

American Federation of Labor and Congress of Industrial Organizations



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

October 1, 2015

CC:PA:LPD:PR (Notice 2015-52)
Room 5203
Internal Revenue Service
PO Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Notice 2015-52

Ladies and Gentlemen:

The American Federation of Labor-Congress of Industrial Organizations ("AFL-CIO") is pleased to submit these comments on Notice 2015-52 ("Notice"), issued by the Department of the Treasury ("Treasury") and Internal Revenue Service ("IRS").¹

The AFL-CIO is a voluntary, democratic federation of 56 national and international labor unions that represent 12.2 million working people. We work every day to improve the lives of people who work for a living. We help people who want to join together in unions so they can bargain collectively with their employers for fair pay and working conditions and the best way to get a good job done. Our core mission is to ensure that working people are treated fairly and with respect, that their hard work is rewarded and that their workplaces are safe. We also provide an independent voice in politics and legislation for working women and men, and make their voices heard in corporate boardrooms and the financial system.

As we have previously advised Treasury and IRS, it is especially important that the agencies act quickly to issue rules for implementing the 40 percent excise tax on high-cost health plans because the tax is already having an adverse impact on workers' health benefits.

¹

The Notice was published on July 30, 2015, and is available at <http://www.irs.gov/pub/irs-drop/n->

Employers are already making changes in benefit packages to cut back and shift costs to employees and retirees.² In workplaces where workers bargain collectively with their employers, employers are raising the excise tax at the bargaining table as a reason to cut health benefits in contracts that are being negotiated (and they have been doing this for several years). The absence of any regulatory guidance for applying the excise tax has greatly complicated the relationship between workers and employers, especially as they negotiate collective bargaining agreements with terms that extend beyond the effective date for the tax.

Summary of Comments

Our comments address the following issues raised in Notice 2015-52:

- For self-insured health care arrangements, the “person that administers the plan benefits,” which is the entity liable for the payment of the excise tax, should generally be the plan sponsor.
- With respect to employer aggregation pursuant to Internal Revenue Code Section 4980I(f)(9), any guidance should permit governmental entities to apply a reasonable, good faith interpretation of the aggregation rules.
- Treasury and IRS should consider aligning the plan year and the taxable period when applicable coverage does not use the calendar year; and the determination period should allow for sufficient time to calculate and allocate any excess benefit.
- Amounts attributable to the excise tax should be excluded from the cost of coverage; and appropriate guidance under Title I of ERISA will be needed to assure that the direct payment of the tax or separate payments to reimburse a third-party coverage provider for the tax may be made from the assets of multiemployer plans, jointly-trusted single-employer plans, and stand-alone retiree health VEBAs.
- The proposed approaches for allocating contributions to the different types of health accounts and avoiding the double counting of salary deferral contributions should be adopted.
- With respect to the age and gender adjustment to the dollar limits, we suggest modifications to the approach outlined in the Notice.

² See, e.g., International Foundation of Employee Benefit Plans, *2015 Employer-Sponsored Health Care: ACA's Impact* (2015) exh. 34 (finding that among organizations currently on pace to trigger the excise tax, 13.2% have already taken action to avoid the tax and 20.8% are currently working on changes to avoid it) available at <http://www.ehd-ins.com/assets/2015/07/HCR-Federal-Courts-Issue-Conflicting-Rulings-on-Subsidies-in-Federal-Exc....pdf>.

Overview of the 40% Excise Tax on High Cost Health Plans and Notice 2015-52

Section 4980I of the Internal Revenue Code of 1986, as amended,³ added by the Affordable Care Act (“the Act” or “ACA”),⁴ imposes an excise tax equal to 40 percent of the cost of employer-sponsored health coverage provided to an employee or retiree that exceeds certain dollar thresholds (the “excess benefit”) in taxable years beginning after December 31, 2017. Liability for the excise tax falls directly on a “coverage provider,” which could be a health insurer, the employer, or a health plan administrator, depending on the particular circumstances. Each employer, however, is responsible for calculating the amount of any excess benefit subject to the tax and notifying each coverage provider of its share of the excess benefit.⁵

The baseline dollar thresholds above which the cost of coverage will be taxed for the 2018 taxable year are \$10,200 for self-only coverage and \$27,500 for other-than-self-only coverage. For multiemployer plans, the threshold is \$27,500 regardless of coverage type. These dollar thresholds might be adjusted upward if health care costs have increased above certain amounts between 2010 and 2018. For 2019, the amounts will be adjusted upward using a measure of overall price inflation in the economy plus one percentage point. In all subsequent years, an adjustment will be made just for overall price inflation. Additional upward adjustments in the amounts might be made in the case of certain retirees, certain plans that cover workers and retirees who are or were employed in specified high-risk professions, and certain plans for which a participating employer’s employee population has age and gender characteristics that are more costly to cover than a population with those of the national workforce.

Section 4980I includes parameters for determining the coverage to which the 40 percent excise tax applies and calculating the cost of that coverage. Coverage that counts generally encompasses any employment-based group health coverage, including health FSAs, HSAs, and Archer MSAs⁶ under certain conditions. There are several significant exceptions, such as certain dental and vision benefits and most other health coverage that qualifies as “excepted benefits.”

³ Unless indicated otherwise, all “Section” references are to sections of the Internal Revenue Code of 1986, as amended (“Code”).

⁴ The “Affordable Care Act” or “Act” refers to the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152.

⁵ In the case of applicable coverage provided through a multiemployer plan (as defined in Section 414(f)), the plan sponsor, not the employer, is responsible. Section 4980I(c)(4)(B).

⁶ While Section 4980I and the Notice reference Archer MSAs, our comments do not address these medical savings accounts because they ceased to be generally available in 2007. See Section 200(i). In addition, Archer MSAs were not a typical feature of collectively bargained plans as they had to be paired with a high deductible health plan and were limited to small employers.

This calculation includes both the employer and the employee shares of the cost of the coverage and is to be done using rules similar to those used to determine COBRA premium amounts.

Notice 2015-52 is the second notice issued this year by Treasury and IRS soliciting stakeholder input on possible approaches that may be incorporated into future regulations implementing Section 4980I. The Notice focuses on four aspects of the tax: (1) identification of the taxpayers who may be liable for the tax; (2) employer aggregation; (3) allocation of the tax among applicable taxpayers; and (4) payment of the tax. The Notice also addresses additional issues related to topics covered in the first notice: the cost of applicable coverage, including the exclusion of amounts attributable to the excise tax and the allocation of contributions to various health accounts, and a proposed approach for determining the age and gender adjustment to the dollar limit. Feedback provided in response to the notices will help inform development of proposed rules for implementing Section 4980I.

Impact of the Excise Tax on Workers' Health Benefits

The AFL-CIO strongly supports the coverage expansions provided by the Affordable Care Act but continues to reject the policy rationale for an excise tax on high cost employer-based health plans.⁷

Employment-based health coverage is an essential component of our patchwork health insurance system and a critical source of health and financial security for Americans. Three-in-five people under age 65—more than 161 million individuals—are covered by employment-based coverage.⁸ Another 13.2 million people age 65 and over have such coverage.⁹ We remain deeply concerned about the impact of the excise tax on the adequacy and availability of employment-based coverage.

⁷ In light of significant concerns about the negative impact the excise tax on high cost health plans will have on workers, retirees and their families, delegates to the AFL-CIO's 2013 Convention adopted a resolution calling for the repeal of the tax. *Resolution 54: AFL-CIO Convention Resolution on the Affordable Care Act*, available at <http://www.aflcio.org/About/Exec-Council/Conventions/2013/Resolutions-and-Amendments/Resolution-54-AFL-CIO-Convention-Resolution-on-the-Affordable-Care-Act>

⁸ U.S. Census Bureau, *Current Population Survey, 2015 Annual Social and Economic Supplement*, t. HI01 Health Insurance Coverage Status and Type of Coverage by Selected Characteristics: 2014, available at http://www.census.gov/hhes/www/cpstables/032015/health/h01_000.htm (last accessed Sept. 28, 2015).

⁹ Id.

The tax is premised on the notion that shifting more health care costs onto individuals will lead them to control health care costs and expenditures in a way that insurance companies, health plans, and health systems experts have been unable to do. During the congressional debate on the Act, proponents of the tax theorized that having *too much* insurance creates a moral hazard that leads individuals to get *too much* health care and/or not shop around for low-cost health care providers. In their view, forcing individuals to have more “skin in the game” in the form of higher out-of-pocket expenses for the health care services that they use would address this problem. This tax was created, therefore, as an incentive for plan sponsors to increase the out-of-pocket costs of workers and/or reduce the scope and value of health care coverage in other ways.¹⁰

This is not a tax on so-called “Cadillac plans” or “excess insurance.” As health care actuaries at the benefits consulting firm Milliman recently concluded, “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.”¹¹ Analyses by Milliman, the Congressional Research Service (CRS), and others bear this out:

- Over time, an increasing share of workers will feel the tax’s impact—including those with average benefits or lower—having their health coverage taxed or cut to avoid the tax.¹² That is because the dollar thresholds used to determine the taxable premium

¹⁰ Jost, T. and White, T., *Cutting Health Care Spending: What Is the Cost of an Excise Tax that Keeps People from Going to the Doctor* (2009) Accessed at http://www.ourfuture.org/files/Jost-White_Excise_Tax.pdf on May 12, 2015.

Congressional Budget Office estimates of early versions of the ACA legislation substantiated that the effect of the tax would be to push people to select coverage with lower premiums, by “choosing health plans that either pay a smaller share of covered health care costs (which would reduce premiums directly as well as indirectly by leading to less use of covered medical services), manage benefits more tightly, or cover fewer services.” Congressional Budget Office, Letter to Sen. Evan Bayh from Douglas Elmendorf (Nov. 30, 2009) p. 8. <http://www.cbo.gov/sites/default/files/11-30-premiums.pdf>

¹¹ Robert H. Dobson and Stuart D. Rachlin, Milliman, *What Does the ACA Excise Tax on High-Cost Plans Actually Tax?* (Dec. 9, 2014) p. 3 available at https://www.nea.org/assets/docs/Milliman--What_Does_the_Excise_Tax_Actually_Tax.pdf. (“Milliman”).

¹² See, e.g., Herring, Bradley and Lisa K. Lentz, “How Can We Bend the Cost Curve? What Can We Expect from the “Cadillac Tax” in 2018 and Beyond?,” *Inquiry*, vol. 48: 322-337 (Winter 2011/2012) p. 334 (“While relatively few people with private insurance are likely to be affected by the Cadillac tax when it is implemented in 2018, the number of affected people is projected to grow rapidly over time.”); Troy, Tevi D. and D. Mark Wilson, American Health Policy Institute, *The Impact of the Health Care Excise Tax on U.S. Employees and Employers* (2014) (“In 2018, the excise tax is anticipated to hit 17 percent of all American businesses, and 38 percent of large employers.”) available at http://www.americanhealthpolicy.org/Content/documents/resources/Excise_Tax_11102014.pdf.

amounts subject to the excise tax will grow only at the rate of inflation and therefore are expected to decrease in real value over time. A recent CRS report using what it describes as a “lower-growth scenario” for employment-based health coverage premiums (4.6% annual growth for self-only coverage premiums) projects that 1-in-10 (10.2%) premiums for self-only coverage will be impacted by the tax in 2018 and that a decade after implementation, 1-in-4 (24.7%) premiums for single coverage will be affected.¹³

- Looking at what would happen in the very first year the tax goes into effect, Milliman’s extensive analysis found it will be applied unevenly across the country because geography (e.g., the way prices demanded by health providers vary from region to region) has the largest impact on premium costs, while benefit levels have a relatively small impact. 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.¹⁴ Those differences are driven overwhelmingly by prices, not utilization.
- Other reports highlight the extent to which other factors drive premium costs. For example, one analysis concludes, “Health risk is a dominant factor for employers in driving plan cost relative to the underlying richness of benefits, as measured by the actuarial plan value.”¹⁵ Plans projected to be affected by the tax had a significantly greater population health risk than other plans, 42 percent more.¹⁶ Furthermore, the Milliman analysis concluded some plans will be subject to the tax because they cover high numbers of women or older adults.¹⁷

The tax is likely to result in health benefit cuts that hollow out coverage through higher deductibles, co-pays, and co-insurance, but Americans are already squeezed by out-of-pocket health care costs:

¹³ Lowry, Sean, Congressional Research Service, *Excise Tax on High-Cost Employer-Sponsored Health Coverage: Background and Economic Analysis* (Aug. 20, 2015) pp. 10, 12 available at <https://www.fas.org/sgp/crs/misc/R44160.pdf> (“CRS”). This analysis did not factor contributions to health accounts, such as FSAs, HRAs, and HSAs, into the total cost of coverage.

¹⁴ Milliman. CRS also showed that there will be enormous variation in impact depending on which state a worker resides. For example, 3-in-10 (29.6%) Alaska worker premiums for self-only coverage are estimated to be affected as soon as the tax goes into effect in 2018, while just 1-in-20 (4.6%) Iowa worker premiums would be impacted. CRS, fig. 1.

¹⁵ Truven Health Analytics, *U.S. Employer “Cadillac” Tax MarketScan Study* (2014) p. 1.

¹⁶ Id. at 6.

¹⁷ Milliman.

- According to a 2014 Commonwealth Fund survey, “More than one of five 19-to-64-year-old adults who were insured all year spent 5 percent or more of their income on out-of-pocket costs, not including premiums, and 13 percent spent 10 percent or more.”¹⁸
- More than four-in-five (83.9%) private-sector workers with health coverage at work had a deductible in 2014¹⁹, compared to just over half (52.1%) in 2003.²⁰
- The average deductible among these workers surged over this same period, increasing approximately two-and-a-half times, to \$1,353 for those with self-only coverage and \$2,640 for those with family coverage.²¹
- A recent Federal Reserve survey shows 30 percent of people who have insurance did not get needed care in the prior 12 months because they could not afford it. For individuals with incomes below \$40,000, 45 percent with insurance did not get needed care.²²

The tax will cut the use of necessary health care services by people who are sick. Decades of research have shown that increased cost sharing will decrease the use of essential and non-essential services in equal amounts. The more recent studies have shown increased cost-sharing has led to increased use of emergency department and hospital care by those with chronic illnesses, resulting in greater overall expenditures for a significant number of people.

¹⁸ Collins, Sara R. et. al, The Commonwealth Fund, *Too High a Price: Out-of-Pocket Health Care Costs in the United States: Findings from the Commonwealth Fund Health Care Affordability Tracking Survey, September-October 2014* (Nov. 2014) p. 1.

¹⁹ Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, *2014 Medical Expenditure Panel Survey-Insurance Component*, t. I.F.1, available at http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2014/tif1.htm.

²⁰ Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, *2003 Medical Expenditure Panel Survey-Insurance Component*, t.I.F.1, available at http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2003/tif1.htm.

²¹ Calculated from Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, *2014 Medical Expenditure Panel Survey-Insurance Component*, t. I.F.2, available at http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2014/tif2.htm, and t. I.F.3, and t. I.F.3., available at http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2014/tif3.htm; and Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, *2003 Medical Expenditure Panel Survey-Insurance Component*, t. I.F.2, available at http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2003/tif2.htm, and t. I.F.3, available at http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2003/tif3.htm.

²² Board of Governors of the Federal Reserve System, *Report on the Economic Well-Being of U.S. Households in 2014* (May 2015) fig. 9, available at <http://www.federalreserve.gov/econresdata/2014-report-economic-well-being-us-households-201505.pdf>.

The literature also shows that elderly and low-income individuals, as well as those with chronic illnesses, are particularly vulnerable to negative health and financial outcomes as a result of these policies^{23, 24}.

- The comprehensive and often cited RAND healthcare investigation that ended in 1982 found that the poorest and sickest of those studied had better health outcomes before cost sharing.²⁵ Similarly, the 2014 Commonwealth Fund survey found that “[t]wo of five (40%) [privately insured] adults with deductibles of 5 percent of income reported that because of their deductible, they had not gone to the doctor when sick, did not get a preventive care test, skipped a recommended follow-up test or did not get needed specialist care.”²⁶
- These findings are broadly consistent with another analysis of existing literature focusing solely on chronically ill patients and cost sharing, which concludes, “[F]or patients with congestive heart failure, lipid disorders, diabetes, and schizophrenia, greater use of inpatient and emergency medical services are associated with higher co-payments or cost sharing for prescription drugs or benefit caps.”²⁷ (Citations omitted)
- An extensive multi-year review of claims data for individuals whose coverage was switched to a consumer directed health plan (CDHP), combining a high-deductible PPO with an HSA or an HRA to cover some out-of-pocket expenses, showed a negative impact on utilization of *necessary* care: “Members enrolled in CDHPs were less likely to receive care for existing chronic conditions...than their non-CDHP counterparts based on a review of eight common conditions.”²⁸

²³ Swartz, Katherine, Cost-sharing: Effects on spending and outcomes. Robert Wood Johnson Foundation (2010), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1.

²⁴ Remler, Dahlia K. and Jessica Greene, “Cost-sharing: A Blunt Instrument,” *American Review of Public Health* (2009).

²⁵ Brook, Robert H. et. al, *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate*. (2006), *available at* http://www.rand.org/pubs/research_briefs/RB9174.

²⁶ Collins, Sara R. et. al, p. 4.

²⁷ Goldman, Dana P., et. al, “Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health,” *JAMA*, Vol. 298: pp. 61-69, No. 1 (July 4, 2007) at pp. 64-65.

²⁸ Truven Health Analytics, *Impact of Consumer-Directed Health Plans on Costs, Utilization, and Care* (April 2015). The eight chronic conditions that were reviewed in this study were asthma, congestive

Our affiliate labor unions report that already in contract negotiations, employers cite the impending tax in demanding health benefit concessions from workers. In recent contracts, deductibles have doubled, out-of-pocket maximums have increased 100 percent, and copayments have increased substantially. Most of these concessions have been made without a corresponding increase in wages. We expect employees in nonunionized workplaces are even more likely to see their benefits decreased without any corresponding increases in their earnings.²⁹

It is against this backdrop that Treasury and IRS will create rules for implementing the excise tax. While the statutory language of Section 4980I lays down parameters, Treasury and IRS will necessarily need to make many decisions about which coverage counts, how the cost of that coverage is to be calculated, and how the dollar limits and upward adjustments to them are to be determined. Given the questionable policy rationale for the tax and the risks it poses to the health and financial security of working families, we continue to urge Treasury and IRS to take every opportunity in the regulatory process to minimize the uneven and inappropriate impact of the tax and its detrimental effects on workers and their families.

Notice 2015-52 Section III. Persons Liable for the §4980I Excise Tax

Section 4980I(c)(1) imposes liability for any applicable excise tax on each “coverage provider,” and Section 4980I(c)(2), in turn, identifies the “coverage providers” for different types of health benefits coverage. For insured coverage, the health insurance issuer is the coverage provider.³⁰ With respect to its contributions to an HSA, the employer is the coverage provider. For all other applicable coverage, “the person that administers the plan benefits” is the coverage provider.

Section 4980I(f)(6) provides “the term ‘person that administers the plan benefits’ shall include the plan sponsor if the plan sponsor administers benefits under the plan.” As Notice 2015-52 recognizes, the statutory language “indicates that the plan sponsor of a self-insured arrangement may be, but is not always, the person that administers benefits under the plan.”³¹ As Treasury and IRS acknowledge, the term “person that administers the plan benefits” is not

heart failure, coronary artery disease, depression, diabetes, hypertension, low back disorders, and osteoarthritis.

²⁹ One analysis of the excise tax on high-cost health plans found that employees hit by the tax from 2018 to 2014 could see an average after-tax decline in their compensation of \$1,050 due to the shift to taxable wages if their employers increased their wages to offsets cuts in their health benefits. The same study concluded that these impacted employees could alternatively see a \$6,150 cut in their health benefits but no increase in their pay. Troy and Wilson, p. 1.

³⁰ Code Section 4980I(c)(2)(A).

³¹ Notice at p. 4.

defined in any other section of the Affordable Care Act or statutory sections addressing health care benefits, whether in the Code, the Employee Retirement Income Security Act of 1974, as amended (“ERISA”) or the Public Health Service Act (“PHSA”).

In light of the absence of any definition, Treasury and IRS describe two possible approaches under consideration for determining the entity to be the person that administers the plan benefits. Under the first approach, the entity performing certain day-to-day functions with respect to the plan, including processing claims, responding to inquiries or providing a technology platform for benefits information would be the person that administers the plan benefits. Treasury and IRS note that a third-party administrator for self-insured benefits would generally be the person responsible for plan benefits under this approach. The second approach would treat the entity with “ultimate authority or responsibility under the plan ... with respect to the administration of the plan benefits..., regardless of whether that person routinely exercises that authority or responsibility” as the person that administers the plan benefits. The administrative matters taken into account could include eligibility determinations, claims administration and service provider arrangements.

The AFL-CIO suggests Treasury and IRS adopt the second approach for determining the entity treated as the person responsible for plan benefits. In most instances, the plan sponsor of a self-insured arrangement will have the ultimate authority or responsibility for the operation of the plan, including the selection, monitoring and retention of service providers, and the governing plan documents are most likely to identify the entity with this ultimate authority or responsibility. Certainly with respect to multiemployer plans, the board of trustees, as the plan sponsor as defined under ERISA §3(16)(B), is generally designated as the ultimate authority with respect to plan administration, and while it does not perform administrative functions on a day-to-day basis, it is responsible for determining the arrangements for providing benefits to plan participants.

In addition, treating the plan sponsor as the person that administers the plan benefits will align responsibility for the excise tax payment under Code Section 4980I(c)(1) and the calculation and determination of the excess benefit subject to any tax under Code Section 4980I(c)(4). In the case of single employer health benefits plans, the employer is responsible for the calculations and notices to coverage providers required under Code Section 4980I(c)(4), while for multiemployer plans, the plan sponsor (i.e., the board of trustees) is responsible. Aligning responsibility for these functions under Code Section 4980I(c) will simplify the complicated tasks required to complete the calculations and provide the notices since the plan sponsor is more likely than any other entity to have the necessary information.

In our view, the first approach could lead to some confusion, particularly because there are likely to be multiple providers, in addition to traditional third-party administrators and plan sponsors, responsible for some day-to-day functions. For example, pharmacy benefit managers may perform certain functions with respect to prescription benefits while the administrative staff

of an offered benefit package, such as a health maintenance organization, would perform those same functions with respect to its coverage. Without clear guidance on which functions are determinative in identifying the person that administers the plan benefits, it could be difficult for the entities involved to know which one is responsible for payment of the excise tax.

Notice 2015-52 Section IV. Employer Aggregation

Consistent with the guidance provided for applying the employer aggregation rules under the employer shared responsibility requirements of Section 4980H,³² we suggest that any guidance Treasury and IRS issue in connection with Section 4980I permit government entities to apply a reasonable, good faith interpretation of Section 414 (b), (c), (m) and (o) in determining whether these employers shall be treated as a single employer.

Notice 2015-52 Section V. Cost of Applicable Coverage

Taxable Period and Determination Period (Sections V-A and V-B)

In the Notice, Treasury and IRS, relying on the definition in Code Section 4980I(f)(8), anticipate the “taxable period” will be the calendar year for all taxpayers. On the related matter of the determination period, Treasury and IRS invite comments on issues raised by the need to determine the cost of applicable coverage reasonably soon after the taxable period.

Setting the calendar year as the taxable period for all taxpayers raises concerns and challenges with respect to applicable coverage offered on other than a calendar year basis. Absent alternatives, employers offering such plans will have to consider costs of coverage bridging two plan years in order to determine the calendar year cost of applicable coverage, imposing additional burdens and complications and potentially encouraging unnecessary plan design changes in anticipation of the excise tax. We urge Treasury and IRS to consider aligning the taxable period with the plan year when applicable coverage does not use the calendar year. At a minimum, an appropriate transition rule should be adopted for 2018.

The Notice recognizes the possible timing issues that can arise in determining the cost of applicable coverage for both self-insured and certain insured arrangements, as well as the different types of account-based arrangements. Treasury and IRS acknowledge that additional time after the end of the calendar year will be needed in order to properly compute the cost of coverage and any excess benefit, as well as allocate any excess among coverage providers. The agencies request comments on the processes expected to be involved in these determinations and the time period necessary to complete them.

³² 79 Fed. Reg. 8548 (Feb. 12, 2014).

With respect to self-insured coverage, we previously suggested that both methods permitted for the COBRA applicable premium calculations—the actuarial basis method and the past cost method—be available for cost determinations under Section 4980I. Using the actuarial basis method to determine the cost of applicable coverage may present fewer timing issues as costs could be determined in advance. There is, however, a risk that even reasonable actuarial estimates may be too high and adjustments following the end of the determination period may be needed. Regardless of the method used, a minimum period following the close of the year is necessary in order to take into account a subsequent run-out period.

As the Notice acknowledges, similar timing issues can also arise in connection with experience-rated insured arrangements or other funding arrangements where the ultimate premium is not determined until after the end of the contract year based on actual experience. Complications may also arise when payments made after the end of the coverage period relate back to the original period of coverage rather than being used as a discount for the next coverage period.

For health benefits coverage subject to ERISA, the existing reporting and disclosure regime, including, in many instances, an independent audit, could be the basis for setting the time period allowed for making any cost determinations under Section 4980I. Permitting this alignment may reduce the burden imposed on plan sponsors and allow sufficient time for calculating and allocating any excess benefit.

Exclusion from Cost of Applicable Coverage of Amounts Attributable to the Excise Tax
(Sections V-C and V-D)

Treasury and IRS suggest it might be feasible to exclude from the cost of applicable coverage any excise tax reimbursement or income tax reimbursement only if it is separately billed and identified as attributable to the cost of the excise tax. They ask whether passing through any or all of these amounts or billing for these amounts separately raises any practical issues or legal barriers. In our view, this suggested approach raises the question of whether Title I of ERISA would permit the fiduciaries of ERISA-covered plans to pay these separately billed amounts from plan assets. If this approach is adopted, it is essential that concurrent guidance be issued detailing the conditions under which these amounts may be paid out of plan assets.³³

³³ Previous guidance from the Departments of Treasury, Labor and Health & Human Services provides that the Patient-Centered Outcomes Research Institute fee imposed by the Act and established under Code Section 4376 could be paid out of plan assets for certain plans, including multiemployer plans. The Departments stated, in part, “The fee involved is not an excise tax or similar penalty imposed on the trustees in connection with a violation of federal law or a breach of their fiduciary obligations in connection with the plan.” U.S. Departments of Labor, Health & Human Services, and the Treasury, “FAQs about Affordable Care Act Implementation Part XI,” (Jan. 24, 2013) Q&A 8, *available at* <http://www.dol.gov/ebsa/faqs/faq-aca11.html>.

While in many cases the costs of employment-based health benefits are paid directly out of employer assets, there are several situations in which the health plan itself is funded, assets are held in trust, and the costs of the plan are paid from plan assets. In these situations, there is no source of funding independent of plan assets to satisfy any obligations related to providing health coverage. These include multiemployer plans defined in ERISA Section 3(37).³⁴ They also include some single employer plans that, like multiemployer plans, are maintained pursuant to one or more collective bargaining agreements and overseen by an independent joint board of trustees, the members of which are appointed by the participating employer and employee organization(s).

In addition, stand-alone retiree health plans use trusts qualified as voluntary employees' beneficiary associations ("VEBAs") established under Code Section 501(c)(9) as the funding mechanism for the ongoing provision of retiree health benefits. These retiree health plans are sponsored by a trustee or a board of trustees that exists solely for the purpose of sponsoring and administering the plan. They typically are funded by one or more payments from the former employer of the retirees, and the costs of health benefits are paid solely from the VEBA assets.

It is essential that guidance be issued permitting amounts attributable to the tax be paid out of plan assets in these circumstances. If not permitted to do this and without any other source from which to pay the excise tax, the board of trustees that also acts as the plan sponsor will be forced to cut benefits to be absolutely sure the cost of coverage does not exceed the applicable tax thresholds. That is, absent such guidance, the tax will become, in practice, an absolute bar on coverage with total costs that exceed the statutory tax thresholds for individuals covered under these plans. This is contrary to the design and purpose of Section 4980I, which is not intended to prohibit health benefits that cost more than certain amounts but only to take away the tax advantages normally accorded employment-based health benefits. We note, in contrast, some excise taxes are clearly intended to prohibit certain practices. The tax on prohibited transactions in Code Section 4975, for example, imposes a 15 percent tax on prohibited transactions involving the assets of certain retirement and similar plans and accounts, and the tax increases to 100 percent of the amount involved if the prohibited transaction is not corrected.

While not addressed in the Notice, the same basic issue arises when the "coverage provider" liable to pay the excise tax is the board of trustees of an ERISA-covered plan or an individual in the direct employ of such a plan, such as the plan administrator. Just as for the types of plans described above, the only source of funding to pay the excise tax is plan assets. The same analysis applies to these plans in this situation as it does when a third party is considered to be a coverage provider and that third party seeks reimbursement from the plan for amounts attributable to the excise tax. Additional guidance detailing when plan assets can be used to pay the tax or amounts attributable to the tax is needed here, too.

³⁴ 29 USC §1002(37).

Also not addressed in the Notice is the legal question of whether any penalty for failure to properly calculate the excess benefit amount under Code Section 4980I(e) may be paid from plan assets. While in most cases the employer is responsible for calculating the amount of the excess benefit, if any, and notifying the Secretary and any coverage provider of any excess amount determined for the provider, and is therefore liable for any applicable penalties, the plan sponsor is responsible in the case of a multiemployer plan.³⁵ For multiemployer plans, the plan sponsor is the joint board of trustees. Further, we expect Treasury will need to issue clarifying guidance that the party responsible for these duties will be the plan sponsor, not the employer, in the case of jointly trusted single-employer health plans and stand-alone retiree health VEBAs. Therefore, we urge Treasury to work with the Departments of Labor and Health & Human Services to address the permissibility of paying this penalty from plan assets.

Allocation of Contributions to HSAs, Archer MSAs, FSAs, HRAs (Section V-E)

With respect to the different types of health accounts, the Notice indicates that Treasury and IRS are considering allocating contributions on a pro-rata basis over the period to which they relate, regardless of when the contributions are actually made.³⁶

The AFL-CIO generally supports the proposed approach as it could simplify the cost of coverage determinations for these account-based arrangements. However, this approach must recognize that certain arrangements, such as HSAs, should not be considered applicable coverage³⁷ and should be coordinated with the cost determination approaches for health reimbursement arrangements (“HRAs”) outlined in Notice 2015-16.³⁸ In addition, as our comments in response to Notice 2015-16 outline, Treasury and IRS should be guided by broad principles regarding cost determinations with respect to HRAs, including disregarding amounts contributed or credited before 2018 and related investment earnings and amounts contributed or credited during a worker’s career if those amounts may be used only during retirement.

³⁵ Code Section 4980I(c)(4).

³⁶ Notice at p. 10.

³⁷ In our comments responding to Notice 2015-16, we explained that most HSAs are not part of group health plans and should be excluded from applicable coverage.

³⁸ Some of the key features of the potential approach of taking into account only amounts made newly available during the year included the exclusion of carry-over amounts or amounts newly available before 2018. Notice 2015-16 at p. 18.

Cost of Applicable Coverage under FSAs with Employer Flex Credits (Section V-F)

As the Notice acknowledges, health FSA balances can include salary deferral contributions made by workers and employer flex credits. Section 4980I(d)(2)(B) provides that the cost of applicable coverage for health FSAs is the greater of the worker's salary reduction contributions or, if there is an additional employer contribution, the amount reimbursed by the FSA.

Treasury and IRS recognize that double-counting of salary reduction amounts could occur if there are carry-over amounts from one year to the next and those amounts are included in the cost of applicable coverage in each year. The Notice proposes two possible safe harbors to address this. The AFL-CIO urges Treasury and IRS to provide rules that avoid inappropriate double counting of salary deferral contributions to FSAs. The safe harbor approaches outlined in the Notice are one way to achieve that goal. Treasury and IRS also should provide rules and guidance to avoid double counting with respect to HRAs.

Notice 2015-52 Section VI. Age and Gender Adjustment to the Dollar Limit

Section 4980I provides that the applicable dollar limitation shall be increased 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.³⁹ 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 Benefit Plan (FEHBP) 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

(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."⁴⁰ (Parenthetical added.)

The statutory language of this provision clearly provides that adjustments occur only if the cost of the baseline FEHBP benefits package 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

³⁹ Code Section 4980I(b)(3)(C)(iii).

⁴⁰ Code Section 4980I(b)(3)(C)(iii)(II).

national workforce. That is, no downward adjustments in the annual dollar limitations can occur. Treasury now affirms this plain language reading of the statute.⁴¹

Treasury and IRS raised several issues related to implementation of the age and gender adjustment in the first notice, Notice 2015-16. The AFL-CIO provided detailed comments in response to those queries, as well as input on additional issues not raised by Treasury and IRS.

In Notice 2015-52, Treasury and IRS suggest the methods to be used in determining the age and gender distribution of the national workforce and the applicable group of employees for whom the adjustment is being calculated and the approach being considered to develop age and gender adjustment tables and to perform the actual adjustment calculations.

Determination of Age and Gender Distribution (Section VI-A)

Treasury and IRS are considering using the Current Population Survey (“CPS”) to determine the age and gender distribution of the national workforce. In particular, they are considering using the same data from the CPS that is summarized in Table A-8a, Employed Persons and Employment-Population Ratios by Age and Sex, Seasonally Adjusted (“Table A-8a”), published annually by the Department of Labor’s Bureau of Labor Statistics (“BLS”). In the Notice, this table is described as providing “the number of individuals participating in the labor force by five-year age bands (up to age 75 and over) and the ratio of male to female workers in each age band.”⁴² Feedback is requested on whether Table A-8a and the CPS are appropriate data sources for this purpose and whether other data sources should be considered.

In our comments on Notice 2015-16, we recommended that Treasury and IRS look to the definition of the labor force used by BLS, including employed and unemployed workers and without regard to the individual worker’s insured status. As the CPS is the data source used by BLS to calculate commonly used statistics for the national labor force, we strongly suggest Treasury and IRS use the CPS as the data source for determining the age and gender distribution for the national workforce for this purpose. The CPS is a monthly survey of households conducted by the Census Bureau for BLS. It has a long track record, having been conducted every month since 1940, and is one of the best known and most relied upon surveys in the U.S., serving as the source for the official monthly unemployment statistics released by BLS.

⁴¹ Notice 2015-52 at p. 13.

⁴² Notice 2015-52 at p. 14. Table A-8a is available at <http://www.bls.gov/web/empst/cpseea08a.pdf>. Table A-8a itself does not provide the precise information described in the Notice. We assume, however, that Treasury and IRS intend to use the underlying data to construct the age and gender bands in the manner described.

We further noted in our comments on Notice 2015-16 that Section 4980I does not define “national workforce” and there does not appear to be a definition of that term elsewhere in federal law. Since Congress provided no specific definition and placed no specific limitations on its meaning, we suggested Treasury and IRS adopt a definition that is consistent with a broad, common sense understanding of this term, as well as allows for easy access to data the federal government already collects. Defining the “national workforce” as only employed persons, as Treasury and IRS would do if they used the same CPS data as are used to construct Table A-8a, is inconsistent with our recommended approach and would narrow inappropriately the scope of American workers used to determine the age and gender distribution.

Treasury and IRS should, instead, define the “national workforce” to be the same as the “civilian labor force,” a term used by BLS. The “civilian labor force” is made up of all persons in the civilian noninstitutional population who are classified as either “employed” or “unemployed,” both of which terms are defined specifically for purposes of the CPS.⁴³

Annual average statistics for the civilian labor force can be found in Table 3, “Employment status of the civilian noninstitutional population by age, sex, and race” on the BLS

⁴³ According to BLS, each is defined in the following way:

Employed persons (Current Population Survey): Persons 16 years and over in the civilian noninstitutional population who, during the reference week, (a) did any work at all (at least 1 hour) as paid employees; worked in their own business, profession, or on their own farm, or worked 15 hours or more as unpaid workers in an enterprise operated by a member of the family; and (b) all those who were not working but who had jobs or businesses from which they were temporarily absent because of vacation, illness, bad weather, childcare problems, maternity or paternity leave, labor-management dispute, job training, or other family or personal reasons, whether or not they were paid for the time off or were seeking other jobs. Each employed person is counted only once, even if he or she holds more than one job. Excluded are persons whose only activity consisted of work around their own house (painting, repairing, or own home housework) or volunteer work for religious, charitable, and other organizations.

Unemployed persons (Current Population Survey): Persons aged 16 years and older who had no employment during the reference week, were available for work, except for temporary illness, and had made specific efforts to find employment sometime during the 4-week period ending with the reference week. Persons who were waiting to be recalled to a job from which they had been laid off need not have been looking for work to be classified as unemployed.

“Glossary,” <http://www.bls.gov/bls/glossary.htm>, U.S. Department of Labor, Bureau of Labor Statistics (last updated Feb. 28, 2008, last accessed Sept. 27, 2015).

website.⁴⁴ The CPS is the data source for Table 3.

It is appropriate to use data for the civilian labor force, including employed and unemployed individuals, to determine the age and gender distribution of the national workforce. Unemployed individuals, like all employed individuals, are part of the pool of individuals who may be enrolled as a primary insured individual in employment-based coverage. In the case of unemployed individuals, they may be eligible to enroll in coverage if they have a right to continuation coverage under federal or state law. Further, multiemployer health plans often provide uninterrupted coverage to some workers during certain periods of unemployment, through the use of hours banks and other provisions. Given these circumstances, it would be inappropriate to exclude unemployed workers from the data set used to determine the age and gender characteristics of the national workforce.

Treasury and IRS will need to decide which time period during which to determine the age and gender composition of the national workforce. As noted, the CPS is fielded monthly, so statistics can be calculated for a monthly period. Averages over longer periods also can be calculated. We suggest Treasury and IRS consider using 12-month averages to smooth month-to-month variations.

Treasury and IRS also are considering requiring an employer to use the age and gender characteristics of its workforce on the first day of the plan year for purposes of the age and gender adjustment. Consideration should be given to allowing an employer to use a snapshot date that occurs before the start of the taxable period. Doing this could provide an employer greater certainty for the amount of the age and gender adjustment. This, in turn, would enable the employer to make more informed plan design decisions prior to the start of the enrollment period for coverage during the taxable period. If Treasury and IRS require the determination of the age and gender distribution to be made on a snapshot date during the taxable period, the employer should be permitted to select the date.

The suggested approach of requiring the first day of the plan year as the snapshot date could be problematic for plans with plan years that are not the same as the calendar year. For such a plan, the regulations would need to make clear whether the snapshot date is the first day of the plan year in effect at the start of the taxable period, the first day of the plan year in effect at the end of the taxable period, or the first day of both plan years that occur in part during the taxable period (which would require two different calculations of the adjustment for the same taxable period).

⁴⁴ “Labor Force Statistics from the Current Population Survey,” t. 3, <http://www.bls.gov/cps/cpsaat03.htm>, U.S. Department of Labor, Bureau of Labor Statistics (*last updated* Feb. 12, 2015, *last visited* Sept. 27, 2015).

Development of Age and Gender Adjustment Tables (Section VI-B)

The Notice describes the approach Treasury and IRS are considering using to develop adjustment tables and the additional steps that would be used to calculate the age and gender adjustment, if any. Treasury and IRS note that the adjustments would be determined separately for self-only coverage and other-than-self-only coverage.

In Notice 2015-16, Treasury and IRS requested feedback on 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.” In our comments on that notice, we encouraged the development of specific tools that simplify the calculation of the adjustment amount. We commend Treasury and IRS for moving forward with this effort and considering a specific approach to developing adjustment tables.

In the first step under consideration, the FEHBP average cost would be determined by aggregating all claims expenses of the FEHBP standard option and dividing that total by the number of employee policyholders. Treasury and IRS are considering using one of two approaches to the claims data on which they would rely: (1) actual claims data from the FEHBP standard option; or (2) national claims data reflecting plans with a design similar to that of the FEHBP standard option. Accurately pricing the FEHBP standard option for the age and gender characteristics of the national workforce, as directed by the statute, would require using actual claims data from a population with the same health status within the age and gender bands suggested by Treasury and IRS as the health status of the national workforce within those bands. Option (2) appears most likely to align with this standard. Therefore, unless it is established that the population covered under the FEHBP standard option has the same or sufficiently similar health status within the suggested age and gender bands to that of the national workforce, option (2) should be selected over option (1). Otherwise, using option (1) could lead to the adjustment being systematically under- or overestimated.

The most recent annual premium cost for the FEHBP standard option is used to determine the premium cost for the national workforce and the employer under the suggested approach. This appears to rely on the actual premium amount allocations between self-only coverage and other-than-self-only coverage used in the FEHBP. We are concerned this is not reflective of the actual relationship between the premium costs of self-only and other-than-self-only coverage and that it would systematically underestimate the amount of the adjustment for other-than-self-only coverage.

As we did in our comments on Notice 2015-16, we urge Treasury and IRS instead to adopt a specific ratio between the premium costs for each kind of coverage. In particular, we urge adoption of the ratio of the other-than-self-only coverage annual dollar limit over the self-only coverage annual dollar limit (\$27,500/\$10,200 in 2018), or 2.7. Therefore, under the

suggested approach, the annual premium cost for other-than-self-only-coverage used in step 4 would be determined by multiplying the most recent annual premium cost for self-only coverage by 2.7.

Feedback is also requested on whether the age and gender adjustment should take into account the age rating scale adopted in regulations for the individual and small group market. Pursuant to the ACA, the premium rate charged by a health insurance issuer for non-grandfathered health insurance coverage in the individual or small group market may vary by age, except that such rate may not vary by more than 3:1 for adults.⁴⁵ Final regulations issued by the Centers for Medicare and Medicaid Services provide for a default federal standard age curve composed of a single age band for children ages 0-20, one-year age bands for adults ages 21-63, and a single age band for adults older than 63.⁴⁶

Taking the age rating scale into account for purposes of determining the age and gender adjustment would be inappropriate. Under the ACA, the age rating limitation applies only to small group plans, not to medium and large group plans or to self-insured plans. Therefore, there is no basis to take the age rating scale into account for non-small group plans. Further, there is no indication Congress intended the adjustment to be applied differently based on whether the coverage is provided by a small group plan or other plan.⁴⁷ Section 4980I includes straightforward language providing the adjustment is to be determined, in part, by calculating the premium cost of the FEHBP's Blue Cross/Blue Shield standard option "for the type of coverage provided such individual in such taxable period if prices for the age and gender characteristics of all employees of the individual's employer."⁴⁸ The "type of coverage provided such individual" is properly interpreted to mean self-only coverage or other-than-self-only coverage, and Treasury and IRS appear to acknowledge this in the Notice.⁴⁹

⁴⁵ 42 USC § 300gg(a)(1)(A)(iii).

⁴⁶ 45 CFR § 147.102(d).

⁴⁷ The only explicit acknowledgement of potential distinctions by size for the excise tax on high-cost health plans appears in the definition of "taxable period," which provides, in part, "The Secretary may have different taxable periods for employers of varying sizes." 26 USC § 4980I(f)(8).

⁴⁸ Code Section 4980I(b)(3)(C)(iii)(II)(aa).

⁴⁹ Notice 2015-52 at p. 14. ("All Adjustments and calculations would be determined separately for self-only coverage and for other than self-only coverage.")

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The AFL-CIO appreciates the opportunity to comment on Notice 2015-52, and we look forward to the prompt release of proposed and final rules governing the 40 percent excise tax on high-cost health plans. If you have any questions about these comments or need any additional information, please do not hesitate to contact me.

Very truly yours,

/s/ Shaun C. O'Brien

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