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Ohio Public Employees Retirement System

September 29, 2015

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

Submitted via E-Mail to: Notice.comments@irs.counsel.treas.gov

Re: Notice 2015-52, Section 4980I — Excise Tax on High Cost Employer-Sponsored Health Coverage

Dear Commissioner Koskinen:

The Ohio Public Employees Retirement System (“OPERS”) appreciates the opportunity to provide comments to the Internal Revenue Service (“IRS”) and the Department of the Treasury (“Treasury”) on Notice 2015-52, Section 4980I — Excise Tax on High Cost Employer-Sponsored Health Coverage (“the Notice”). Previously, OPERS submitted comments on May 15, 2015, on Notice 2015-16, which was the first issuance of guidance on the excise tax on high cost employer-sponsored health coverage (the “Excise Tax”).

With assets of \$91.2 billion, OPERS is the largest state pension fund in Ohio, the 11th largest public retirement system and the 15th largest retirement system in the United States. The system provides retirement, disability and survivor benefit programs for public employees throughout the state and currently services more than 1 million members, including 347,000 active employees and over 203,000 retirees and beneficiaries who are receiving monthly pension benefits, which may include health care coverage.

OPERS operates three retirement plans that provide retirement benefits for most of Ohio’s public employees: a traditional defined benefit plan (the “Traditional Pension Plan”); a defined benefit plan with elements of a defined contribution plan (the “Combined Plan”); and a defined contribution plan (the “Member-Directed Plan”) (together, the “Retirement Plans”). The

Retirement Plans are funded by a combination of employer contributions, employee contributions, and the return on investments of such contributions.

OPERS provides retiree health care coverage for 226,000 eligible benefit recipients of the Traditional Pension Plan and the Combined Plan (including eligible spouses and dependents) who have at least ten qualifying years of employer contributions at retirement. These eligibility requirements increased to twenty qualifying years of employer contributions and age 60 (or any age with 30 qualifying years of employer contributions) for employees retiring from the Traditional Pension Plan or Combined Plan on or after January 1, 2015.

In addition, approximately 3,500 participants in the Member-Directed Plan gradually vest in a Retiree Medical Account (an “RMA”) funded by a voluntary employee beneficiary association (“VEBA”) within the meaning of Section 501(c)(9) of the Internal Revenue Code (the “Code”). The RMA can be used to pay for qualified medical expenses after the participant retires or otherwise separates from public employment and receives a complete distribution of his or her account in the Member-Directed Plan.

Effective October 1, 2015, Medicare-eligible retirees who are participants in the Traditional Pension Plan or Combined Plan and satisfy the age and employer contribution requirements will be eligible to receive a monthly HRA allowance to use toward the purchase of an individual Medicare Advantage or a Medicare Supplement plan and a Medicare Part D prescription drug plan.

OPERS’ eligible benefit recipients include pre-Medicare participants (those under age 65), Medicare eligible participants (age 65 and older), and disability benefit recipients. In 2016, it is estimated that the OPERS Health Care Fund (the “Fund”) will provide retirement health care coverage to over 75,000 non-Medicare eligible retirees/dependents and approximately 149,000 Medicare eligible retirees/dependents in the Traditional Pension Plan and Combined Plan. These numbers include almost 20,000 disabled retirees (disabled dependents are not included in this count).

OPERS is one of a relatively few retirement systems to set aside assets to pre-fund retiree health care coverage. The health care trust fund is one of the strongest in the nation at approximately 62% funded. At the end of 2014, OPERS’ estimated health care funding liability was \$19.4 billion, while funding value of assets within the fund were \$12.1 billion.

Even taking into account the Fund’s strong financial position (particularly relative to other large public retirement systems), offering OPERS retirees continued access to quality health care coverage has become increasingly difficult due to the significant increase in costs that a retiree-only plan faces when compared to an active employee plan. In addition to the regular cost increases that OPERS faces due to the high number of baby boomers who have retired and are continuing to retire, a number of current health care components also disproportionately impact

retiree-only plans. These components include (1) the need for more expensive, quality health care later in life (e.g., approximately 27 percent of an individual's lifetime health care costs are in the last 6 months of life); (2) higher rates of specialty prescription drug costs for those retirees under age 65; and (3) the higher cost of services for plans, like OPERS', that provide health care coverage to disabled retirees, who are more likely to incur higher health care costs due to their disability. For example, in 2014, the average dollar amount paid for an OPERS disabled non-Medicare benefit recipient was 2.66 times higher than a non-disabled non-Medicare benefit recipient.

Given the disproportionately higher costs that OPERS incurs on a consistent basis as a retiree-only plan, we will be heavily impacted by the administration and imposition of the Excise Tax. We understand that the Notice and Notice 2015-16 are just the initial steps in the ongoing process of implementing the Excise Tax. We are concerned, however, that the Excise Tax will have a profound effect on retiree-only plans like OPERS that are already impacted by rising health care costs due to health care inflation and the disproportionate costs associated with health care coverage for a retiree population. Ultimately, our hope is that an exemption from the Excise Tax, which was enacted to generate tax revenue, be created for retiree-only health care plans such as that offered by OPERS, which is not an employer but is a tax exempt governmental plan striving to offer quality health care coverage to its retirees. We recognize that such an exemption from the Excise Tax would require legislative action.

As an employer, OPERS offers a health care plan, which includes medical and prescription drug coverage, to its approximately 600 employees. Additionally, OPERS employees have the option of contributing to a flexible spending account (FSA) through pre-tax payroll deduction that can be used for the payment of certain medical expenses. OPERS anticipates that, over time, the Excise Tax will impact the health care plan and FSA offered its employees while the health care plan that OPERS, as governmental plan, offers its retirees will be immediately impacted.

We appreciate the opportunity to provide comments regarding the Notice and look forward to continuing to work with the Treasury and the IRS as they issue guidance on implementing this tax. If you have any questions, please contact Ellen Leach, Associate Counsel at eleach@opers.org or (614) 222-0050.

Our detailed comments are attached to this letter.

Respectfully,



Karen E. Carraher
Executive Director
Ohio Public Employees Retirement System

**Comments and Recommendations on Notice 2015-52, Section 4980I — Excise Tax on
High Cost Employer-Sponsored Health Coverage**

**1. Treating the Person that Administers Plan Benefits as the Person Liable for the Section
4980I Excise Tax**

Issue:

Code section 4980I(c)(1) provides that the coverage provider is liable for the Excise Tax. Under the statute, in the case of applicable coverage other than coverage provided under an insured group health plan or under an HSA or an Archer MSA, the coverage provider is the “the person that administers the plan benefits.” Code section 4980I(c)(2)(C).

In the Notice, Treasury and IRS invite comments on whether the person that administers the plan benefits would be (1) the person responsible for performing the day-to-day functions that constitute the administration of plan benefits, or (2) the person that has the ultimate authority or responsibility under the plan 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. Comments are also requested on whether the person that administers the plan benefits would be easy to identify in most circumstances under either of the two approaches identified above.

Comment:

We recommend that IRS and Treasury adopt the Notice’s second proposed approach under which the person that administers plan benefits (and is thus, liable for payment of the Excise Tax) is the person that has the ultimate authority or responsibility under the plan with respect to the administration of plan benefits (including final decisions on administrative matters), regardless of whether that person routinely exercises that authority or responsibility. For purposes of this approach, we agree with the suggestions in the Notice that this person (or entity) would be identifiable based on the terms of the plan document, and that the relevant types of administrative matters over which this individual or entity 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).

Determining the person(s) liable for the Excise Tax under this “ultimate authority” approach will be administratively simple for the IRS as large governmental plan sponsors like OPERS generally are vested with ultimate decision-making authority for healthcare plans, regardless of whether the plan sponsor performs the day-to-day administrative functions of the plan itself or contracts with a third party administrator. This approach is also administratively simpler for

governmental plans that cover large active and retiree populations as the calculation and payment of the Excise Tax can be more efficiently determined by a single entity, the plan sponsor.

2. Application of Dollar Limit Adjustments

Issue:

It is currently unclear how the dollar limit adjustments provided in Section 4980I(b)(3)(C)(iv) operate in conjunction with one another.

Comment:

Code section 4980I(b)(3)(C) provides baseline per-employee, annual dollar limits for 2018 and then provides for various possible adjustments that will apply to increase these dollar limits. Notice 2015-16 provides that IRS and Treasury intend to include rules on these adjustments in proposed regulations and request comments on the adjustment of the dollar limits. Under these adjustments, employers will be permitted to adjust the applicable dollar limit based on several factors, including gender, age, qualified retiree status, and participation in a plan sponsored by an employer the majority of whose employees covered by the plan are engaged in a high risk profession. It is still unclear, however, how the various dollar limit adjustments operate in conjunction with one another. Governmental plans like OPERS with significant retiree-only populations need to understand how the various dollar adjustments will operate in tandem with each other in order to project the possible impact of the Excise Tax and design the most cost-effective benefit package they can offer to properly manage the Excise Tax.

We request that Treasury and IRS make clear that the various adjustments apply in the aggregate – e.g., any age and gender adjustment would apply in addition to any adjustments to the applicable dollar limit for qualified retirees and employees in high risk professions. Specifically, Treasury and IRS should issue guidance clarifying that the applicable dollar limit for each participant should be determined by (1) adding any applicable age and gender adjustment to the baseline per-participant annual dollar limit of \$10,200 (adjusted for inflation), and (2) then adding the exception amount (\$1,650 for individuals or \$3,450 for family coverage, adjusted for inflation) for a participant who is a qualified retiree (and their qualified dependents if family coverage).

Also, as requested in our prior comment letter to Notice 2015-16, with respect to determining whether an individual is a “qualified retiree” and therefore eligible for the exception amount provided under Section 4980I(b)(3)(C)(iv), we encourage Treasury and the IRS to provide an exemption from the age 55 requirement for public plans that recognize retirement eligibility for individuals under the age of 55 who have attained certain service requirements and otherwise meet the requirements of Section 4980I(f)(2). The requirement that individuals attain age 55 to

be considered a “qualified retiree” currently excludes certain individuals under the age of 55 who otherwise would qualify as an eligible retiree under the terms of their applicable plan as a result of having attained certain service requirements. Excluding such individuals has the potential to result in uneven application of the adjustment to the dollar limit for retirees as the increased dollar limit for coverage could be applied for certain eligible retirees age 55 and over, but not for retirees under age 55 who similarly qualify for retiree status under the terms of their health plan.

3. Age and Gender Adjustment to the Dollar Limit

Issue:

Section 4980I(b)(3)(C)(iii) provides generally for a possible increase in the applicable dollar amounts for an employer if the age and gender characteristics of the employer’s workforce are different from those of the national workforce. Specifically, it provides that the applicable dollar limit is increased by an amount determined based on the excess of the premium cost of the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan (“FEHBP”) for a type of coverage priced on the age and gender characteristics of the employer’s workforce compared to the premium cost of the coverage priced for the age and gender characteristics of the national workforce. In the Notice, Treasury and IRS indicate they are considering using the Current Population Survey as 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 Bureau of Labor Statistics.

Treasury and IRS invite comments on whether Table A-8a and the Current Population Survey more generally is an appropriate source of data for the age and gender characteristics of the national workforce for purposes of Section 4980I and whether other sources of data for the age and gender characteristics of the national workforce should be considered.

Comment:

For purposes of determining the age and gender characteristics of the national workforce, we support and recommend that Treasury and IRS use the Table A-8a published annually by the Department of Labor Bureau of Labor Statistics. We believe that the Table A-8a, which provides the number of participating individuals by five-year age bands and the ratio of male to female workers in each age-band, is an appropriate source of data for the age and gender characteristics of the national workforce.

4. Determination Period for the Cost of Applicable Coverage

Issue 1:

Treasury and IRS indicate in Section V.B. of the Notice that employers will be required 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 timely manner. The Notice states that “...[i]f the cost of applicable coverage is determined based on a period ending at or before the beginning of the applicable calendar year, then the necessary information should be available to the employer ‘relatively soon’ after the applicable calendar year ends to permit it to calculate any excess benefit for each employee and allocate any excess benefit among coverage providers.” Treasury and IRS have invited comments on any issues raised by the anticipated need to determine the cost of applicable coverage for the taxable period.

Comment 1:

We request that Treasury and IRS clarify or provide further guidance as to what length of time is considered to be “sufficiently soon” or “relatively soon” after the end of the taxable year to enable coverage providers to calculate any excess benefit for each participant and allocate any excess benefit among coverage providers. We recommend that Treasury and IRS provide a minimum period of at least 60 days after the end of the taxable year to allow coverage providers to calculate any excess benefit for each participant and allocate any excess benefit among coverage providers.

Issue 2:

Section V.B of the Notice provides that experience-rated arrangements may provide for payments to be made or discounts to be applied after the end of a coverage period that relate back to the coverage provided during that coverage period. Treasury and IRS have requested comments on how such payments or discounts may be reflected in the total cost of applicable coverage, including comments on any administrative issues that might arise if the payments or discounts are attributed back to the original period of coverage rather than accounted for during the period of coverage in which the amounts are paid or the discounts applied.

Comment 2:

For purposes of recognizing payments or discounts associated with experience-rated arrangements, we recommend that IRS and Treasury adopt an approach whereby the plan sponsor reports a subsequent payment or discount related to the original period of coverage in the year that the payment or discount is received (i.e., on a cash basis), rather than applying the subsequent payment or discount to the original coverage period. Recognizing such amounts on a cash basis is significantly simpler and would be administratively feasible for large governmental

plans because the plan sponsor would not be required to revise applicable tax filings and returns in order to recognize subsequent payments or credits.

5. Exclusion from Cost of Applicable Coverage Amounts Attributable to the Excise Tax

Issue:

Section V.C. of the Notice provides that the IRS and Treasury anticipate that, if a person other than the employer is the coverage provider liable for the Excise Tax, that person may pass through all or part of the amount of the Excise Tax to the employer in some instances. In determining the cost of applicable coverage, Section 4980I(d)(2)(A) provides that “any portion of the cost of such coverage which is attributable to the tax imposed under this section shall not be taken into account.” The Notice provides that this indicates that the Excise Tax reimbursement should be excluded from the cost of applicable coverage and that it is anticipated that future regulations will reflect this interpretation. Treasury and the IRS anticipate that the amount the coverage provider passes through to the employer for reimbursement may also include an additional amount to account for the additional income tax the coverage provider will incur by receiving the Excise Tax reimbursement. The Notice provides that IRS and Treasury are also considering whether some or all of the income tax reimbursement could be excluded from the cost of applicable coverage and requests comments on administrable methods for exclusion of the reimbursement.

Comment:

We support the Notice’s proposed approach that all of the Excise Tax reimbursement should be excluded from the cost of applicable coverage in the future regulations. We also support the approach to exclude all of the income tax reimbursement from the cost of applicable coverage.

6. Allocation of Contributions to HSAs, Archer MSAs, FSAs, and HRAs

Issue:

Section 4980I(d)(1)(A) indicates that applicable coverage includes coverage under certain HSAs, Archer MSAs, FSAs, or HRAs. In determining the cost of coverage for such accounts, Section 4980I(d)(2)(D) provides that if the cost of applicable coverage is determined on other than a monthly basis, the cost is allocated to months in a taxable period on such basis as the Secretary may prescribe.

Section V.E. of the Notice indicates that Treasury and the IRS are considering an approach under which contributions to account-based plans would be allocated on a pro-rata basis over the

period to which the contribution relates (generally, the plan year), regardless of the timing of the contributions during the period. It is anticipated that this allocation rule would apply to HSAs, Archer MSAs, FSAs, and HRAs that are applicable coverage.

Comment:

We recommend that Treasury and IRS adopt the approach proposed in the Notice under which contributions to account-based plans, including HSAs, Archer MSAs, FSAs, and HRAs that are applicable coverage, would be allocated on a pro-rata basis over the plan year, regardless of the timing of the contributions during the period. While OPERS, as an employer, offers its employees an optional FSA, participation in a FSA is not an option offered by OPERS under its retiree-only health care plan. It would be administratively complex and costly for OPERS to determine the cost of applicable coverage for such accounts on a basis (e.g., monthly or quarterly) other than an annual basis. OPERS can more easily determine the cost of applicable coverage for these accounts, by ratably allocating the annual amounts of employee and employer contributions made during the plan year.

7. Cost of Applicable Coverage under FSAs with Employer Flex Credits

Issue:

Section 4980I(d)(2)(B) indicates that the cost of applicable coverage of an FSA for any plan year will be the greater of the amount of an employee's salary reduction or the total reimbursements under the employee's FSA. The Notice indicates that under this general rule, in determining the portion of the cost of applicable coverage attributable to non-elective flex credits contributed to an FSA by an employer (either in combination with employee salary reduction contributions or without), the cost of the non-elective flex credit would be the amount that is actually reimbursed in excess of the employee's salary reduction election for that plan year. Under this general rule, the cost of applicable coverage of the FSA would not be known until some point in time after the end of the taxable year. With regard to amounts carried over to a subsequent year, this rule would take such amounts into account in a later year if the reimbursements in the subsequent year exceeded the amount of employee salary reduction in the subsequent year.

To avoid the double counting inherent in the above approach, Treasury and IRS have proposed providing a safe harbor under which the cost of applicable coverage for the plan year would be the amount of an employee's salary reduction without regard to carry-over amounts. Unused amounts that are carried forward would be taken into account when initially funded by salary reduction, but would be disregarded when used to reimburse expenses in a later year. This safe harbor would be limited to cases in which non-elective flex credits are not available for use in the FSA. Treasury and the IRS invite comments concerning whether these potential approaches, including the proposed safe harbor, are administrable.

Comment:

As stated above, although OPERS, as an employer, offers its employees an optional FSA, participation in a FSA is not an option which OPERS offers under its retiree-only health care plan. OPERS recommends that Treasury and the IRS adopt the proposed safe harbor method outlined in the Notice for cases in which non-elective flex credits are not available for use in the FSA. Under this safe harbor, the cost of applicable coverage for the plan year would be the amount of an employee's salary reduction without regard to carry-over amounts. Unused amounts that are carried forward would be taken into account when initially funded by salary reduction but would be disregarded when used to reimburse expenses in a later year.