



Ohio Public Employees Retirement System

May 15, 2015

The Honorable John Koskinen
Commissioner
Internal Revenue Service
CC:PA:LPD:PR (Notice 2015-16)
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Submitted via E-Mail to: Notice.comments@irs.counsel.treas.gov

RE: Notice 2015-16, Section 4980I — Excise Tax on High Cost Employer-Sponsored Health Coverage

Dear Commissioner Koskinen:

The Ohio Public Employees Retirement System ("OPERS") appreciates the opportunity to provide comments to the Internal Revenue Service ("IRS") on Notice 2015-16, Section 4980I — Excise Tax on High Cost Employer-Sponsored Health Coverage ("the Notice").

With assets of \$91.2 billion, OPERS is the largest state pension fund in Ohio, the 11th largest public retirement system and the 15th largest retirement system in the United States. The system provides retirement, disability and survivor benefit programs for public employees throughout the state and currently services more than 1 million members, including 347,000 active employees and over 203,000 retirees and beneficiaries who are receiving monthly pension benefits, which may include health care coverage.

OPERS operates three retirement plans that provide retirement benefits for most of Ohio's public employees: a traditional defined benefit plan (the "Traditional Pension Plan"); a defined benefit plan with elements of a defined contribution plan (the "Combined Plan"); and a defined contribution plan (the "Member-Directed Plan") (together, the "Retirement Plans"). The Retirement Plans are funded by a combination of employer contributions, employee contributions, and the return on investments of such contributions.

OPERS provides retiree health care coverage for 226,000 eligible benefit recipients of the Traditional Pension Plan and the Combined Plan (including eligible spouses and dependents) who have at least ten qualifying years of employer contributions at retirement. These eligibility requirements increased to twenty qualifying years of employer contributions and age 60 (or any age with 30 qualifying years of employer contributions) for employees retiring from the Traditional Pension or Combined Plan on or after January 1, 2015. In addition, approximately 3,500 participants in the Member-Directed Plan gradually vest in a Retiree Medical Account (an "RMA") funded by a voluntary employee beneficiary association ("VEBA") within the meaning of Section 501(c)(9) of the Internal Revenue Code (the "Code"). The RMA can be used to pay for qualified medical expenses after the participant retires or otherwise separates from public employment and receives a complete distribution of his or her account in the Member-Directed Plan.

OPERS' eligible benefit recipients include pre-Medicare participants (those under age 65), Medicare eligible participants (age 65 and older), and disability benefit recipients. In 2016, it is estimated that the OPERS Health Care Fund (the "Fund") will provide retirement health care coverage to over 75,000 non-Medicare eligible retirees/dependents and approximately 149,000 Medicare eligible retirees/dependents in the Traditional Pension and Combined Plans. These numbers include almost 20,000 disabled retirees (disabled dependents are not included in this count).

OPERS is one of a relatively few retirement systems to set aside assets to pre-fund retiree health care coverage. The health care trust fund is one of the strongest in the nation at approximately 64% funded. At the end of 2014, OPERS' estimated health care funding liability was \$20.0 billion, while assets within the fund were \$12.8 billion.

Even taking into account the Fund's strong financial position (particularly relative to other large public retirement systems), offering OPERS retirees continued access to quality health care coverage has become increasingly difficult due to the significant increase in costs that a retiree-only plan faces when compared to an active employee plan. In addition to the regular cost increases that OPERS faces due to the high number of baby boomers who have retired and are continuing to retire, a number of current health care components also disproportionately impact retiree-only plans. These components include (1) the need for more expensive, quality health care later in life (e.g., approximately 30 percent of an individual's lifetime health care costs are in the last 6 months of life); (2) high rates of specialty prescription drug costs for those retirees under age 65; and (3) the higher cost of services for plans, like OPERS', that provide health care coverage to disabled retirees, who are more likely to incur higher health care costs due to their disability. For example, in 2014, the average dollar amount paid for an OPERS disabled non-Medicare benefit recipient was 2.66 times higher than a non-disabled non-Medicare benefit recipient.

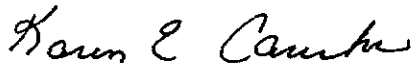
Given the disproportionately higher costs that OPERS incurs on a consistent basis as a retiree-only plan, we will be heavily impacted by the administration and imposition of the excise tax on high cost employer-sponsored health coverage (the "Excise Tax").

We understand that the Notice is just the first step in the ongoing process of implementing the Excise Tax. We are concerned, however, that future guidance will exacerbate the already profound impact of the Excise Tax, particularly for retiree-only plans like OPERS that are impacted by rising health care costs due to health care inflation and the disproportionate costs associated with health care coverage for a retiree population, and therefore more likely to be affected by the Excise Tax.

We appreciate the opportunity to provide comments regarding the Notice on the Excise Tax and look forward to continuing to work with the Treasury and the IRS as they issue guidance on implementing this tax. If you have any questions, please contact Ellen Leach, Associate Counsel at eleach@opers.org or (614) 222-0050.

Our detailed comments are attached to this letter.

Respectfully,



Karen E. Carraher
Executive Director
Ohio Public Employees Retirement System

**Comments and Recommendations on Notice 2015-16, Section 4980I — Excise Tax on
High Cost Employer-Sponsored Health Coverage**

**1. Treating Pre-65 and 65 and Over Retired Employees as Similarly Situated
Beneficiaries**

Issue:

In the Notice, Treasury and the IRS invite comments on whether additional guidance would be beneficial under Section 4980I(d)(2)(A), which states that, for applicable coverage provided to 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.”

Comment:

Treasury guidance should expressly clarify that a plan may aggregate all retired employees in determining the cost of applicable coverage provided to retirees under the plan, regardless of their age and whether the retired employees are covered under the same health care coverage package.

As noted in the Notice, Code Section 4980I(d)(2)(A) provides that a plan may elect to treat retired employees who have not yet attained age 65 and retired employees who are age 65 or older as similarly situated beneficiaries for purposes of determining the cost of coverage. The statutory language thus does not appear to require a distinction between retired employees who are and are not covered by the same coverage package.

In order for retiree-only plans to continue to provide quality health care coverage to their eligible retiree populations, it is critical that Treasury and the IRS allow a retired employee who has not attained age 65 and a retired employee who has attained age 65 to be treated as similarly situated beneficiaries, regardless of the coverage package offered to the retiree. Retiree-only health care plans are disproportionately impacted by higher costs when compared with plans covering active employees. This is due in large part to the fact that retirees over age 65 are generally less healthy than younger individuals and are therefore more likely to require additional, and more expensive, medical care, including prescription drug benefits and long-term or end of life care.

Absent the ability for retiree-only plans to aggregate pre-Medicare and Medicare-eligible retirees as a similarly situated group, it is likely that the higher cost of coverage for pre-Medicare retirees (determined as a stand-alone group) will hit the applicable dollar threshold at an early date, which would require the payment of the Excise Tax for a majority of the plan’s retiree population. In order to stay under the applicable dollar threshold, OPERS will

have to reduce its OPERS-sponsored coverage levels, which will in effect pass along all future health care inflation to its plan participants who utilize health care services. These increased retiree health care expenses will occur through a combination of higher member co-pays, co-insurance levels, annual deductibles, and out-of-pocket maximums paid by OPERS retiree health care participants. Also, since OPERS will not be able to increase retiree pensions to offset these shifted health care costs, OPERS retirees will most likely have to spend more of their fixed retiree income on health care expenses, which may take away from other discretionary spending and/or their ability to pay for basic living expenses. A concern of OPERS is that as OPERS has to reduce its relative health care coverage levels to stay under the applicable dollar threshold, OPERS retirees may forego “necessary health care services” as these services may be cost-prohibitive based on their health care payment obligations; this is of particular concern for OPERS retirees with low pension-levels and without other sources of income or public assistance options.

2. Age and Gender Adjustment Factors

Issue:

Section 4980I(b)(3)(C)(iii) provides generally for a possible increase in the applicable dollar amounts for an employer if the age and gender characteristics of the employer’s workforce are different from those of the national workforce. Specifically, it provides that the applicable dollar limit is increased by an amount determined based on the excess of the premium cost of the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for a type of coverage priced on the age and gender characteristics of the employer’s workforce compared to the premium cost of the coverage priced for the age and gender characteristics of the national workforce. In the Notice, Treasury and IRS invite comments on whether to develop safe harbors that adjust dollar thresholds for employee populations with age and gender characteristics that differ from the national workforce.

Comment:

We recommend the development of safe harbors that increase the dollar limit thresholds if the age and gender characteristics of the employee population (including retired employees) are different from that of the national workforce. In particular, safe harbors providing for age-based adjustments to the dollar limit will be extremely important for retiree-only plans, like OPERS, that incur a disproportionate amount of higher health care costs as a result of providing coverage to retiree populations that are older than typical non-retiree populations. Studies such as “Health Care Costs-From Birth to Death”, sponsored by the Society of Actuaries (released in June 2013), suggest that health care costs increase by around 4% per year between ages 50 and 64 solely due to age. For example, an otherwise identical plan and population with an average age of 60 would have an average dollar cost around 22% higher

than one with an average age of 55. Consistent with the definition of employee in section 4980I(d)(3), any such safe harbors should take into account “former employees”, including retirees.

We also request that Treasury and the IRS clarify that the proposed age and gender adjustments may also be applied to individuals who qualify for the adjustments provided in the statute for qualified retirees and high-risk professions. We also support the proposed age and gender adjustments be applied annually.

3. Defining Qualified Retirees to Include Individuals Who Have Attained Age 55

Issue:

Section 4980I(b)(3)(C)(iv) provides that an additional amount is added to the dollar limits for an individual who is a “qualified retiree.” For this purpose, Section 4980I(f)(2) defines a “qualified retiree” as “any individual who (A) is receiving coverage by reason of being a retiree, (B) has attained age 55, and (C) is not entitled to benefits or eligible for enrollment under the Medicare program under title XVIII of the Social Security Act.” By including the age 55 requirement in the definition of “qualified retiree”, the statute prohibits the dollar adjustment for qualified retirees from being applied to individuals under the age of 55 who otherwise qualify as an eligible retiree under the terms of their applicable plan based on having attained certain service requirements. Code Section 4980I(g) grants the Secretary the authority to prescribe such regulations as may be necessary to carry out Code Section 4980I.

Comment:

We encourage Treasury and the IRS to exercise their regulatory authority under Section 4980I(g) to provide an exemption from the age 55 requirement for public plans that recognize retirement eligibility for individuals under the age of 55 who have attained certain service requirements and otherwise meet the requirements of Section 4980I(f)(2).

A number of public plans define retirement eligibility based on an individual’s achievement of certain service requirements regardless of age. For example, OPERS currently provides retiree-only health care coverage for eligible benefit recipients who have 20 qualifying years of employer contributions at age 60 and for eligible benefit recipients at any age who have 30 qualifying years of employer contributions. Applying the current definition of a “qualified retiree” under Section 4980I(f)(2), an OPERS qualified retiree with 20 years of contributions who is age 60 will be a “qualified retiree” under the statute and will be eligible for the qualified retiree adjustment to the dollar limit for coverage in Section 4980I(b)(3)(C)(iv), while an OPERS retiree who is age 52 with 30 years of employer contributions will still be a “retiree” for purposes of the plan, but will be ineligible for the qualified retiree dollar adjustment.

The requirement that individuals attain age 55 to be considered a “qualified retiree” under the statute therefore currently excludes certain individuals under the age of 55 who otherwise would qualify as an eligible retiree under the terms of their applicable plan as a result of having attained certain service requirements, but who will be ineligible for the qualified retiree dollar adjustment. Excluding such individuals has the potential to result in uneven application of the adjustment to the dollar limit for retirees as the increased dollar limit for coverage could be applied for certain eligible retirees age 55 and over, but not for retirees under age 55 who similarly qualify for retiree status under the terms of their health plan.

4. Using Actuarial Value or Safe Harbors for Determining the Cost of Coverage

Issue:

In the Notice, Treasury and the IRS invite comments on whether any alternative approaches to determining the cost of applicable coverage would be consistent with the statutory requirements and would be useful.

Comment:

We request that Treasury and the IRS exercise their regulatory authority to issue safe harbors under which the cost of applicable coverage could be based on actuarial values as opposed to determining the cost of coverage provided to each group of similarly situated employees.

Determining the actual cost of coverage will be administratively complex and expensive to issuers, administrators and employers. To reduce such costs and administrative complexity, we recommend that Treasury and the IRS create safe harbors that allow employers to base the cost of coverage on more readily ascertainable factors, such as actuarial value levels. Treasury and the IRS could, for example, provide that as long as a retiree-only plan’s actuarial value is below a certain threshold percentage (e.g., the actuarial value of traditional Medicare coverage), the Excise Tax would not be applied. Such a safe harbor could also be determined by reference to a threshold based on the metal levels used for Health Insurance Marketplace plans (e.g., gold level plans). Because other provisions of the Patient Protection and Affordable Care Act already require plans to calculate actuarial values, tying safe harbors to actuarial value levels would avoid administrative burdens while tying the cost of the plan to a clear, available metric.

As an alternative to using actuarial values as a benchmark, we request that Treasury and the IRS use their regulatory authority to provide transition or temporary, limited non-enforcement rules for retiree-only plans.