Notice 2015-16

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Executive Vice President

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Executive Vice President

ROCIO SÁENZ
Executive Vice President

SERVICE EMPLOYEES
INTERNATIONAL UNION
CTW, CLC

1800 Massachusetts Ave., NW
Washington, DC 20036

202.730.7000
www.SEIU.org

May 15, 2015

VIA ELECTRONIC SUBMISSION

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

RE: Notice 2015-16

To Whom it May Concern:

The Service Employees International Union ("SEIU") submits our comments below in response to Notice 2015-6 seeking input on a range of issues related to the excise tax on high cost employer-sponsored health coverage under Internal Revenue Code Section 4980I.

SEIU is the largest healthcare union in the country, with more than 1.1 million members in the field, including nurses, LPNs, doctors, lab technicians, nursing home workers, and home care workers. As the largest property services union, SEIU represents 225,000 members in the building cleaning and security industries, including janitors, security officers, superintendents, maintenance workers, window cleaners, and doormen and women. With more than 1 million local and state government workers, public school employees, bus drivers, and childcare providers, SEIU is the second largest public services union.

SEIU has been an ardent supporter of the Affordable Care Act, from the initial stages of bill writing through Supreme Court defense, and we have a deep interest in successful implementation of the law. We also recognize the importance of controlling health care costs and have worked actively with employers of our members on cost-control initiatives. We are concerned, however, that implementation of the excise tax could have negative and unintended consequences for our members, particularly—but not only—those who work in the public sector. In many cases, our members have sacrificed wage increases at the bargaining in exchange for maintaining robust health coverage. While in theory a

reduction in the level of benefit should result in higher wages, this is less likely to be true in the public than in the private sector. In many states where we represent workers, tight city and state budgets have led to changes in health coverage that shift costs to employees without a commensurate increase in wages, leaving workers less well-off economically and creating potential barriers to appropriate preventive care. In other cases, higher costs for plans are the result of demographic and geographic factors, not overly generous coverage. A failure to make appropriate adjustments to the excise tax calculation will result in further negative pressure. As rulemaking proceeds, we hope you will carefully design the excise tax calculation and related rules in a manner that achieves, rather than subverts, the broader goals of the law.

Sincerely,

Arun Ivatury
Director of Policy

Robyn Martin
Senior Policy Analyst

Section 4980I of the Code, added by the Affordable Care Act (ACA), imposes an excise tax of 40 percent on the cost for employer-sponsored health coverage ("applicable coverage") that exceeds a statutory threshold, which is subject to various adjustments. Thus, the exact amount of tax liability will be a function of the calculation of the cost of applicable coverage and the adjustments made to the threshold dollar limit. We offer comments in each of these areas.

Applicable Coverage Cost

Exclusion of Certain Benefits

SEIU supports the proposed exclusion from applicable coverage of certain excepted benefits, including self-insured limited scope dental and vision benefits and employee assistance programs (EAPs). In addition, we suggest excluding costs for other benefits that will improve the quality of health care coverage for our members, such as wellness programs, chronic disease prevention, and management coaching program.

Rules for Health Flexible Spending Arrangements (FSAs)

The regulations as written include both the employee and employer share of the premium and also include FSAs used to offset out-of-pocket costs such as copays. Co-pays for physician visits, pharmaceuticals, lab work, and diagnostic testing are increased in plan designs to reduce premiums and to remain under the excise tax thresholds. Co-pays place an undue burden on families and early retires with chronic illnesses while doing nothing to reduce the overall cost of care. Including FSA contributions in the applicable cost could ultimately create disincentives for families and people with chronic illness to seek care.

Dollar Limit Adjustments

Age and Gender Adjustments

The law states that the annual dollar limit against which coverage costs are measured will increase if the cost of providing coverage under a standard benefit package is higher for the employees of an employer than for the national workforce as a whole because of differences in the age and gender characteristics between the two groups.[1] In particular, the amount of the adjustment is equal to the "excess (if any) of—

> (aa) the premium cost of the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for the type of coverage provided such individual in such taxable period if priced for the age and gender characteristics of all employees of the individual's employer, over

[1] 26 USC § 4980I(b)(3)(C)(iii).

(bb) that premium cost for the provision of such coverage under such option in such taxable period if priced for the age and gender characteristics of the national workforce."[2]

The language of this provision clearly provides that adjustments will come into effect only if the cost of the plan for the employees of the employer is greater than it would be for employees who are representative of the age and gender composition of the national workforce – that no downward adjustments in the annual dollar limitations can occur.

The Treasury and IRS notice gives no indication of how they are considering implementing the age and gender adjustment provision. Feedback is requested regarding whether it would be "desirable and possible to develop safe harbors that appropriately adjust dollar limit thresholds for employee populations with age and gender characteristics that are different from those of the national workforce" but they raise no other issues about how this provision should be implemented.

SEIU encourages Treasury and IRS to explore the development of specific tools (such as tables or calculators) that simplify the calculation of the adjustment amount, if any. SEIU joins the labor community in being concerned about the potentially high cost of determining whether and how much of an adjustment is permitted if this has to be done on a sponsor-by-sponsor basis without the availability of simplifying, cost-saving tools. Use of any such tools should be at the election of the party responsible for calculating any excess benefit amount. We acknowledge the potential complications associated with developing safe harbors and tools that simultaneously factor in the impact of differences in the age and gender composition of a workforce compared to the national workforce. Given that, we are not expressing a point of view at this time about whether it is possible to develop specific safe harbors or tools that appropriately adjust the dollar limitations.

Although the discussion of the age and gender adjustment provision in Notice 2015-16 is limited to soliciting feedback on whether safe harbors can and should be developed, Treasury and IRS will face several other important implementation issues. These include, but are not limited to, the following:

- The law does not define "national workforce," and there does not appear to be a definition of that precise term elsewhere in federal law. Since Congress provided no specific definition and placed no specific limitations on its meaning, we suggest Treasury and IRS adopt a definition that is consistent with a broad, common sense understanding of this term and that allows for easy access to data already collected on a regular basis by the federal government. We recommend Treasury and IRS look to the definition of the labor force used by BLS, including employed and unemployed workers and without regard to an individual worker's insured status, as one approach.

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[2] 26 USC § 4980I(b)(3)(C)(iii)(II).

- Because the federal employee workforce may differ in some important respects compared to the national workforce and any given employer's workforce, it is important that Treasury and IRS pay particular attention to whether adjustments need to be made in the comparative premium cost calculation performed under this provision. One area of concern is how premium costs are determined for self-only coverage compared to other-than-self-only coverage.
- Treasury and IRS may need to define the relevant pool of employees for determining the age and gender characteristics used in doing the premium cost calculation. How this group is defined will determine whether the age and gender adjustment provides a meaningful adjustment to the annual limitation for the pool of employees covered under a benefit package.

Adjustments for High-Risk Professions

Treasury and IRS ask for input on whether further guidance should be provided for the definition of "employees engaged in a high-risk profession" as an annual upward adjustment to the specified dollar thresholds is permitted for this class of workers. Section 49801 provides that for an individual "who participates in a plan sponsored by an employer the majority of whose employees covered by the plan are engaged in a high-risk profession or employed to repair or install electrical or telecommunications line."

We believe that you should provide clear guidance as to whether an employee satisfies this definition with respect to the categories of individuals for which no specific definition is provided by reference to another statutory provision: "individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders)."

With respect to "individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders)," we suggest providing guidance clarifying that:

- With respect to "emergency medical technicians" and "paramedics," those responsible for calculating any excess amount may rely on commonly used occupation categories that align with each of these, such as the Bureau of Labor Standards' (BLS's) Standard Occupational Classification (SOC) definition for "Emergency Medical Technicians and Paramedics;"[3]
- Given the lack of any federal legal definition of "first-responders" or any formal occupational category used by BLS covering "first-responders", and in light of the inclusion of medical technicians and paramedics as separately enumerated "individuals who provide out-of-hospital emergency medical care" and law enforcement officers and employees in fire protection activities as distinct high-risk

[3] Bureau of Labor Statistics, U.S. Dept. of Labor, Occupational Employment Statistics: Occupational Employment and Wages, May 2014: 29-2041 Emergency Medical Technicians and Paramedics, http://www.bls.gov/oes/current/oes292041.htm (Mar. 25, 2015), last accessed May 7, 2015.

professions, "first-responders" includes (but is not limited to) individuals trained in their jobs to provide emergency medical care or basic life support in response to a disaster or emergency situation, including individual health emergencies, which may encompass every worker in a job site who may be called upon to provide medical or environmental assistance in an emergency;

- The broad category of "individuals who provide out-of-hospital emergency care" includes any individual whose job requires training to provide emergency medical care or basic life support, including workers in hospital and other emergency settings, such as mobile mental health crisis units.

Moreover, many of our members who work in health care and social services settings but do not provide emergency care could be reasonably considered to be high-risk, even though they are not explicitly included in the category of high-risk professions delineated in the law. For instance, in some states (Connecticut[4], Illinois[5], and California[6]), nurses and other hospital workers are considered to be in high-risk occupations, as nearly half of all injuries in this setting result from healthcare patients.[7] The Bureau of Labor Statistics indicates that fatal injuries in health settings are greater than in many other job sectors.[8] Hospital workers are often faced with the regular threat of blood, airborne and bodily fluid infections and viruses like Ebola, not to mention workplace violence, and daily activities that include lifting heavy patients, health workers are in occupations that are high-risk. Similarly, human services workers such as those providing direct services in group homes for people with mental illness and substance abuse disorders have been victims of violence and would also reasonably fall into the category of high-risk employees. SEIU urges the Service to recognize a broader group of hospital and human service workers fall into the category of "individuals who provide out-of-hospital emergency care" even if their primary worksite is within a hospital.

Health Cost Adjustment Percentage

The dollar limits will be increased by an amount tied to the annual Consumer Price Index for All Urban Consumers (CPI-U) increases. SEIU is concerned that this measure does not appropriately measure health cost growth and will lead to greater numbers of employers becoming subject to the excise tax, even though they have taken steps to control health cost growth. We encourage Treasury and IRS to tie the increase to the rate of national health

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[4] List of occupations designated as high-risk or safety sensitive by the labor commissioner of the State of Connecticut. (2010). https://www.ctdol.state.ct.us/wgwkstnd/highrisk.htm

[5] Violence in the Workplace. (2013). http://illinoisinjuryprevention.org/Factsheet%20-%20Workplace%20Violence.pdf

[6] Labor Section Code 6400-6413.5. http://www.leginfo.ca.gov/cgi-bin/displaycode?section=lab&group=06001-07000&file=6400-6413.5

[7] Violence in the Workplace. (2013). http://illinoisinjuryprevention.org/Factsheet%20-%20Workplace%20Violence.pdf

[8] Bureau of Labor Statistics, Fatal occupational injuries by industry and event or exposure, all United States, 2013. http://www.bls.gov/iif/oshwc/cfoi/cftb0277.pdf

expenditures, or a measure that similarly reflects reasonable expectations about health cost growth.

Adjustments for Geographic Variation in Cost

While the excise tax statute is silent on the issue of geography, we believe that you should consider potential inclusion of a geographic adjustment in final regulations governing the excise tax. In 2014, the Milliman actuarial firm analyzed the factors that drive premium growth in various regions of the U.S., focusing on the projected impact of the excise tax on high cost plans in 2018. The results show that the tax will be applied unevenly across the country because, in many areas, geography (e.g., the way prices demanded by health providers vary from region to region) will have the largest impact on premium costs, while benefit richness will have a relatively small impact. As a result, "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 richness and beyond the control of health plan members." In some areas of the country, an average "Chevy" level of coverage will be taxed, while in others a "Cadillac," platinum level of benefits will not be taxed.9 Analyses we undertook following passage of the ACA suggest that employers in a number of our states, particularly in the northeast, could be hit hard by the excise tax simply because of the higher regional health costs. Given the potential negative impact the tax could have in these areas workers and employers, we urge the Department to take every opportunity in its regulatory process to minimize the uneven impact of the tax.

[9] Milliman. What does the ACA excise tax on high-cost plans actually tax? (December 9, 2014) Accessed at: https://www.nea.org/assets/docs/Milliman--What_Does_the_Excise_Tax_Actually_Tax.pdf