

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: Comments on IRS Notice 2015-16

To Whom It May Concern:

The Society for Human Resource Management ("SHRM"), International Public Management Association for Human Resources ("IPMA-HR") and National Public Employer Labor Relations Association ("NPELRA") welcome the opportunity to submit the following comments in response to Internal Revenue Service (IRS) Notice 2015-16, dealing with the Internal Revenue Code (IRC) Section 4980I excise tax on high cost employer-sponsored health care coverage.

Founded in 1948, SHRM is the world's largest HR membership organization devoted to human resource management. Representing more than 275,000 members in over 160 countries, the Society is the leading provider of resources to serve the needs of HR professionals and advance the professional practice of human resource management. SHRM has more than 575 affiliated chapters within the United States and subsidiary offices in China, India and United Arab Emirates.

IPMA-HR represents public sector human resource professionals and human resource departments. Since 1906, IPMA-HR has enhanced public sector human resource management excellence through research, publications, professional development and conferences, certification, assessment and advocacy.

NPELRA is the premier national organization for public sector labor relations and human resource professionals. NPELRA is a network of state and regional affiliates with over 2,000 members across the country. The governmental agencies represented by NPELRA employ more than 4 million workers in federal, state and local government, including education.

The impact the excise tax will have on employer-sponsored health plans is of great concern to our members. We appreciate this opportunity to offer comments, insights, and recommendations for the upcoming guidance that the Service will be issuing in the future.

Applicable Coverage

Inclusion of Retiree-Only Plans. In Notice 2015-16, both Sections III(A) and III(B)(6) reference inclusion of retiree coverage in the calculation of the excise tax. Both properly reference IRC Sections 4980I(d)(3)

and 4980I(b)(3)(C)(iv), which include former employees in the definition of those who are to be included in the excise tax calculation. However, both of those IRC Sections can be read to only include former employees in an employer-sponsored plan that includes both active (defined elsewhere as two or more current employees) and former employees, and not as an excepted benefit under Section 9831(a)(2). Since the Service is looking to that Section in Notice section III(F) to apply to limited-scope dental and vision benefits in much the same manner, we believe that the Service could and should read Section 4980I(d)(3) and 4980I(b)(3)(C)(iv) to only include former employees who remain in a plan with two or more current employees.

This conclusion is further supported by the inherent nature of the cost of retiree-only health plans. Since most self-funded plans and virtually all fully-insured retiree-only plans are now age-based in order to comply with Public Health Service Act ("PHSA") Section 2701 (utilizing single-digit age-increasing costs from ages 21 through 63, and still higher costs for those aged 64 and above) applying the 4980I excise tax to employers who only have high-cost participants by definition in a retiree-only plan was not the intent of Congress in passing Section 4980I as part of the PPACA. To say otherwise would imply that the 8 percent of employers still sponsoring retiree-only health plans would terminate those plans rather than face application of an excise tax to participants solely because the plans were comprised of older former employees.

We recommend interpreting Sections 4980I(d)(3) and 4980I(b)(3)(C)(iv) to only include former employees where they were participants in an employer sponsored plan that included two or more current employees, utilizing the definition under IRC Section 9831(a)(2).

The Inclusion of Plans Where State Law Prohibits Changes. In some states, public sector employers (and, in certain circumstances, private sector employers) are precluded from altering plans for active employees and/or retirees. Applying the 4980I excise tax to these employer plans would place them in the no-win situation of wishing to avoid the excise tax through reductions in benefits to current or former employees and not being able to do so. It cannot reasonably be assumed that Congressional intent in passing 4980I was to cause a permanent ever-increasing excise tax on those employers who were statutorily unable to make adjustments in the plan design in order to lower the costs of the plan.

We recommend the exclusion of employers with plans in existence on or after the date that Section 4980I Proposed Regulations are issued from Section 4980I where the employer is prohibited by state law from making any reduction in the health benefits offered by that employer. Alternatively, allow an adjustment to the Applicable Dollar Limit upon which the Section 4980I excise tax is based (as defined in Section 4980I(C)) to the current applicable aggregate cost of coverage in existence on the date the excise tax first becomes effective for employers that are statutorily unable to reduce benefits for current employees or retirees.

Determination of Cost of Applicable Coverage

Similarly-Situated Individuals. In Section IV(C) of Notice 2015-16, the Service is considering a number of different options for determining the cost of applicable coverage. We applaud the general approach

here to enable employers some latitude in determining who “similarly-situated” employees are by aggregating all those in self-only and other-than-self-only coverage, and then allowing permissive disaggregation within the other-than-self-only coverage category. However, further guidance is requested in addition to these considerations based upon the ages (and thus applicable coverage costs) in defining “similarly-situated” employees.

As noted in Notice section V(C)(3), due to the effect of age-rating required in PHSA Section 2701, particularly in small to mid-sized employer group health plans, many plans are now rated not on a composite basis but rather on an individual-by-individual billing line-item based solely upon age. This often occurs not just for the employee, but each member of the employee’s family as well. There is currently little to no guidance on how to apply COBRA in this circumstance, and since the 4980I excise tax is likely to use a “COBRA-like” premium under Section 4980B(f)(4), this will be very difficult for employers. We would suggest that employers with an age-based list-bill be permissively allowed to calculate their cost of applicable coverage on the basis of the mid-point/median in the age-rated structure for those aged 21 through 63, as delineated in PHSA 2701. Otherwise, this would dramatically penalize employers who happened to have a greater number of older employees, and would not be based in any sense on the design of the plan as excess coverage. That is, cost would be the only 4980I driver without regard to public policy goals that promote older workers in the workplace. For example, two employers offering identical community-rated plans located next door to each other could easily find themselves having one employer paying zero in 4980I tax obligation because they had a young workforce, while their neighbor with exactly the same community-rated plan design paid hundreds of thousands of dollars in 4980I costs because they employed older workers. This is clearly not the intended outcome of Section 4980I.

For these reasons, we recommend that for all employer group health plans that are individually age-rated, allow a permissive use of the age-based premium midpoint/median to calculate the aggregate average cost component of 4980I. This would solve the issues identified above regarding community-rated plans, as well as remove an age-based disparity against a workforce comprised of older employees.

We applaud the Service’s suggested “aggregation by benefit package” approach towards calculating the average cost component. Further, the “mandatory disaggregation method” into self-only and other-than self-only coverage levels within an aggregated plan and then the “permissive aggregation” within the other-than-self-only levels allows employers some degree of flexibility in what in the marketplace is a common practice—namely, the offering of employee plus spouse, employee plus child(ren), and family coverage options.

In the same Notice section, Treasury and the Service are considering allowing “permissive disaggregation” at the option of the employer based upon a “broad standard (such as limiting permissive disaggregation to bona fide employment-related criteria)...or a specific standard (such as a specific list of limited specific categories for which permissive disaggregation is allowed).” The Notice asks which approach to permissive disaggregation is preferable, broad or specific.

We recommend that Treasury and the Service provide both a broad standard recognizing the complexity of organizations and their structures today, as well specific safe-harbors that employers could utilize. We suggest that some specific safe-harbors might include not only those listed in the Notice, but also a safe harbor based not just on the number of individuals receiving other-than-self-only coverage, but their ages (and thus their costs) as well.

Self-Insured Methods. The Notice's section IV(C)(2) seeks comments on self-insured methods for calculating the costs of the plan, and references IRC Section 4980B(f)(4). As noted in section IV(D) of the Notice, Treasury and the Service are also considering permitting the optional use of an actual cost method for 4980I (but not COBRA) purposes. We recommend allowing for such a permissive third method for determining applicable coverage costs here as well.

Notice section IV(C)(2)(a) suggests that Treasury and the Service are concerned about the possibility of abuse if a self-insured plan switches between the two allowable methods of COBRA premium calculation "too frequently." We believe this concern is misplaced. It is already difficult in the self-funded environment, particularly among smaller to mid-sized organizations that experience wider swings in health care utilization and excess-loss premium costs from year-to-year, to properly select the correct methodology without incurring significant additional costs. The proposal to issue a rule that only permitted changes to the calculation method every five years after adopting one of those methods could cause many of those self-funded plans to eliminate coverage altogether. The proposal is based upon, as the Notice says, "the possibility of abuse" (emphasis added). COBRA was enacted over 30 years ago, and to our knowledge such a possibility would have arisen many times in that period, but has not. We thus would strongly discourage Treasury and the Service from adopting such a rule. Section 4980B(f)(4) provides two options with an annual timeframe for utilizing them. We strongly believe it should remain so.

Notice section IV(C)(2)(b) seeks comments on the Actuarial Basis Method of calculating COBRA under IRC Section 4980B(f)(4)(b)(ii)(I). Again, we strongly discourage Treasury and the Service from looking at a 30 year-old law for an issue that doesn't exist. We do not have any evidence that employers are abusing the use of the actuarial basis method of calculating COBRA premiums, so we do not believe that as suggested in the Notice, a "specific list of factors that must be satisfied to make an actuarial determination" or "some accreditation of individuals making actuarial estimates" is justified. We recommend that Treasury and the Service remove this section from the final regulation.

Notice section IV(C)(2)(c)(i) seeks comments regarding the Measurement Period under the Past Cost Method, and contemplates requiring that the 12-month measurement period end not more than 13 months before the beginning of the current determination period. We are somewhat confused by this proposal, since unless health costs are declining at too rapid a rate (which no one in any of our rather large organization base of members has experienced), we don't understand why an employer might choose a past cost period more than 13 months before the beginning of the determination period. We understand that there's a *possibility* that an employer could abuse this by choosing a very high cost year a decade prior, but we've yet to see that occur. Further, since Treasury and the Service are considering imposing this rule not just for COBRA calculations under IRC Section 4980B(f)(4)(B)(ii) but under 4980I as

well, we can only interpret this as a reduction in the clear statutory language that permits a choice of two methodologies. We strongly oppose any such restrictions inherent in this contemplated approach and request that this be dropped from the final regulation.

Health Reimbursement Accounts or Arrangements (HRA). In Notice Section IV(C)(3), Treasury and the Service seek comments on HRAs and their treatment for determining the cost of applicable coverage under 4980I. The contemplated approach of including in the calculation the newly-available amounts contributed each year by the employer (in 2018 and beyond), rather than the full amount available to a participant is a step in the right direction, but is still inappropriate for both COBRA and 4980I purposes. As noted in the Notice, “such an approach could overvalue an HRA.” It most certainly would. The experience of our members is that typically only 10-25 percent of an HRA’s contributed value is actually paid out each year to participants. Further, this approach would require some 4980I tax refund mechanism when the employee with the HRA terminated employment and forfeited those amounts that had been previously taxed under 4980I to the employer. Without such a tax refund mechanism, the employer would be paying 4980I tax on the total amount of contributions made to an employee’s HRA, not on the basis of claims utilization. It is interesting that for COBRA purposes the Notice contemplates disallowing the use of minimum or maximum individual exposure, but considers a maximum contribution here for 4980I purposes. We recommend averaging the other-than-self-only pool (if provided) over the number of individuals covered in that pool (not over the number of employees) to determine the applicable cost of coverage. In the alternative, we would support the Notice’s suggestion of an additional, not replacement, option of averaging actual claims plus administrative costs over the number of employees.

In the same Notice section, there is justifiable concern about HRAs providing some or all of their benefits for the reimbursement of the employee contribution towards the cost of coverage. Since the underlying coverage is already included in the 4980I applicable cost, this would truly be double-dipping, applying the 4980I tax on the same amount twice, once in the underlying coverage and again in the HRA. Since this tool is fairly common among our member organizations, we believe that the rule should enable an employer to exclude any HRA amount used to reimburse an employee contribution to a plan. This is not difficult administratively (and certainly much less administratively difficult than other proposals from the Notice such as the restrictions contemplated on COBRA calculation methods and 4980I inclusions).

In a similar vein, the Notice seeks comments on excluding HRA amounts that can be used for a range of benefits that are otherwise not applicable coverage for purposes of 4980I. Since IRS Notice 2013-54 et seq., there are many HRAs in use today that provide benefits solely or in part for certain excepted benefits. We believe that employers should be allowed to deduct from the cost of applicable coverage any HRA amounts expended on such not-otherwise-applicable benefits. From an administrative standpoint, an employer choosing to utilize this reduction would be readily able, given today’s technology, to differentiate such HRA claims costs.

We believe that employers should be able to determine for themselves if they wish to take on any administrative burden if all of these proposed ideas for the calculation of HRA costs of applicable coverage are adopted, in line with our comments above.

Applicable Dollar Limit

Potential Approach for Application of Dollar Limit to Employees with both Self-Only and Other-Than-Self-Only Applicable Coverage. Notice section V(B) contemplates two approaches to dealing with the applicable dollar limit under 4980I for employees with both self-only and other-than-self-only coverage for example, if an employee chooses self-only medical coverage and also participates in a health care FSA and/or an HRA that allows family members to have eligible claims and reimbursements. The Notice contemplates two alternative approaches. The first applies a “majority of cost” test to determine whether the applicable dollar limit is the self-only or other-than-self-only limit. We believe this is a reasonable approach. The second approach, calculating a composite rate based upon the pro-rata costs of each type of coverage towards the total, would be difficult, particularly if our earlier comments regarding individual age-by-age rates are considered.

Dollar Limit Adjustments. Notice section V(C) seeks comments on 4980I(b)(3)’s dollar limit adjustments. We believe this is a critical area for guidance. While 4980I(b)(3)(C)(ii) provides that a health cost adjustment percentage is applied to the baseline per employee dollar limits for 2018, 4980I(b)(3)(v) provides that for taxable years after 2018 a cost-of-living adjustment is provided. We believe that Treasury and the Service should adopt the same health cost-adjustment percentage as called for pre-2018 in 4980I(b)(3)(C)(ii). Without that consideration, given the fact that for the past three decades the rate of increase in health costs has been many multiples of any generic cost-of-living adjustment, many commentators have noticed with alacrity that the 4980I excise tax would, within the next decade, apply to virtually every employer offering any form of health coverage. In reviewing the Congressional Record, this was clearly not the intent in enacting 4980I.

Notice section V(C)(1) seeks comments on how an employer determines if a qualified retiree is eligible for enrollment in Medicare. We have absolutely no idea. Therefore, in line with our previous comments about carving out qualified retirees in a retiree-only plan, we would support guidance that allows employers a presumption to consider any retiree in a plan with two or more current employees who is under age 65 to not have, nor be eligible for Medicare enrollment, thus enabling the employer to utilize the dollar adjustment for qualified retirees under 4980I(b)(3)(C)(iv).

Notice section V(C)(2) seeks comments regarding the dollar adjustment for high-risk professions. This is of particular concern to our organizations for a number of reasons, not the least of which is that for many public-sector employers with police, fire, EMS, and other high-risk professionals, the only way to qualify for this adjustment is to spin-off the participants in the health plan into multiple plans in order to satisfy 4980I(b)(3)(C)(iv)’s requirement that “the majority (of participants)... covered by the plan are engaged in a high-risk profession.” For example, without creating many separate plans, a city with 100 employees, 20 of whom are police, firefighters, and EMS employees and the remaining are civil servants in other departments, would not qualify for the dollar adjustment since the majority of participants are not in the high-risk category. Therefore, we believe for purposes of 4980I(b)(3)(C)(iv) Treasury and the Service should allow a permissive disaggregation of a single plan to apply the statutory adjustment for those participants in a high-risk profession, without having the complexity of creating multiple plans in order to apply the statutory adjustment.

As noted earlier in various sections of these comments, we have many thoughts on Notice section V(C)(3). We believe that a median/mid-point approach to those plans that are individually age-by-age rated (and in particular community-rated plans) should be permitted for the initial calculation of applicable cost. In addition, for the determination under 4980I(b)(3)(C)(iii) we believe that employers should have a safe-harbor for utilizing the age and gender based adjustments simply on the average age of those covered under an applicable plan compared to the average age of the national workforce. We propose that for each additional year for which the employer plan's average age is over the national average, an employer be able to utilize an adjustment of \$500 in the applicable rate.

Conclusion

In conclusion, we understand that this is a daunting task for rulemaking and appreciate the opportunity to offer comments, thoughts, and ideas on what could work for the next round of pre-guidance from the Treasury and the Service.

Sincerely,

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