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Notice 2015-16

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Submitted by e-mail to Notice.comments@irs.counsel.tres.gov

May 15, 2015

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

Ladies and Gentlemen:

On behalf of its 3 million members, the National Education Association is pleased to submit these comments on Notice 2015-16 (the Notice), related to Internal Revenue Code section 4980I, which creates the excise tax on high-cost employer-sponsored health coverage. NEA has been a longtime supporter of the Affordable Care Act. We note that the ACA already has strengthened health benefits for children and families and provided an opportunity for millions of Americans to obtain quality, affordable care.

Despite NEA's overall support of the ACA, we are obligated to point out that the statutory language on the excise tax on high-cost plans is so poorly structured that, in some circumstances, it can lead to tax liabilities based in part on employees' age and sex. When drafting section 4980I, Congress knew that the excise tax on high-cost plans had the potential to indiscriminately affect women and older workers. Indeed, on February 22, 2010, the White House announced changes to proposed legislative language on the excise tax that it said would "ensure that the tax affects firms equitably...by including an adjustment for firms whose health costs are higher due to the age or gender of their workers."¹

The "age and gender adjustment" is the statute's attempt to correct for the impact of age and sex on premiums.² The statutory language establishing the adjustment is flawed: It fails to consistently correct for the impact of age and sex on premiums. The actuarial firm Milliman found:

Based on our current interpretation of Section 4980I, the age/gender adjustment is defined as a dollar amount. This is consistent with the fact that the thresholds are

¹ The White House, "The President's Proposal," February 22, 2010. Available on the Internet at: <https://www.whitehouse.gov/sites/default/files/summary-presidents-proposal.pdf>. NEA access date: April 20, 2015.

² 26 U.S.C. § 4980I(b)(3)(C)(iii).

expressed as dollar amounts. This approach disadvantages employers with higher-than-average costs.... That is, the age/gender adjustment for employers with higher-than-average costs will understate the age and gender impact while the age/gender adjustment will overstate the age and gender impact for employers with lower-than-average costs.³

As a result, actions taken by employers to ameliorate the impact of the excise tax may disproportionately affect older workers and women. Until about age 60, women are, in general, more expensive to insure than men; the discriminatory impact of the excise tax on high-cost plans will, in general, begin to disproportionately hit men after that age. As noted later in this letter, even given the flaws in the language related to the age and gender adjustment, we believe that it will play a significant role for our members and their plans. We provide estimates of the potential impact of the adjustment and recommendations for regulatory action.

We are also deeply concerned that many other factors beyond plan design can affect tax liabilities, including the geographic location of plan members. In fact, Milliman found that “although the excise tax is often referred to as a tax on overgenerous health benefits, it is likely to be a tax based on factors other than benefit level and beyond the control of health plan members.”⁴ Milliman determined, “Unexpected consequences of the tax, therefore, include imposing a tax on moderate-benefit plans based primarily on geography, age, and gender, while failing to impose a tax on rich-benefit plans for the exact same reasons.”⁵

NEA has clearly indicated to Treasury and IRS, as well as to the White House and Congress, that we believe that this section of the Affordable Care Act should be repealed. Nonetheless, NEA understands that the regulatory process is under way, and we are committed to contributing to that process. For that reason, we appreciate the opportunity to respond to specific questions raised in the Notice and to comment on several 4980I-related issues beyond its scope.

Notice 2015-16 Section III—Definition of Applicable Coverage

IRC section 4980I defines “applicable employer-sponsored coverage” broadly to include, with respect to any employee, “coverage under any group health plan made available to the employee by an employer which is excludable from the employee’s gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of section 106).”⁶ With respect to the types of coverage included and excluded from the definition of applicable employer-sponsored coverage, we urge the Department of the Treasury and Internal Revenue Service to take the following steps.

³ Milliman, “What Does the Excise Tax on High-Cost Plans Actually Tax?” December 9, 2014, p. 21. Available on the Internet at: http://www.nea.org/assets/docs/Milliman--What_Does_the_Excise_Tax_Actually_Tax.pdf. NEA access date: April 20, 2015.

⁴ Ibid.

⁵ Ibid.

⁶ 26 U.S.C. § 4980I(d)(1)(A).

Limited-Scope Dental and Vision Benefits and Employee Assistance Programs

The National Education Association strongly supports the possible approach identified in Notice 2015-16 with respect to self-insured limited-scope dental and vision coverage that qualifies as an excepted benefit. Specifically, we urge Treasury and IRS to exclude such coverage from the definition of applicable employer-sponsored coverage. Doing so would create greater consistency between insured and self-insured plans providing such benefits. In the context of section 4980I, there is no justification for the disparate tax treatment of such coverage. Similarly, we support the possible regulatory approach identified in the Notice with respect to employee assistance programs (EAPs) whereby EAPs that are considered excepted benefits would be excluded from the definition of applicable employer-sponsored coverage.

Applicable Coverage in the Context of Tax-Favored Accounts

IRC section 4980I carries with it the potential to establish contradictory tax rules for excluded coverage and coverage in the form of health flexible spending arrangements (FSAs), health reimbursement arrangements (HRAs), and health savings accounts (HSAs). For example, while a fully insured limited-scope dental or vision plan is clearly excluded from the definition of applicable employer-sponsored coverage, FSA, HRA, or HSA funds used to reimburse costs associated with a fully insured limited-scope dental or vision plan could potentially be considered applicable coverage.

NEA urges the Department of the Treasury and IRS to issue rules that would allow employers the option to exclude from applicable coverage all reimbursements from FSAs, HRAs, and/or HSAs used for otherwise excludable coverage. The administrative difficulty of excluding such reimbursements may, in some instances, dissuade employers from excluding them, but allowing employers the option to do so would permit employers to apply a conceptually consistent approach to applicable coverage without necessarily requiring them to do so.

To the extent that HRAs or HSAs are used to pay for premiums for applicable coverage, we also urge that regulations clarify that the amounts used to pay such premiums do not themselves constitute applicable coverage. To do otherwise would establish the nonsensical double-counting of both the premium for applicable coverage and payment of the premium.

We also urge that regulations clarify that contributions to an HSA do not constitute applicable coverage unless the HSA is a group health plan. Not all HSAs are group health plans,⁷ and we are concerned that the Notice indicates, broadly, “Treasury and IRS anticipate that future proposed regulations will provide that (1) employer contributions to HSAs...including salary reduction contributions to HSAs, are included in applicable coverage.”⁸

⁷ Department of Labor, Field Assistance Bulletin 2004-1.

⁸ Notice 2015-16, III(D), p. 8.

Also related to HSAs, Treasury and IRS should clarify an ambiguity regarding the treatment of employee pre-tax salary-reduction contributions to such accounts. As the Notice states, an employee's after-tax contribution to an HSA can be deducted under IRC section 223, thereby establishing a tax benefit for the employee contribution that is not considered applicable coverage for purposes of IRC section 4980I.⁹ A similar tax-advantaged contribution to an HSA—made pre-tax—should not lead to different treatment in the context of the excise tax on high-cost plans. Workers should not be required to go through additional administrative hoops—after-tax contribution to an HSA followed by a deduction of that contribution—in order for the contribution not to count as applicable coverage for excise tax purposes. For these reasons, we believe that the appropriate clarification for Treasury and IRS to make is that when HSAs are group health plans, employee pre-tax salary-reduction contributions are not considered applicable coverage.¹⁰

Medigap and Other Supplemental Coverage

The National Education Association encourages Treasury and IRS to explicitly exclude from the definition of applicable coverage Medigap and other supplemental coverage. Such coverage is considered excepted, including for other Affordable Care Act-related purposes. IRC section 4980I does not state that such excepted benefits fall within the definition of applicable coverage, but explicit regulatory recognition that they are excluded would provide important regulatory clarity.

Limited Wraparound Coverage

NEA encourages Treasury and IRS to consider limited wraparound coverage benefits to be excepted benefits outside the definition of applicable coverage for purposes of IRC section 4980I. Such treatment of limited wraparound coverage would be consistent with the content of final regulations to become effective on May 18, 2015, that “amend the regulations regarding excepted benefits under the Employee Retirement Income Security Act of 1974, the Internal Revenue Code, and the Public Health Service Act to specify requirements for limited wraparound coverage to qualify as an excepted benefit.”¹¹

On-Site Medical Clinics

Although an excepted benefit as per IRC section 9832(c)(1)(G), on-site medical clinics are, for purposes of the excise tax, explicitly included within the definition of applicable coverage.¹² We appreciate that Treasury and IRS recognize the potential for regulations related to on-site clinics to create burdensome reporting requirements related to the incremental costs associated with on-site medical clinics. Regulations must allow for the exclusion of the broadest possible set of covered services with the least amount of administrative burden possible.

⁹ Notice 2015-16, III(D), p. 8.

¹⁰ If an HSA is not considered group health coverage, no contribution should be considered applicable coverage.

¹¹ 80 FR 13995.

¹² 26 U.S.C. § 4980I(d)(1)(B)(i).

NEA supports the exclusion of the additional services listed in the Notice—immunizations; injections of antigens provided by employees; provision of a variety of aspirin and other nonprescription pain relievers; and treatment of injuries caused by accidents at work beyond first aid. In addition, we believe it consistent with the goals of excluding certain types of services provided by on-site clinics and minimizing burdensome reporting requirements to expand the list of excluded services to include additional services, as identified by the AFL-CIO:

The services available should be expanded to include, at a minimum, prescriptions for acute minor conditions, any assessments or screenings related to wellness programs, primary care and coordination of care for individuals with chronic conditions. All clinic services should be available to dependents of workers, including spouses and children, as well as retired workers. The excluded clinics should not be limited to those located in worksites. The suggested expansion of the clinic exclusion reflects the changing nature and use of clinics by employers and some multiemployer plans.¹³

Notice 2015-16 Section IV—Determination of Cost of Applicable Coverage

The Notice indicates that Treasury and IRS are considering whether rules adopted for purposes of IRC section 4980I should be applied for purposes of determining the COBRA applicable premium. Recognizing that section 4980I(d)(2)(A) indicates that the cost of coverage for excise tax purposes shall be determined pursuant to rules similar to rules in section 4980B(F)(4)—related to continuation coverage—NEA believes that the rules for section 4980I should include some appropriate distinctions from the rules for COBRA, discussed where applicable below.

In general, an overriding goal for section 4980I should be to allow employers flexibility in determining the cost of applicable coverage. Given the different purposes served by the excise tax and continuation coverage, attempting to develop rules that apply to both would likely create unnecessarily complicated and administratively burdensome approaches to the excise tax.

Similarly Situated Individuals

The Notice indicates that Treasury and IRS anticipate the following potential sequence of steps for determining the cost of coverage. First, the cost for any specific type of applicable coverage for an employee “will be based on the average cost of that type of applicable coverage for that employee and all similarly situated employees.”¹⁴ Then, “each group of similarly situated employees would be determined by starting with all employees covered by a particular benefit package provided by the employer, then subdividing that group based on mandatory disaggregation rules, and allowing further subdivision of the group based on permissive disaggregation rules.”¹⁵

¹³ American Federation of Labor-Congress of Industrial Organizations, letter to the Department of the Treasury and Internal Revenue Service on Notice 2015-16, May 15, 2015.

¹⁴ Notice 2015-16, IV(C)(1), p. 13.

¹⁵ Ibid.

NEA believes that this potential approach outlined by Treasury and IRS is workable provided that reasonably flexible rules are built into the process and, where appropriate, employers are permitted to elect which of several options to use.

Aggregation by Benefit Package

The Notice requests feedback on “the extent to which benefit packages must be identical to be considered the same for this purpose and, if differences are permitted, the nature and extent of those permitted differences.”¹⁶ Requiring that benefit packages be identical in order for employees to be considered similarly situated would be unworkable and unnecessarily restrictive. Different groups of employees could potentially bargain slightly different benefits—one with and one without \$5.00 copayments for generic pharmaceuticals, for example—but such distinctions would hardly merit consideration.

We understand the logic behind suggesting that benefit packages be distinguished, at least in part, by the plans’ deductibles, copayments, and coinsurance—the “standard option” and “high option” offered as examples in the Notice.¹⁷ Distinguishing benefit packages by plan type—HMO vs. PPO, for example—appears to us to be less relevant than distinguishing them by actuarial value. As a result, we encourage Treasury and the IRS to permit employers the option of aggregating similarly situated employees by benefit package as determined by the packages’ actuarial values. A reasonable range of values—those within 5 or 10 percentage points of each other—would serve this purpose.

In addition to the actuarial value approach described above, we would also support an approach that allowed employers the option of using a reasonable, good-faith interpretation of what constitutes similar benefit packages. Such an approach would require guidelines as to what factors could be taken into consideration. Such factors could include, but would not necessarily be limited to, deductibles, copayments, coinsurance, and out-of-pocket limits.

Permissive Aggregation within Other-Than-Self-Only Coverage

NEA agrees with Treasury and IRS that IRC section 4980I(d)(2)(A) does not require that the cost of coverage for other-than-self-only coverage be determined based on the number of people receiving coverage in addition to the employee. We support the potential approach identified in the Notice: “...an employer could treat all employees who are enrolled in the same benefit package and who receive coverage for one or more individuals in addition to the employee as similarly situated for purposes of determining the cost of applicable coverage for that group.”¹⁸

¹⁶ Ibid., p. 14.

¹⁷ Ibid., p. 13.

¹⁸ Ibid., p. 14.

Consistent with the language cited above, we encourage Treasury and IRS to explicitly recognize that employers could take this approach but could also choose to treat as similarly situated individuals those in separate plan levels (employee plus 1 separately from full family coverage, for example).

Permissive Disaggregation

NEA can foresee possible advantages and disadvantages to a broad standard or a more specific standard related to permissive disaggregation for purposes of IRC section 4980I. We appreciate that the Notice indicates that Treasury and IRS are considering permitting—but not requiring—distinctions that have been traditionally made in the group insurance market.¹⁹

We urge the adoption of an approach to permissive disaggregation that does not allow the carving up of risk pools into groups so small that they bear little or no resemblance to the groups for which premiums or premium equivalents for the applicable coverage are developed or that do not serve a legitimate policy purpose. To the extent that a more specific standard is permitted, for example to account for legitimate geographic differences, Treasury and IRS should establish guidelines for the appropriate application of the specific standards. We are concerned that some employers might identify small groups in order to target group members for benefit changes or for the abandonment of employer-sponsored coverage; we encourage Treasury and IRS to adopt anti-abuse rules that would prohibit such actions.

We also ask that Treasury and IRS keep in mind the importance of aligning the groups of employees used to determine the cost of applicable coverage with the groups used to determine the age and gender adjustment, as we discuss in this letter's treatment of that adjustment.

Aggregation of Retirees

IRC section 4980I includes several provisions specific to retirees, including one related to how retirees can be treated for purposes of determining similarly situated employees. The statute says, "In 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."²⁰

It would be helpful for Treasury and IRS to issue guidance on how such aggregation should take place, including reiteration that all pre-65 and 65-and-older retirees enrolled in applicable coverage through a plan may be aggregated, regardless of the specific benefit package or benefit type in which they are enrolled. Guidance should also clarify that pre-Medicare-eligible retirees could

¹⁹ Notice 2015-16, IV(C)(1), p. 14.

²⁰ 26 U.S.C. § 4980I(d)(2)(A).

potentially be aggregated with active employees, if their benefits packages otherwise meet the aggregation requirements, and that aggregation—or disaggregation—of retirees is optional. Similarly, the guidance should recognize the same aggregation options for retired public employees who are not eligible for Medicare because they were not permitted to contribute to the program when active.

Regulations should also clarify that the increased dollar limit for qualified retirees²¹ applies regardless of how such retirees are integrated for purposes of determining similarly situated employees. Given that some state and local government employees were never permitted to pay the Medicare tax when active, we also strongly urge Treasury and IRS to clarify that the definition of “qualified retiree” includes those who, regardless of age, did not qualify for or become eligible for participation in the program because of this prohibition. Although the definition of “qualified retiree” by its terms includes all covered retirees age 55 and older who are ineligible for Medicare, express clarification is necessary to avoid harming seniors for whom their former employer’s plan remains primary past age 65 because they could not contribute to the Medicare program when active.

Self-Insured Methods

Consistent with our general interest in ensuring appropriate flexibility with respect to the determination of the cost of coverage, NEA encourages Treasury and IRS to allow both the actuarial basis method and past cost method for determining the cost of coverage for self-insured plans. However, we do not believe that regulations should require that a valuation method be used for a period of at least five years. More frequent changes to the method—including annual changes—should be permitted. We do agree that using the past cost method should be prohibited if “there is a significant difference between periods in coverage under, or in employees covered by, the plan.”²²

Regulations should indicate that, when the actuarial cost method is used, the person responsible for determining the cost have the appropriate skills and credentials to do so.

NEA believes that estimates made under the actuarial basis method should be based on the expected actual cost to the plan, not the minimum or maximum exposure that the plan could have for the determination period. In general, it would be better to establish a broad standard instead of a list of factors that must be satisfied.

²¹ 26 U.S.C. § 4980I(b)(3)(C)(iv).

²² Notice 2015-16, IV(C)(2)(a), p. 16.

Regardless of whether the actuarial basis method or past cost method is used, we believe that Treasury and IRS should specify costs that must be excluded. NEA agrees with the AFL-CIO in that:

All federal, state, and local taxes and assessments, and regulatory licenses and fees should be excluded, including but not limited to those enacted as part of the Affordable Care Act, such as the Patient Centered Outcomes Research Institute fee and the Health Insurance Providers fee. Additional exclusions should include any expenses incurred in connection with the determination and reporting of any excludable taxes, assessments and fees, as well as, for insured plans, any broker's commissions or fees.²³

We also urge Treasury and IRS to require the deduction from premiums of medical loss ratio rebates from carriers to policyholders.

Health Reimbursement Arrangements

Although NEA appreciates concerns raised by Treasury and IRS that allowing multiple methods for determining the cost of coverage under an HRA could "increase administrative complexity materially,"²⁴ we are deeply concerned about the potential for some methods to lead to double-counting or to the counting of reimbursements for coverage that would otherwise be excluded from the cost of coverage. Any eventual regulations must ensure that employers can avoid such problems. Given that the various methods considered in the Notice might be advantageous or harmful in different situations, we believe that allowing employers to choose between methods is appropriate. We must also point out that some level of additional administrative complexity is inevitable in the implementation of the IRC section 4980I; we do not believe it reasonable or necessary to prioritize the avoidance of complexity over double-counting or the counting of otherwise excluded benefits.

As a general matter, we strongly urge Treasury and IRS to ensure that any amounts contributed or credited to an HRA prior to 2018 (and any investment earnings) not count toward the cost of coverage. The Notice indicates the potential to include contributions made in 2017 for non-calendar-year plans ending in 2018, but, as noted toward the end of this comment letter, we believe that transition rules are in order that would provide relief for non-calendar-year plans until the first day of the plan year beginning after December 31, 2017.

Given that some HRAs are established as retiree-only plans, we also believe that regulations should clarify that any contributions made to a retiree HRA during an employee's active service should be disregarded while the employee is working. Investment earnings on contributions or credits, whether for retiree-only or other HRAs,

²³ American Federation of Labor-Congress of Industrial Organizations, letter to the Department of the Treasury and Internal Revenue Service on Notice 2015-16, May 15, 2015.

²⁴ Notice 2015-16, IV(C)(3), p. 19.

should be disregarded unless and until they are used to reimburse expenses that fall within the definition of applicable coverage.

If a full-service HRA that is not integrated with the employer's plan, but is instead integrated with the group health plan of a different employer, such as a spouse's plan, the cost of the plan with which it is integrated should not be counted in addition to cost of the HRA. Costs from a plan from one employer should not be aggregated with costs from the plan of another employer for purposes of determining the cost of applicable coverage.

In addition, in order to ensure that costs that would otherwise be excluded can be excluded when reimbursed through an HRA, we believe that employers should be able to exclude reimbursements for excepted benefits or other excluded benefits. When HRAs can be used for multiple types of reimbursements—some that should count and some that should not—the cost of the HRA could be determined proportionally, such that costs for excluded benefits are not counted. We do not believe that the administrative requirements for doing so would be overly burdensome, and, in any case, it would be highly inappropriate to require the potential generation of tax liabilities based on HRA reimbursements for costs that would otherwise be excluded.

Determination Period

NEA sees no reason why COBRA requirements related to determining applicable premiums in advance for a 12-month period should necessarily apply to IRC section 4980I. In fact, in the context of the excise tax on high-cost plans, doing so could cause unnecessary harm to employers and employees. Although some employers may benefit from knowing in advance what the excise tax liability will be, the risk that actual costs for a self-insured plan would be lower than costs projected in advance—and that taxes would be paid based on the inaccurate projection—could outweigh any advantages to knowing the liability in advance. In any case, employers should be allowed to elect either method.

Notice 2015-16 Section V—Applicable Dollar Limit

Employees with both Self-Only and Other-Than-Self-Only Coverage

The Notice recognizes that some employees could have both self-only and other-than-self-only coverage, providing the example of an employee with self-only major medical coverage and an HRA that covers the employee and the employee's family. Either potential method for determining which applicable dollar limit applies would be workable—the primary coverage approach, in which the employee's primary coverage/major medical coverage would determine which limit to apply, or the prorated approach, in which a composite limit would be used. We urge Treasury and IRS to permit either method.

Adjustments for Qualified Retirees

Treasury and IRS ask for comments on how an employer can determine that an employee is not eligible for enrollment under the Medicare program. As noted above, some state and local government employees are precluded from participating in the Medicare program by virtue of their public service, because their employers did not permit participation. The regulations should expressly clarify that, regardless of their age, such retirees should remain “qualified employees” for purposes of receiving the adjustment to the dollar limit.

NEA also encourages Treasury and IRS to indicate that surviving spouses of qualified retirees also receive the adjustment for qualified retirees. Such an interpretation of the statute follows logically from the definition of an “employee” for purposes of IRC section 4980I, which includes “any former employee, surviving spouse, or other primary insured.”²⁵

The Age and Gender Adjustment

The National Education Association appreciates the inclusion of the age and gender adjustment within section 4980I. The amount of the adjustment will be determined by pricing the Blue Cross/Blue Shield standard benefit plan option under the Federal Employees Health Benefits Plan based on the age and sex characteristics of the employees of the employer. Then, the plan will be priced based on the age and sex characteristics of the national workforce. The thresholds will be increased by the dollar-based difference between the two.²⁶

Given that NEA’s membership comprises a higher percentage of women and older workers than the national workforce, as shown in Table One, we know that the adjustment will be a significant factor for our members and their health plan coverage. Below, we respond to the adjustment-related question included in the notice—whether it would be desirable and possible to develop safe harbors that appropriately adjust the dollar limit thresholds for employee populations with age and sex characteristics that are different from those of the national workforce. In addition, we provide broader observations on the adjustment.

We believe that it is crucial for Treasury and IRS to develop easy-to-use tools for estimating the age and gender adjustment. If employers are dissuaded from applying the adjustment because of the cost or complication of doing so, the adjustment may not be used. As the following material highlights, the development of such tools will not be easy if they are to reflect the complicated nature of the adjustment—but such tools are necessary.

²⁵ 26 U.S.C. § 4980I(d)(3).

²⁶ 26 U.S.C. § 4980I(b)(3)(C)(iii).

The Potential Significance of the Age and Gender Adjustment

The National Education Association commissioned an actuarial firm to develop a calculator that allows us to estimate what the age and gender adjustment might be.²⁷ Table One provides a sense of the scale of potential age and gender adjustments.

TABLE ONE: Hypothetical 2018 Age and Gender Adjustments by Group (As if each group were all of the employees used to determine the adjustment)				
	NEA Teachers	NEA Support Professionals	U.S. Education Labor Force	National Workforce
Adjustment for Self-Only Coverage	\$1,516.00	\$3,764.00	\$1,286.00	\$0.00
Adjustment for Other-than-Self-Only Coverage	\$4,093.00	\$10,163.00	\$3,471.00	\$0.00
Average age	45.50	51.80	44.40	42.30
Female percentage	76.30%	80.20%	68.90%	46.80%
NOTES: Teachers include other education-related salaried professionals. Support professionals include paraprofessionals, food-service workers, and custodians, among other employees. The U.S. education labor force includes all public and private sector education employees, including but not limited to NEA members. Estimated adjustments are based on census data in five-year age brackets (with those below 25 or 65+ aggregated), not on average ages and average percentages of females. Data for NEA teachers and support professionals are from 2014. Data for the U.S. labor force and U.S. education labor force are from 2013.				

The table indicates that the national workforce leads to no adjustment, because that is the group used as the statutorily defined benchmark against which an employer's employees are measured. If NEA member teachers were the group whose demographics were used to determine the adjustment, we estimate that the adjustment for self-only coverage would be \$1,516 in 2018 and the adjustment for other-than-self-only coverage would be \$4,093 in that year. If based on the age

²⁷ NEA's estimates are based on the plan design of the 2014 Blue Cross/Blue Shield standard option plan of the Federal Employees Health Benefits Program, with the premium for self-only coverage projected forward to 2018 using eight separate trend rates and utilization rates for different categories of medical services. The estimates assume mid-level provider network discounts, loosely managed benefits, a medical loss ratio of 85 percent, and a claims adjustment for other-than-self-only coverage of 2.70.

and sex of our education support professionals, we estimate that the adjustments would be \$3,764 and \$10,163 in 2018, respectively. These estimates were made using age and sex data broken into five-year age groupings. Table One indicates the averages, but the averages were not used to estimate the adjustments.

The Development of Safe Harbors for the Age and Gender Adjustment

The Notice asks whether it would be desirable and possible to develop safe harbors that appropriately adjust dollar limit thresholds for employee populations with age and sex characteristics that are different from those of the national workforce. Facilitating the use of the age and gender adjustment is an important policy goal. To the extent that safe harbors allow employers to more effectively apply the adjustment, safe harbors will be highly desirable—as long as they meet three criteria: They lead to reasonable approximations of the adjustment, do not lead to a *systematic undervaluing* of the adjustment, and/or do not foreclose the use of other appropriate methods of determining the adjustment.

Of these three criteria, the most difficult one to achieve relates to whether it is possible to develop safe harbors that provide an appropriate adjustment. Any safe harbor used for the age and gender adjustment will have to incorporate both the interrelationship of age and sex and the impact on premiums of the distribution of members by their age and sex. A calculator would be more likely to accurately capture the complicated nature of the age and gender adjustment, but a table that achieved the same goal would also be acceptable. To the extent that Treasury and IRS develop a table for determining the age and gender adjustment, the table must not undervalue the adjustment.

It would be easier, but less reliable, to use averages to determine the age and gender adjustment. With respect to pricing health insurance premiums, age and sex are interrelated. That is, age and sex *interact with each other* to affect premiums differently at each combination of age and sex. As a result, averages are likely to render an inaccurate age and gender adjustment.

Two groups of employees with the same number of women and men would lead to very different premium calculations depending on the age distribution of the employees. Take, for instance, two employee groups, both having two-thirds women and employees with an average age of 45. If the men and women in the first group were spread evenly between all age groups but the second had all younger women and all much older men, the resulting adjustments would be markedly different. Using our age and gender adjustment calculator, the adjustment for self-only coverage for the first group turned out to be \$1,669. The adjustment for the second was \$4,831. Meanwhile, when we estimated the adjustment simply using the average age of 45 (with the same male/female split of 33.3% to 66.6%), the adjustment was \$1,440.

In short, to facilitate accurate age and gender adjustments, we strongly urge Treasury/IRS to develop a calculator for determining the age and gender adjustment or, if not, detailed tables that capture the relevant nuances of the relationship between age, sex, and premiums.

Additional Regulatory Needs Regarding the Adjustment

Treasury and IRS will need to produce detailed rules related to the age and gender adjustment. Among the issues to be addressed are these.

The “National Workforce”

As you are aware, the premium for the baseline plan—the Blue Cross and Blue Shield standard option plan in the Federal Employees Health Benefit Program—determined using the age and sex characteristics of the national workforce is the cost against which the premium determined using the age and sex characteristics of the employer’s employees is measured. If the premium using the employer’s data is costlier than the premium using the national workforce demographics, the adjustment is the dollar-based difference between the two. Thus, the national workforce constitutes a key component of the age and gender adjustment. However, no formal data set defining the “national workforce” exists.

NEA believes that Treasury and IRS should identify a readily available, pre-existing data set for use as the national workforce. The Department of Labor’s Bureau of Labor Statistics annually produces “Labor Force Statistics from the Current Population Survey,” which includes the employment status of the civilian non-institutional population by age and sex. We encourage Treasury and IRS to adopt this, or a similar, data set. The data used for determining the age and sex characteristics of the national workforce should not take into consideration workers’ access to health benefits.

Another necessary component of rulemaking related to the national workforce will be identification of the appropriate date as of which data must be current for use in determining the age and gender adjustment.

The Ratio of the Adjustment for Self-Only Coverage to the Adjustment for Other-than-Self-Only Coverage

When developing premiums, it is common for tiers for other-than-self-only coverage to be determined based on a claims adjustment relative to the premium for self-only coverage. Rather than require separate rules for determining the self-only and other-than-self-only premiums used for determining the adjustments, it would be helpful for Treasury and IRS to establish rules for determining the self-only coverage and require the use of a single claims adjustment for other-than-self-only coverage. For this purpose,

the ratio between the base dollar limit for other-than-self-only coverage (\$27,500) and the base dollar limit for self-only coverage (\$10,200)—2.70—would be appropriate. We are concerned that other ratios would be arbitrary and subject to abuse.

Determining the Age and Sex of an Employer's Employees

Treasury and IRS will also need to develop rules related to how employers determine the age and sex of their employees, including as of when the data should be gathered and how to define “all employees of the individual’s employer,” the statutory term that refers to the employees whose age and sex characteristics are to be used, in part, for calculating the adjustment.²⁸ Given that the statute defines “employee” to include “any former employee, surviving spouse, or other primary insured individual,”²⁹ Treasury and IRS will need to limit the scope of the phrase “all employees of the employer” so that not *all* former employees are included.

Defining “All Employees of the Individual’s Employer”

We believe that it is reasonable to interpret the statutory language to refer to former employees, surviving spouses, and other primary insured individuals currently in an employer-sponsored plan. We also believe that Treasury and IRS should consider ways to ensure that “all employees of the employer” has meaningful specificity with respect to employees; it would be reasonable to interpret this phrase in the context of employees to refer to groups of similarly situated individuals as determined for purposes of IRC section 49801.

Determining the Plan Design to be Used for Pricing Premiums

Although the statute identifies the plan to be used for pricing the premiums that are to be compared to determine any adjustment, it does not indicate an “as of” date for that plan’s design. The benchmark plan design—the Blue Cross/Blue Shield standard benefit plan option under the Federal Employees Health Benefits Plan—could change from year to year. The only reference to a timeframe in the relevant subsection of the law is to the type of benefits received by an individual during the tax year; for example, the dollar limit for the self-only coverage is to be used if the individual was provided self-only coverage during the tax year. For purposes of determining adjustments, rules will be needed for identifying which year’s plan design can or must be used, and in what circumstances it can or must be used.

²⁸ 26 U.S.C. § 4980I(b)(3)(C)(iii)(II)(aa).

²⁹ 26 U.S.C. § 4980I(d)(3).

Guidelines for Pricing Premiums

Determination of any age and gender adjustment will require the pricing of premiums using the plan design of the Blue Cross/Blue Shield standard benefit plan option under the Federal Employees Health Benefits Plan. Given the many factors in addition to employees' age and sex that could potentially affect the premium cost—including but not limited to assumptions about administrative expenses, network discounts, and the degree of active health care management—Treasury and IRS will need to develop guidelines for how adjustment-related premiums are to be priced.

Clarifications Related to the Age and Gender Adjustment

Need to Educate Employers about Using the Age and Gender Adjustment to Mitigate Excise Taxes

The fact that the age and gender adjustment is flawed does not mean that it is insignificant. In fact, given how potentially important it will be to NEA members and their health plans, we urge Treasury and IRS to use guidance and public speaking opportunities to educate the public about the adjustment. Many employers are currently developing excise tax strategies based on inaccurate estimates of potential excise tax liabilities because they are not incorporating the age and gender adjustment. These strategies are harmful to the active and retired employees whose health benefits are threatened. We urge Treasury and IRS to encourage such employers to take account of the age and gender adjustment.

Reiteration that No Downward Adjustments Are Possible

IRC section 4980I indicates that the dollar limits “shall be increased” by the difference between the benchmark plan’s premium as determined using the age and sex characteristics of the employer’s employees and the same characteristics of the national workforce.³⁰ Not only does the statute refer only to a potential *increase*, not a potential decrease, the relevant language indicates that the adjustment is to be based on the amount that the premium using the age and sex characteristics of the employer’s employees *exceeds* the premium using the characteristics of the national workforce.³¹ The statute makes no mention of an amount by which the first premium is less than the second.

NEA requests that Treasury and IRS reiterate that the age and gender adjustment can only boost applicable dollar limits. We know from firsthand experience that consultants providing advice on this portion of

³⁰ 26 U.S.C. § 4980I(b)(3)(C)(iii).

³¹ 26 U.S.C. § 4980I(b)(3)(C)(iii).

the tax code can erroneously suggest that the age and gender adjustment could decrease the dollar limits.

Transition Rules

Notice 2015-16 does not refer to transition rules, but we fully expect that, as with regulations related to IRC section 4980H (shared responsibility for employers), such rules will be included in future guidance on the excise tax on high-cost plans. Early notification of transition rules would greatly facilitate preparation for the tax by employers and employees.

Transition Rule for Non-Calendar-Year Plans

The excise tax is predicated, in large part, on the understanding that employers will change their health plans rather than pay the excise tax.³² However, it is crucial that employers not be spurred by the tax code to make plan design changes based on outdated and inaccurate information, which will be the harmful result of requiring non-calendar-year plans to implement IRC section 4980I starting in the tax year beginning after December 31, 2017. Even if employers were to use the actuarial basis method for determining the cost of coverage for purposes of IRC section 4980I for the first plan year beginning after December 31, 2017, they would generally not produce such determinations until after the prior plan year had begun. For example, for a plan year starting September 1, 2018, the premium or premium equivalent would likely be prepared three to nine months before the beginning of the new plan year. As a result, employers would be unable to make reasonable plan design changes based on accurate information about the cost of coverage until after the start of a plan year that would carry into 2018.

We urge Treasury and IRS to issue transition rules similar to those established for section 4980H. Those rules provide relief for the period before the first day of the plan year beginning after the provision would otherwise have taken effect.³³ For purposes of section 4980I, that would be the period before the first day of the plan year beginning after December 31, 2017.

Transition Rule for Small Employer Groups (with Under 100 employees)

NEA requests that Treasury and IRS delay the application of IRC section 4980I to small employer groups (those with up to 100 employees) for at least a two-year period, until 2020. The delay in implementation of the Small Business Health Options Program

³² As the Congressional Budget Office has indicated, “The excise tax on high-cost health plans also increases CBO’s projections of revenues from individual income and payroll taxes, because firms are expected to respond to the tax by shifting to lower-cost insurance plans—thereby reducing nontaxable labor compensation and increasing taxable compensation.” Indeed, CBO’s 2014 estimate of \$108 billion in increased federal revenue that would be generated by the excise tax from 2015-2024 assumed that 72 percent of the increase would come from “the associated effects of changes in employees’ taxable compensation.” Congressional Budget Office, “The Budget and Economic Outlook: 2014 to 2024,” p. 89 (footnote 8) and p. 112 (footnote 8). Available on the Internet at: https://www.cbo.gov/sites/default/files/45010-Outlook2014_Feb_0.pdf. NEA access date: May 15, 2015.

³³ 79 FR 8570.

(SHOP) exchanges and anticipated uncertainty about risks and costs associated with the small group ratings rules necessitate a transition period for smaller employers.

The ACA expands the definition of small employers for health insurance purposes to include those with up to 100 employees for plan years that begin on or after January 1, 2016. Insured group health plans with up to 100 employees will be required to move to the small group market on or after January 1, 2016. As a result, employer groups with 51 to 100 employees will be required to follow the small group market's far more stringent benefits coverage, actuarial value, and premium rating restriction requirements.

According to a 2015 Issue Brief from the American Academy of Actuaries, groups with 51 to 100 employees will, most likely, experience increases in premiums as a result of the small group restrictive rating, additional benefit and cost-sharing requirements, and anticipated adverse selection.³⁴ Small groups of up to 50 employees could also see premium changes by the addition of the larger group to the pool. The small group expansion should be allowed a minimum of two years of experience to see how it will impact both the up-to-50 group and the 51-to-100 group.

In addition, many insured plans with 51 to 100 employees have until 2017 to move to the small group market, furthering the need for a transition period.

Also, the rules apply to small groups whether they purchase coverage through or outside the SHOP. Small employer groups have experienced frustrations and delays with the SHOP. For example, online SHOP enrollment in federally facilitated exchanges only became possible for 2015 coverage. Also, some states delayed the launch of their SHOPs. Insurer participation, employee choice, and employer contribution issues, among other concerns, have been a challenge for SHOPs. Several more years of experience with the up-to-50 group before adding the 51-to-100 employee group to the SHOPs is absolutely necessary.

The National Education Association appreciates the opportunity to comment on Notice 2015-16. We would be pleased to provide further information on the issues addressed in this letter or to answer any questions you may have.

Sincerely,



Kim Anderson
Senior Director
Center for Advocacy and Outreach

³⁴ American Academy of Actuaries, "Potential Implications of the Small Group Definition Expanding to Employers with 51-100 Employees," March 2015. Available on the Internet at http://www.actuary.org/files/Small_group_def_ib_030215.pdf. NEA access date: May 14, 2015.