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

Ladies and Gentlemen:

On behalf of its 3 million members, the National Education Association is pleased to submit these comments on Notice 2015-52 (the Notice), related to Internal Revenue Code section 4980I, which creates the excise tax on high-cost employer-sponsored health coverage. As we have in prior comment letters on multiple subjects, we begin by noting that NEA has been a longtime supporter of the Affordable Care Act. The law has already strengthened health benefits for children and families and provided an opportunity for millions of Americans to obtain quality, affordable care.

Against the backdrop of our support for the Affordable Care Act, we again feel obligated to point out that IRC section 4980I wrongly equates high premiums with overly generous health benefits. In fact, it is so poorly structured that it is likely to lead to tax liabilities that vary based on where health plan members live, their age, and their sex.[1] Depending on such demographic factors, some health plans offering moderate benefits will face a steep tax, while plans with better benefits may not face any tax at all. Similarly, plans for workers who live in a city with high health care costs might generate a large tax, while workers with the exact same health benefits in lower-cost areas might cause no tax.

We believe that the ACA would be stronger without the excise tax in any form; we support full repeal of IRC section 4980I. However, we also recognize the importance of contributing to the regulatory process.

[1] Milliman, "What Does the Excise Tax on High-Cost Plans Actually Tax?" December 9, 2014, p. 1. Available on the Internet at: http://www.nea.org/assets/docs/Milliman--What_Does_the_Excise_Tax_Actually_Tax.pdf. NEA access date: April 20, 2015. Milliman found, for example, that the self-only premium for a typical platinum-level plan, projected forward to the year 2018, would be $16,689 in San Francisco, California, but $10,831 in Huntington, West Virginia—due solely to differences in area-specific health care costs and area-specific network discounts.

The entity liable for paying the excise tax (Notice, Section III)

For NEA affiliates with members in self-insured health plans, a key excise tax-related issue is likely to be how regulators define "coverage provider." The ACA indicates that "coverage providers" are responsible for paying the excise tax.[2] For fully insured plans, the coverage provider is the insurance company. The entity considered the coverage provider for self-insured plans, however, is not so clear under the statute. For self-insured plans, the coverage provider is "the person that administers the plan benefits"[3] (with the understanding that, in this context, "person" really means "entity"). Given that the statute does not define "the person that administers the plan benefits," it is not clear to regulators what should cause an employer or a different entity to be responsible for paying the tax. Regulators are considering two possible ways to approach the issue.

1. The person that administers the plan would be the entity "responsible for performing the day-to-day functions that constitute the administration of plan benefits, such as receiving and processing claims for benefits, responding to inquiries, or providing a technology platform for benefits information."[4] In general, this would be the third-party administrator (TPA) if one is used for this purpose.

2. The person that administers the plan "would be the person that has the ultimate authority or responsibility under the plan or arrangement with respect to the administration of the plan benefits (including final decisions on administrative matters), regardless of whether that person routinely exercises that authority or responsibility."[5] Regulators indicate that, for this purpose, "the relevant types of administrative matters over which the person that administers plan benefits would have ultimate authority or responsibility could include eligibility determinations, claims administration, and arrangements with service providers (including the authority to terminate service provider contracts)."[6] In this context, the administrator would not necessarily be the entity responsible for the day-to-day routine administration of the plan; rather, it would more likely be the entity identified in plan documents as having ultimate decision-making authority.

Some third-party administrators (TPAs) exert substantial control over plan design and benefits-related decision-making, so we are concerned that if such TPAs are not responsible for paying the excise tax, they will lack incentive to identify appropriate cost-saving measures of their own. On the other hand, we are also concerned that if TPAs pass on both the cost of the tax and the cost of any income tax on reimbursed taxes, employers and, ultimately, employees may be exposed to even greater harm by the tax. In addition, it is common for the day-to-day

[2] 26 U.S.C. 4980I (c)(1).
[3] 26 U.S.C. 4980I (c)(2)(C).
[4] Notice, section III(B), p. 4.
[5] Notice, section III(B), pp. 4-5.
[6] Notice, section III(B), pp. 4-5.

administration of different components of our members' plans to be handled by different entities, a reality that would complicate excise tax-related decision-making should "coverage provider" be defined in terms of day-to-day administrative authority. For these reasons, we would support rules establishing the person (entity) with ultimate decision-making authority as the coverage provider, as established in plan documents.

Employer aggregation (Notice Section IV)

Absent pre-existing standards for employer aggregation in the public sector, we would support an approach similar to the one adopted in regulations related to IRC section 4980H (shared responsibility for employers). Those regulations, which refer only to private sector aggregation rules, indicate that governmental employers should make a "reasonable, good faith interpretation" of the private sector rules.[7]

Taxable period/cost of applicable coverage (Notice Section V-A)

Under the statute, the excise tax on high-cost plans is to be determined and paid for "taxable periods," which the statute says is a calendar year or some other shorter period.[8] The statute also indicates that the taxable period could vary depending on employer size.[9] In effect, that language recognizes that the taxable period need not be the calendar year in every case. The Notice indicates that regulators anticipate issuing regulations identifying the calendar year as the taxable period for all employers.[10]

Given that plan year start dates for NEA members' plans vary widely, we are concerned about unnecessary administrative complexities that would result from the taxable period being set as the calendar year for every employer. We urge Treasury and the IRS to allow usage of the plan year as the taxable period. At a minimum, taxpayers should be permitted to extend the due date for the payment of the tax imposed by IRC section 4980I to allow for the determination of costs as per the processes and plan years in place.

Determination period/cost of applicable coverage (Notice Section V-B)

The Notice indicates that Treasury and the IRS want employers "to determine the cost of applicable coverage provided during a taxable year sufficiently soon after the end of that taxable year to enable coverage providers to pay any applicable tax in a reasonably timely manner."[11] Although this is a reasonable goal in the abstract, the establishment of a hard deadline for the determination of costs could prove unworkable, particularly if set too short. NEA affiliates report that, in some cases, final costs are not known for as long as a year after the end of the plan year or potentially even longer. Any determination period identified in regulations must allow for

[7] 79 FR 8548.
[8] 26 U.S.C. 4980I(f)(8).
[9] 26 U.S.C. 4980I(f)(8).
[10] Notice, section IV(A), p. 5.
[11] Notice, section IV(B), p. 6.

plans to follow their processes for determining costs without having to worry about artificial deadlines.

In this context, we must also point out that we would not support regulations that, for the determination of the cost of coverage, relied only on the estimation of future costs. No matter how well done the underwriting or actuarial estimates, such estimates will almost always turn out to need after-the-fact adjustment without which excise taxes could potentially be collected based on inaccurate costs.

Exclusion from the cost of coverage of amounts attributable to the tax/cost of applicable coverage (Notice Section V-C)

If an entity other than an employer is responsible for paying the excise tax, that entity is likely to require the employer whose employees' coverage generate the tax to reimburse it for the amount of the excise tax it pays. That reimbursement, however, will generally be considered taxable income to for-profit entities that receive it. Given that excise tax payments are not deductible,[12] NEA members' employers could ultimately face two excise tax-related costs:

1. The excise tax reimbursement—reimbursement paid to the coverage provider that pays the excise tax, and

2. Income tax reimbursement to cover additional income tax paid by the coverage provider that receives excise tax reimbursement.

The Notice indicates that it "may not be feasible to exclude amounts that are not separately billed."[13] As a result, regulators "anticipate that coverage providers would be permitted to exclude the amount of any excise tax reimbursement or income tax reimbursements only if it is separately billed and identified as attributable to the cost of the excise tax."[14]

NEA believes that separate billing may be the most feasible approach for handling reimbursements. However, we urge that rules for transparency be included in regulations related to billing related to excise tax payments and reimbursements. In our experience, when premium- and rate-setting take place behind closed doors, costs are more likely to be exaggerated and, as a result, our members are more likely to unwittingly pay a portion of overpriced premiums or premium equivalents. The same is likely to be true of the pass-through of the excise tax.

Given that the statute explicitly calls for the exclusion of excise tax payments from the determination of the cost of coverage in IRC section 4980I(d)(2)(A), regulators have a statutory basis for ensuring that transparency requirements are woven into the process related to excise tax payments and reimbursements. Without such transparency, coverage providers could—intentionally or not—include tax payments within the cost of coverage under this section. The

[12] 26 U.S.C. 4980I(f)(10).
[13] Notice, section V(C), p. 7.
[14] Notice, section V(C), p. 7.

process should require detailed disclosure to plan participants and their union representatives of all excise tax-related calculations in a standard and easy-to-understand format.

Cost of coverage/allocation of contributions to HSAs, Archer MSAs, FSAs, HRAs

The Notice indicates that regulators are considering a rule under which "account-based plans would be allocated on a pro-rata basis of the period to which the contribution relates (generally, the plan year), regardless of the timing of the contributions during the period.[15] In general, this approach appears workable, as long as appropriate rules are in place to exclude certain account-based costs from the cost of coverage. In our comments on Notice 2015-16, we outlined the costs we believed should be excluded, including FSA, HRA, or HSA funds used to reimburse costs associated with otherwise excludable limited-scope dental or vision plans and HSAs that are not group health plans.[16]

Cost of coverage/health FSAs with employer flex credits (Notice Section V-F)

Health FSA account balances can include contributions from pre-tax employee salary reductions and/or from employer flex credits. The statute generally indicates that, for excise tax purposes, the cost of coverage for health FSAs is the greater of the amount of an employee's salary reduction or, if there is an employer contribution on top of the employee salary reduction amount, the amount reimbursed by the FSA.[17]

As indicated in the Notice, the statutory language could potentially lead to the double-counting of salary-reduction amounts if an employee carries amounts over from one year to the next. Regulators suggest two possible safe harbors to address carryovers. The important goal of avoiding the double counting of contributions in the contexts described in the Notice does appear to require safe harbors, and NEA would support their use if less complex mechanisms for excluding carryover amounts cannot be identified.

Age and gender adjustment to the taxable thresholds/determination of age and gender distribution (Notice Section VI-A)

The Affordable Care Act's excise tax on high-cost plans includes an "age and gender adjustment."[18] The adjustment is designed to compensate for the fact that the age and sex of plan members affects plan costs. Under this section of the law, the taxable thresholds will be higher—meaning taxes will be lower—to the extent that the age and sex of an employer's employees would lead to higher-cost health coverage than health coverage priced using the age and sex characteristics of the national workforce. This component of the ACA was included to correct for

[15] Notice, section V(E), p. 10.
[16] National Education Association, comment letter on Notice 2015-16, pp. 3-4.
[17] 26 U.S.C. 4980I(d)(2(B)).
[18] 26 U.S.C. 4980I(b)(3)(C)(ii).

a serious problem that legislators knew could result from IRC section 4980I: tax liabilities generated due to the age and sex of plan members.[19]

On average, NEA members tend to come from a higher-cost demographic relative to the national labor force (being, on average, older and in plans with a higher proportion of women), so the adjustment is likely to be significant for NEA members in many cases. The statute, though, is vague or confusing as to the specifics of the adjustment, so regulators' decisions will play a significant role in determining how effectively the goal of countering the discriminatory impact of the excise tax is met.

One of the first steps in calculating the age and gender adjustment will be to determine the age and sex characteristics of the employer's work force and the same characteristics of the national workforce. The adjustment is the dollar-based difference in the cost of a benchmark plan when priced based on these demographic factors.[20]

The term "national workforce" will need to be defined by regulators, because no official data set is defined that way. The Notice suggests using a table from the Current Population Survey that provides seasonally adjusted age and sex data excluding the unemployed.[21] Instead, NEA urges Treasury and the IRS to use a data set consistent with a broad, common sense understanding of the term "national workforce," one that is based on the civilian labor force and includes both employed and unemployed workers. We believe it appropriate to include unemployed individuals in the data set because, in some circumstances, such people can be covered under employer-sponsored insurance, including, for example, those with COBRA continuation coverage. The data set more reflective of an appropriate definition of "national workforce" can be found in Current Population Survey Table 03: http://www.bls.gov/cps/cpsaat03.htm.

With respect to when an employer's workforce demographics must be determined, the Notice suggests that employers use a snapshot date that is the first day of the plan year. We encourage regulators to allow employers to use a different snapshot date, both to allow employers and employees to anticipate plan design changes and to make it more likely that work force demographics are representative of the age and sex distribution of employees generally expected to be employed. In some education contexts and depending on when plan years begin, the regular fluctuation of personnel could lead to differences between expected demographics and the demographics at the beginning of the plan year. Such fluctuation could occur at the end of an academic year, when some turnover can take place, or when employees without a contract or reasonable assurance that they will resume work after summer break receive unemployment insurance during that time but are then rehired when summer ends.

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[19] On February 22, 2010, the White House announced changes to proposed legislative language on the excise tax that it said would "ensure that the tax affects firms equitably…by including an adjustment for firms whose health costs are higher due to the age or gender of their workers." The White House, "The President's Proposal," February 22, 2010. Available on the Internet at: https://www.whitehouse.gov/sites/default/files/summary-presidents-proposal.pdf. NEA access date: April 20, 2015.

[20] 26 U.S.C. 4980I(b)(3)(C)(ii).

[21] Notice 2015-16, III(D), pp. 13-14. The data set can be found at http://www.bls.gov/web/empsit/cpseea08a.htm.

Age and gender adjustment to the taxable thresholds/development of age and gender adjustment tables (Notice Section VI(B))

One of the many complicated components of the age and gender adjustment is the methodology established in the statute for determining the adjustment: A benchmark plan (the Federal Employees Health Benefit Plan's Blue Cross/Blue Shield standard option) is to be priced using the age and sex characteristics of the employer and of the national work force, and the dollar-based difference between the two is the adjustment (although, as reiterated in the Notice, the adjustment can only increase the taxable thresholds and cannot decrease them).[22]

Rather than price the benchmark plan independently for purposes of the adjustment, regulators suggest the following process:[23]

> **STEP ONE: Determine the average cost for the benchmark plan's coverage.** All claims expenses would be aggregated and divided by the number of "coverage units" (with each policyholder being a coverage unit). The Notice indicates that either actual claims data for the benchmark plan will be used or national claims data for a plan with a design similar to the benchmark plan will be used.
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> NEA believes it better to use claims data for a plan with a design similar to the benchmark plan and that has a demographic profile similar to that of the national workforce. Under the methodology proposed by regulators, such claims data would lead to a distribution of expenses more reflective of the average cost for each age and sex group and, therefore, group ratios more reflective of the national workforce. We believe that the age and sex distribution of participants in the benchmark plan are skewed far more toward older and Medicare-eligible individuals than the national workforce.
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> **STEP TWO: Determine the average cost for each age and gender group.** The claims data would be separated into male/female groups and separated into multi-year age groupings. The average cost for a particular sex/age group would be determined by dividing the claims for that group by the number of coverage units in that group.
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> **STEP THREE: Determine group ratios.** Each average group cost would be divided by the average cost of the benchmark plan to establish the ratio of the group average cost to the benchmark plan's average cost. This ratio would be determined periodically but not annually.
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> **STEP FOUR: Determine group premium cost.** The group ratio would be multiplied by the most recent annual premium cost of the benchmark plan. The dollar amounts representing each group premium cost would be used to populate an adjustment table.
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> NEA recognizes and appreciates regulators' attempt in this stage of the methodology to establish a relatively simple way to determine the price. Our concern is that the actual

[22] Notice 2015-16, IV, p. 13.
[23] Notice 2015-16, IV(B), pp. 14-15.

premiums for the benchmark plan can be set based, in part, on factors other than the costs of providing coverage. For example, the premium for self-only coverage can be subsidized by the premium for family coverage, or vice versa. In addition, one or both premiums could be adjusted by the carrier to respond to perceived competitive pressures within the pool of plans offered to federal employees.

When we modeled the methodology, we found that subsidization of one premium by the other appeared to affect the resultant age and gender adjustment. To correct for the fact that the premiums of the benchmark plan are not a pure reflection of the cost of the plan, Treasury and the IRS could use (or contract with an appropriate firm to apply) a standard methodology for pricing the benchmark plan's design using the age and sex characteristics of the national workforce. The resultant premium for self-only coverage could then be used to develop continuance tables. The premium for family coverage should be determined using the ratio of the self-only taxable threshold to the other-than-self-only threshold (1:2.7).

Should the approach in the preceding paragraph prove unworkably complicated for Treasury and the IRS to implement, we believe regulators could minimize the potential distortion in the age and gender adjustment that stems from using actual benchmark premiums by using only the premium for self-only coverage premium. In this approach, the family coverage continuance table would then be developed using the ratio of the self-only taxable threshold to the other-than-self-only taxable threshold.

STEP FIVE: Determine national premium cost. To determine the cost of the premium priced for the national work force, each group premium cost would be multiplied by the fraction of employees in the national work force who are in that group. The product of each calculation in this step would be added together to yield the national premium cost. Regulators would publish this amount annually.

STEP SIX: Determine the employer's premium cost. Each employer would determine the fraction of its employees who are in each age and gender group. Then, the employer would multiply the group premium cost from the relevant adjustment table by the fraction of its employees in each group. The product of these calculations would be added together to yield the employer's premium cost.

STEP SEVEN: Determine the adjustment. The employer's premium (Step Six) and the national premium (Step Five) would be compared to determine the adjustment. If the employer premium is larger than the national premium, the adjustment would be the dollar-based difference. An online calculator into which the age and sex of an employer's employees could be entered would be very helpful.

The Notice requests feedback on whether the age and gender adjustment should factor in the age rating scale adopted in regulations for the individual and small group market. NEA believes that it would be inappropriate for regulations related to IRC section 4980I to factor in that scale. The statute does not recognize different adjustments based on plan size. Establishing

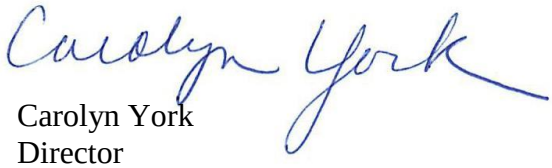
separate adjustments based on plan size would be inappropriate, therefore, and applying individual and small group ratings criteria to larger group plans would be conceptually untenable. Applying the individual and small group age banding for purposes of the age and gender adjustment would alter the pricing of the plans and the group ratios in Step Three of the proposed methodology.

Notice and payment/notice of calculation of applicable share of excess benefit (Notice Section VII(A))

In some states, employees receive health benefits through a pooled group health plan offered through a voluntary employee beneficiary association (VEBA) or other pooled arrangement offering insured products. In such instances, the VEBA or other pooled arrangement could potentially more efficiently and cost-effectively notify the Secretary and each coverage provider of the employer-specific amounts of the excess benefit subject to the tax imposed by IRC section 4980I(a). With the goal of minimizing cost and administrative burden, we urge that Treasury and the IRS permit (not require) VEBAs or other pooled arrangements to be the entity that notifies the Secretary and coverage provider as per IRC section 4980I(c)(4)(A)(ii).

Thank you very much for your attention.

Sincerely,



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