these approaches and encourage Treasury and IRS to include a sufficient medical inflation factor in any specific dollar limit. Some clinics may offer services beyond *de minimis* services. In that case, plans should still be able to exclude the *de minimis* services from the cost of applicable coverage and should have flexibility to determine how to determine the costs to exclude.

B. Potential Approaches for Determining Cost of Applicable Coverage

1. Aggregation and Disaggregation

The Notice identifies several possible approaches to aggregating costs by benefit package, with some approaches of mandatory aggregation, mandatory disaggregation, permissive aggregation, and permissive disaggregation. We encourage Treasury and IRS to provide maximum flexibility to plans to permissively aggregate or permissively disaggregate. This flexibility should include the ability to permissively aggregate or disaggregate retirees and actives. Specifically, we encourage use of a broad standard approach to both permissive aggregation and permissive disaggregation based on bona fide employment-related factors such as collective bargaining unit, benefit package, geographic area, job classification, etc. This would allow each plan to determine the most efficient and cost-effective way to determine the costs of applicable coverage without being subject to abuse. Treasury and IRS should also confirm in future guidance that when pre-65 retirees are aggregated with other groups (older retirees or actives, or both) that the qualified retiree adjustment to cost still applies.

2. Self-Insured Cost Methods

The Notice discusses use of the actuarial basis method and the past cost method. We support providing flexibility for plans to select which method to use. The Notice seeks comments on whether allowing the use of different methods for purposes of the excise tax would cause administrative concerns or raise other issues and notes Treasury and IRS concerns in the COBRA context. Under the statute the excise tax rules can differ from the COBRA rules and we suggest that Treasury and the IRS address any COBRA concerns separately. The Massachusetts Coalition and MBTC support allowing plans to change methods from year to year for purposes of the excise tax. If annual change turns out to be

administratively burdensome for a particular plan, then that plan presumably will decide not to use the flexibility to make annual changes. But, for example, for a plan that successfully implements cost saving measures that result in lower costs, the plan should be able to take advantage of doing so and switch from an actuarial method to a past cost method or vice versa. Since one of the purposes of the ACA is intended to "bend the cost curve" plans that succeed in doing so should not be disadvantaged.

To the extent that Treasury and the IRS are concerned about plans changing to plan costs when claims are low, we suggest that a rule be adopted which would restrict the change in method from one year to the next to plans where there has been no material changes in eligibility rules, increase in employee contributions or employee premium requirements, or material change in plan design which would result in anticipated decrease in claims. Absent one of those changes, plans should be free to change from one method to another to reflect innovative structures such as ACO arrangements that would decrease plan costs.

Further, all taxes and fees, both federal and state, should be excluded from the determination of cost, including but not limited to the Patient Centered Outcomes Research Institute fee, the Health Insurance Providers fee, and the Transitional Reinsurance Program contribution. Finally, the additional administrative expenses associated with determining and paying the excise tax should not be included in the cost of applicable coverage.

3. Determination Period

The Notice states that Treasury and IRS are considering whether the determination period for purposes of the cost of coverage should be determined in advance for a 12-month period or based on actual costs after the end of the year. The Massachusetts Coalition and MBTC recommend that both methods be permitted so that the plan sponsor could use the method that minimizes the excise tax. If actual costs came in below the reasonable actuarial estimate made in advance, it would be unfair to assess the excise tax on the estimated amount.

4. HRAs

The Notice states that HRAs will be considered applicable coverage and seeks comments on various methods to determine the cost. Multiemployer plans that use HRAs do so in different ways. HRAs may be used to fund the employee's share of the cost of coverage instead of a deduction from pay, particularly in industries where work patterns vary. HRAs can be used for benefits that do not constitute applicable coverage, to pay copays or deductibles, or other ways. As a result, we recommend providing flexibility to plans to determine the cost of coverage under an HRA. The cost should not include an HRA or the portion of an HRA that is used to pay the employee portion of the cost of coverage. Plans should be permitted to use reasonable assumptions to determine the portion to be allocated to the cost of coverage and the portion allocated to benefits that constitute applicable coverage.

C. Dollar Limit Adjustments

1. Qualified Retirees

The statute provides that the dollar limit is increased for a "qualified retiree." Qualified retirees generally means retirees at least age 55 who are not entitled to Medicare benefits. The Notice asks for comments on how a plan determines that the retiree is not eligible for Medicare. We suggest that Treasury and IRS create a safe harbor that permits a plan to presume that a retiree age 65 and older is entitled to or eligible to enroll in Medicare since that is the age of general Medicare eligibility. Retirees

younger than age 65 are eligible for Medicare only if disabled or with end stage renal disease. As a result, for retirees younger than 65, there should be a rebuttable presumption that they are not eligible for or enrolled in Medicare. Plans should be entitled to rely on a written inquiry to the retiree, no more frequently than annually, and assume if the retiree does not advise otherwise that an under age 65 retiree is not eligible for Medicare and, therefore, is a qualified retiree (if at least age 55).

2. High Risk Professions

The dollar limit is increased for an individual who participates in a plan if a majority of the employer's employees covered by the plan are engaged in a high risk profession. First, we suggest that future guidance clarify that, in the case of a multiemployer plan, this means a majority of the participants covered by the multiemployer plan. We recommend that multiemployer plans have flexibility to determine whether the majority test is met on a plan-wide basis or benefit package by benefit package basis.

Second, the statute defines high risk professions, as, among other things, law enforcement officers, firefighters, EMTs and other first responders, longshore work, construction, mining, agriculture, forestry, and fishing. Many Massachusetts Coalition members and all MBTC members include a majority of employees engaged in construction. Employees engaged in high risk occupations are expected to have higher claims usage and therefore be more costly to cover. We encourage Treasury and IRS to provide for the broadest possible definition of high risk profession for purposes of Section 4980I.

Finally, high risk employees also include retirees who retired from a high risk profession if the retiree worked for at least 20 years in a high risk profession. Treasury and IRS seek comments on how an employer determines whether an employee was engaged in a high risk profession for at least 20 years. Multiemployer health plans do not have access to an employee's complete employment records. Such plans generally receive remittance reports indicating periods of employment for a contributing employer (typically monthly) and corresponding contributions. A multiemployer plan should be entitled to a presumption if contributions are required on an individual's behalf pursuant to a collective bargaining agreement covering only high risk professions. In that case, the multiemployer plan should be entitled to treat the individual as being engaged in a high risk profession.

3. Age and Gender

The statute provides for increases in the dollar thresholds that trigger the excise tax if the age and gender characteristics "of all employees of the individual's employer" exceed those of the national workforce. Multiemployer plans should count only the age and gender characteristics of the participants and beneficiaries of the plan. The age and gender characteristics of other employees who are not eligible to participate in the plan are not relevant since the multiemployer plan is not responsible for their claims. We support, as discussed in the Notice, development of safe harbor tables to make it easier for plan sponsors to calculate the appropriate threshold.

4. Geographic Areas with Higher than Average Costs

Some geographic areas also have higher than average claims costs simply because the cost of medical care is higher. As a result, plans in some areas of the country incur greater costs merely due to location than a plan in a lower cost part of the country with the exact same plan design. The Massachusetts Coalition and MBTC are in one of those high cost areas and, in our view, use of the same dollar threshold regardless of location is simply unfair. We recognize the constraints of the statutory language, but request that due consideration be given to providing a geographic adjustment as well.

On behalf of its member multiemployer health plans, the Massachusetts Coalition and MBTC appreciate the opportunity to submit these comments.

Please contact us if you need additional information from our organizations.

Sincerely,

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