



American Federation
of Teachers, AFL-CIO

AFT Teachers
AFT PSRP
AFT Higher Education
AFT Public Employees
AFT Nurses and Health
Professionals

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October 1, 2015

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

Submitted to: Notice.comments@irscounsel.treas.gov

Dear Ladies and Gentleman:

On behalf of our 1.6 million members, the American Federation of Teachers (AFT) welcomes the opportunity to comment on Notice 2015-52, which focuses on who is obligated to pay the excise tax, how to determine the cost of coverage for the tax, and determining the age and gender adjustments to applicable tax thresholds specified in the law. We previously commented on Notice 2015-16, and have appended those comments to this letter. The excise tax penalizes working men and women for costs that are out of their control, such as regional cost of living differences and skyrocketing prescription drug prices. We therefore have a vital interest in the effects of this tax on our members.

Some have argued that the excise tax will help bend the cost curve by suppressing the demand for unnecessary care. However, we believe that the imposition of this tax will force workers to agree to high deductible health plans that will shift even more costs over to those who are unable to pay. Studies have shown that when more costs are shifted to consumers, they are less likely to seek care, including care that is medically necessary. Because workers do not have the knowledge or skill to determine if recommended care is necessary or unnecessary, they will be forced to make medical decisions based on costs and consequently put their health at risk.

Persons Liable for the \$4980I Excise Tax

A 40 percent excise tax will be imposed on health coverage providers starting in 2018, if the aggregate cost of the employer-sponsored health plan for its employees exceeds the threshold amounts. The language in the statute states that the health coverage provider is the health insurer in a fully insured group plan. However, in the case of a self-insured health plan, the coverage provider is defined as "the person that administers the plan benefits." As this term is not defined elsewhere in the Act, ERISA, or the Code, Treasury and IRS are considering two alternative approaches to identify the person who administers the plan benefits. One approach is to consider the plan administrator as the person who administers the plan benefits. A second approach would consider the entity

with the ultimate authority over the plan as the person who administers the plan benefits.

AFT strongly recommends the adoption of the second approach, which would designate the person who administers the plan benefits as the person with ultimate authority or responsibility under the plan, regardless of whether that person regularly exercises that authority. In virtually every instance we are aware of, the employer plan sponsor of a self-funded health plan has ultimate authority over carrier selection, eligibility determinations, and claims adjudication. Because the employer plan sponsor has this authority, federal rules and regulations should ensure that the employer plan sponsor also has the burden of paying the tax. However, as the example below indicates, weak regulation allow employer plan sponsors to shift tax burdens to unions and, ultimately, working men and women.

In collective bargaining, the union and employer negotiate over plan designs, premium sharing and out-of-pocket costs. Once an agreement is reached it is left to the employer plan sponsor to bid out the specifications of the agreed upon plan, determine whether to fully insure or self-fund the benefit, and select the appropriate vendors to carry out the agreed upon plan terms. Moreover, during the period of the collective bargaining agreement, the employer bears the risk of loss for cost overruns.

We especially believe that the employer plan sponsor should be assigned this role where it has parceled out part of its plan administration to an employee welfare fund. Hundreds of thousands of New York State, City, County and School District employees are covered by an employer-sponsored group health plan and a negotiated supplemental plan provided by a separate self-insured and self-administered welfare fund. Because the collective bargaining agreement affixes the dollar amount of the supplemental benefit contribution made to the welfare fund, and because this amount is budgeted by the employer plan sponsor, it should be made part of the employer's cost of health care. In short, employers should not be able to unbundle their health account budgets and then assign part of their possible tax obligation to the welfare fund.

Taxable Period

Treasury and IRS state that the taxable period under §4980I (f)(8) is a calendar year. A number of school district health plans shifted from fiscal year to calendar year plan year when plan design shifted from indemnity plans with a supplemental major medical rider to the preferred provider network model. However, many school districts have retained the fiscal year plan year to be consistent with the school year budgets. They establish a benefit year to coincide with the plan year (i.e., July 1) and measure the out-of-pocket costs over the next twelve months to determine when the deductible and stop loss limits are met. On the following July 1, the benefit period is restarted and the accumulation of out-of-pocket costs for deductible and stop loss treatment starts anew.

For a self-insured plan to determine the cost of coverage using actual costs, we imagine that a school district operating on a fiscal year plan year basis (i.e., July 1 through June 30) would combine actual claims costs from the first six months of the calendar year (January 1-June 30) with plan costs for the last six months of the current calendar year (July 1-December 31) to determine a calendar year cost. This pattern would be repeated in the second and subsequent years. The resulting excise tax, if any, could be apportioned on a monthly basis over the next 12 months. In this manner, the actual costs incurred in the previous twelve months would be used to determine the cost of coverage for the application of the tax. As school district fiscal years vary between July 1 and September 1, a system using the September 1 date would add eight months of plan costs from the prior fiscal year (January 1-August 30), plus costs for the rest of the current year (September 1-December 31) to calculate the calendar year cost. Regulations must reflect school district's varying fiscal years and allow districts flexibility in determining the taxable period for calculating the cost of coverage.

Determination Period

Treasury and IRS imagine that plans will determine the cost of coverage soon after the end of the taxable year. However, the run-out of claims period coupled with the application of provider rebates and premium discounts or additional rate hikes for experienced rated plans may prevent a plan from knowing the true annual costs of the plan for several months after the close of the plan year. If Treasury and IRS support the use of actual claims costs for calculation of the determination period, we recommend that plans sponsors be given a three-month period after the end of the plan year to account for the claims run out and other adjustments. Plan sponsors can then allocate an excise tax going forward based on the cost of the prior year's plan. Alternatively, we recommend that employer plan sponsor estimate the cost of the current year's coverage based on the average cost of claims over the prior three years. Such a rolling average would speed up the calculation time and be a reasonable approximation of actual costs for the current year.

A third option would be to let an employer use an actuarial projected cost for the determination period. While actuarial costs almost always overstate actual plan costs (because of the addition of profit margin and medical trend in the calculations), there may be instances where these projections might be appropriate. We therefore recommend that plan sponsors be given the flexibility to choose either start-of-the year actuarial projections or actual costs to determine the cost of the plan.

Excluding the Excise Tax from the Cost of Coverage

The excise tax will be paid by the insurer in a fully insured group plan. For self-insured plans, "the person who administers the plan benefits" is responsible for paying the tax. Because the law clearly provides that the cost of coverage does not include amounts attributable to the tax itself, Treasury and IRS have a concern about how the amount of

money that could be charged to the plan sponsor by an insurer or other provider is to be determined.

The coverage provider responsible for paying the tax will most likely want to be made whole by the employer-plan sponsor. Since the excise tax is not a deductible expense for the taxpayer, the excise tax reimbursement received by the coverage provider from the plan sponsor would be considered income to the coverage provider. As a result, the coverage provider will likely demand a payment that covers the direct cost of the excise tax, plus the added income tax that will be owed on that payment. For example, an insurer who was in the 20 percent tax bracket and incurred an excise tax payment of \$1,000 would require reimbursement of the \$1,000 excise tax plus \$250 to cover the cost income tax the insurer would on the reimbursed \$1,000.

The sting of making an insurance company whole will be especially felt by small and medium sized school districts that fully insure their health plans to protect themselves from uncertainty. These tax-exempt entities will end up paying a higher effective tax rate than the tax-exempt plan sponsor with self-insured coverage and that is treated as a coverage provider. In order to make the tax on the tax transparent, insurers should be required to list the excise tax and the reimbursement for additional income tax owned separately.

Age and Gender Adjustments

The 40 percent health benefits tax is to be paid on the aggregate cost of coverage in excess of the 2018 thresholds of \$10,200 for self-only coverage and \$27,500 for other than self-only coverage. These thresholds are subject to several adjustments including one for employers with a workforce whose age and gender characteristics are more costly to cover than the national workforce. The notice proposes a seven-step process that would be used to determine the relative premium costs for various age and gender groups. Ultimately, the process is then used to determine the age and gender adjustments that should be applied to each employer given the composition of its workforce. Making adjustments will help level the playing field for employers with age and gender characteristics that vary from the national workforce, like K-12 education.

The following comparison shows the age and gender differences between K-12 teachers and the national workforce. The biggest difference exists between the gender-mix of these three groups. Nine out of ten registered nurses and three-fourths of educators are women compared to only 47 percent for the national workforce. Assuming that the cost of care for these groups is generally the same as national averages, we would expect the proposed adjustment to adequately reflect this variance.

Distribution of Employees by Age and Gender						
	Less than 30 years	30-49 years	50-54 years	55 years or older	Male	Female
K-12 Educators¹	15%	54%	12%	19%	24%	76%
Registered Nurses²	N/A	N/A	N/A	26%	9%	91%
National Civilian Labor Force³	25%	42%	11%	22%	53%	47%

¹ National Center for Education Statistics, School and Staffing Survey, 2011-2012

² U.S Bureau of Labor Statistics, Quarterly Census of Employment and Wages, 2015

³ U.S. Bureau of Labor Statistics, Employment Status of the Non-Institutional Population by Age, Sex and Race, 2011

We support the seven-step approach embodied in the proposal and believe that it will simplify the calculation of the age and gender adjustments. However, we urge Treasury and IRS to conduct trial calculations to test whether the proposed process produces reasonable results, before the final rules are published. We would also like to point out several areas of concern for Treasury and IRS consideration and change before the proposed rules are published.

- First, we need to know the demographic distribution of the population that was used to develop the self-only and other than self-only relationship of \$10,200 and \$27,500. As age and gender characteristics of a given population are highly correlated with average claims costs, the adjustments used to calculate self-only and other than self-only thresholds are important considerations. Once these factors are known, the benchmarks can be adjusted to reflect employer costs based on their respective age and gender content. We also recommend that that Treasury and IRS adopt a definition of the national workforce that also considers the use of COBRA coverage by the unemployed.
- Second, as many plan sponsors will make plan design decisions before the start of the plan year to avoid tripping over the excise tax thresholds, sponsors should be permitted to select a determination date for age and gender adjustments prior to the start of any plan year. The Notice suggests that Treasury and IRS might require that the date be set on the first day of the plan year.
- Third, Treasury and IRS must define the relevant pool of employees for determining the age and gender characteristics used for the premium calculation. We recommend that employers be given flexibility in determining the group of covered employees for the purpose of calculating the age and gender adjustment. For example, a school district or hospital might match the health care costs for its entire workforce (including part-time, substitute and seasonal employees) with the costs for the national workforce by age and gender to determine the age and gender adjustment for the entire group. Alternatively, if Treasury and IRS require employees be grouped by plan design, when calculating the cost of the coverage, then the same group of employees should be

used for the age and gender calculations. Separately calculating the age and gender adjustment by benefit package will ensure a more equitable calculation.

- Fourth, the seven-step pricing model would be used to calculate any adjustment separately for self-only and other than self only coverage. Implicit in this model is the relationship between the costs of each type of coverage that currently exists in the Federal Employees Health Benefit Plan, even though this may not represent the cost relationship that exists in many employer-based health plans. We recommend that Treasury and IRS adopt an explicit cost relationship in its pricing model based on ACA's relationship between self only and other than self-only coverage of 2.7 (\$27,500/\$10,200).

Thank you for this opportunity to comment on this Notice. We look forward to working with the Treasury and IRS on developing fair and reasonable final rules to regulate the tax on high cost health plans in the days ahead.

Sincerely,

A handwritten signature in cursive script, appearing to read "John D. Abraham".

John Abraham

Co-Manager, Center for Workers' Benefits & Capital Strategies

JA : mb opeiu#2 afl-cio