NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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Submitted electronically to:
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CC:PA:LPD:PR (Notice 2015-16)
Room 5203
Internal Revenue Service
PO Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Notice 2015-16

Dear Ladies and Gentlemen:

The National Coordinating Committee for Multiemployer Plans (NCCMP) appreciates the opportunity to provide comments on the above-referenced Notice issued by the Department of Treasury (Treasury) and the Internal Revenue Service (IRS). Notice 2015-16 (the "Notice") describes a number of approaches Treasury and IRS are considering with respect to certain issues under Internal Revenue Code ("Code") § 4980I (the excise tax on high cost employer-sponsored health coverage) and invites comments on these approaches and related issues. Treasury and IRS have indicated that other issues relating to the excise tax will be addressed in a subsequent notice and, after comments have been reviewed, proposed regulations will be issued. NCCMP has both general and specific comments relating to the issues raised in the Notice. NCCMP also looks forward to providing additional comments on issues under § 4980I as further guidance is developed.

The NCCMP is the only national organization devoted exclusively to protecting the interests of the over 20 million active and retired American workers and their families who rely on multiemployer plans for retirement, health and other benefits. The NCCMP's purpose is to assure an environment in which multiemployer plans can continue their vital role in providing benefits to working men and women. The NCCMP is a nonprofit, non-partisan organization, with members, plans and contributing employers in every major segment of the multiemployer plan universe, including in the airline, agriculture, building and construction, bakery and confectionery, entertainment, health care, hospitality, longshore, manufacturing, mining, retail food, service, steel and trucking industries.

BACKGROUND RELATING TO MULTIEMPLOYER PLANS

One of the crowning achievements of collective bargaining over the past 50 years is the creation of thousands of labor-management, multiemployer health and welfare trust funds that provide to covered workers and their dependents various benefit coverages, including medical, hospitalization, preventive and wellness care, prescription drugs, dental care, and vision care. These trust funds are often referred to as "Taft-Hartley funds" because they are regulated by the Labor Management Relations ("Taft-Hartley") Act of 1947, as well as by ERISA and the Code. We note, however, that some single-employer plans may operate as joint labor-management funds and therefore believe the more appropriate term is "multiemployer" plans with respect to comments contained herein.

Multiemployer plans provide health and welfare plan coverage to plan participants and their dependents pursuant to the negotiated wages, hours, and other terms and conditions of employment (including requiring contributions to be made to a multiemployer benefit trust) of a collective bargaining agreement between one or more unions and more than one employer. Even for employees who are not union members but whose work is covered as part of a certified bargaining unit, existing labor law provides that discussions of employee benefits are a mandatory subject of bargaining and therefore subject to negotiation with the union under their status as the statutory bargaining agent. The Affordable Care Act (ACA) did not repeal the Labor Management Relations Act. Relationships are established between employers and employees under the Taft- Hartley Act, and these relationships should continue to be recognized in regulations implementing the ACA.

Health and welfare trust funds cover workers in industries as diverse as agriculture, aerospace, bakery and confectionery, building and construction, trucking, transportation, retail, food production, distribution, and sales, clothing, health care, textiles, service, mining, entertainment, hospitality, maritime, longshore, and manufacturing. But for these trust funds, millions more working families would be uninsured and at risk for financial ruin in the event of a serious illness. Indeed, were it not for these plans, many millions of workers in these funds would not be eligible for coverage even under the enhanced eligibility requirements mandated for employers by the ACA. The transient, project-based, mobile and seasonal employment patterns that characterize many of these industries would prevent workers from obtaining health coverage absent a central, pooled fund through which portable coverage is provided to workers as they move from employer to employer.

GENERAL COMMENTS ON NOTICE 2015-16

The § 4980I excise tax has already begun to impact employment-based health plans, despite the 2018 effective date. Plan sponsors are already examining whether current plan designs will trigger the excise tax and trying to anticipate what benefit designs will be consistent with avoiding the tax. The tax imposes significant new burdens on multiemployer plans, employers, and insurers, from both a planning and compliance perspective. Ultimately, however, it is plan participants who will bear the burden of the tax. Although the tax has sometimes been referred to briefly as the "Cadillac plan" tax, with the implication that only "luxury" health plans will be

affected, it is now well recognized this is a misnomer. The parameters of the tax are such that many fairly basic plans will be affected merely because health care costs continue to increase. The impact may also depend on geographic area, age, and gender. Perhaps it would be more accurate to describe the tax as the "basic transportation car" or even "scooter" tax.

Although the statutory incidence of the tax is placed not on employees, the practical reality of the market place is that the cost will be passed on in one way or another to plan participants and beneficiaries. Given this reality, it is particularly important that Treasury and IRS implement the specifics of the tax in a reasonable manner, and in such a way as to avoid unnecessary burdens on all those affected.

In particular, NCCMP encourages the Treasury and IRS to keep in mind the following general comments as guidance is developed under § 4980I:

- **The details of the § 4980I calculations should fully implement the statutory provisions for multiemployer plans, as contained in § 4980I(b)(3)(B)(ii).** The statute explicitly states: "Any coverage under a multiemployer plan (as defined in [Code] section 414(f)) shall be treated as coverage other than self-only coverage." Consistent with this statutory directive, multiemployer plans are not required to calculate a separate cost for self-only coverage. Self-only coverage is not relevant in the case of multiemployer plans; indeed, the statute specifies that all multiemployer coverage is other than self-only. The Notice correctly follows the statute in this regard; however an example of how cost is determined for multiemployer plans would be helpful. Further details on this issue are provided below.

- **Plans and employers should have flexibility with respect to calculating the cost of applicable coverage.** The Notice indicates that Treasury and IRS may be concerned that providing multiple methods of determining cost may increase administrative complexity and that only one method, at least for some types of coverage, would minimize these concerns. While in some situations it may be true that options increase complexity that is not the case here. Plans and employers will need to create new systems in order to properly plan for and calculate the excise tax, but these systems will be built to some extent on existing practices and systems, which may vary among different plans/employers. For example, given the lack of guidance under COBRA, plans and employers do not currently all calculate COBRA cost in precisely the same way. Allowing flexibility to calculate cost will help reduce administrative burdens and complexity with respect to § 4980I.

- **Strict consistency with COBRA rules for calculating cost should not be required.** The statute provides that cost of applicable coverage is determined under rules "similar to" the rules used for COBRA purposes. § 4980I(d)(2)(A). The Notice references a number of places where § 4980I provides specific rules for determining cost that may be differ from COBRA. Further, because COBRA and § 4980I serve different purposes, there may be many reasons why COBRA and § 4980I cost calculations should be different. We suggest that it is appropriate to focus here on the specific rules for calculating the excise tax, and address COBRA separately.

SPECIFIC COMMENTS ON NOTICE 2015-16

1. Potential Approaches for Determining Cost of Applicable Coverage; Similarly Situated Individuals -- Section IV.C.1.

Notice 2015-16: Section IV.C. proposes to determine a group of similarly situated employees by starting with all employees covered by a particular benefit package provided by the employer, then subdividing that group based on mandatory disaggregation rules, and allowing further subdivision of the group based on permissive disaggregation rules.

NCCMP Comments:

Background

Statutory provisions

Section 4980I(b)(3) provides: "Any coverage provided under a multiemployer plan (as defined in section 414(f)) shall be treated as coverage other than self-only coverage." As a result of this statutory directive, provisions in § 4980I relating to self-only coverage are not relevant for multiemployer plans. Thus, for example, in determining cost, the plan is treated as exclusively providing other-than-self-only coverage (so that a separate determination of cost for self-only coverage is not required). Further, the threshold for other-than-self-only coverage applies in calculating the excise tax.

While the statute is clear on its face, we thought some background on this statutory provision could be of interest. Accordingly, background information and legislative history are discussed below.

History of § 4980I(b)(3)(B)(ii)

The Patient Protection and Affordable Care Act (HR 3590), Public Law 111-148 (PPACA), was enacted on March 23, 2010. The bill that became PPACA passed the Senate on December 24, 2009.[1] The House, in turn, passed the Senate-approved bill, without amendment, on March 21, 2010. The bill was signed by the President two days later. PPACA added § 4980I to the Code, creating the excise tax on high-cost plans. Section 4980I, as originally enacted, did not address multiemployer plans.

After the Senate passed HR 3590, sponsors of multiemployer plans expressed concern about the application of the law to such plans. Specifically, plan sponsors were concerned that plans not be required to consider costs separately for self-only coverage, and other-than-self-only coverage. Multiemployer plans are established differently from single-employer plans, in that the plans are financed by contributions from contributing employers which are made based on the terms of a collective bargaining agreement (CBA). Plan contributions are generally made

[1] The underlying bill, HR 3590, had initially passed the House on October 8, 2009. That bill, however, was unrelated to health care reform. The Senate amendment replaced the House version in its entirety with health care reform provisions; thus, the bill as adopted by the Senate on December 24, 2010, was the bill that was ultimately enacted.

based on the formula set forth in a CBA – the most common of which is a set dollar amount per hour worked, regardless of the type of health coverage an individual receives from the multiemployer plan. For example, an employer could be required to pay $10.00 per hour worked by a covered employee to the multiemployer plan. The plan then would provide health benefits to the employee and their dependents (if any) based on the plan's eligibility rules. Very few multiemployer plans charge employees directly for health coverage. Consequently, the self and other-than-self dichotomy set forth in HR 3590 was unworkable for multiemployer plans.

Subsequently, the Health Care and Education Reconciliation Act of 2010 (H.R.4872), Public Law 111-152 (HCERA), passed the Senate on March 23, 2010 and was signed into law on March 30, 2010.[2] Section 1401 of this law amended the recently-passed PPACA to add the multiemployer coverage rule. Specifically, Code § 4980I, as added by § 9001 of PPACA and amended by § 10901 of PPACA, was again amended to add a new clause:

> "(ii) MULTIEMPLOYER PLAN COVERAGE.— Any coverage provided under a multiemployer plan (as defined in section 414(f)) shall be treated as coverage other than self-only coverage."

The Joint Committee on Taxation (JCT) published a report on the legislation on March 21, 2010.[3] The JCT report is often cited as the only legislative history regarding the taxation provisions of the ACA. Page 63 of the report states:

> For all employees covered by a multiemployer plan, the family threshold applies regardless of whether the individual maintains individual or family coverage under the plan. For purposes of the provision, a multiemployer plan is an employee health benefit plan to which more than one employer is required to contribute, which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer.

Thus, although the legislative history need not be consulted given the clear meaning of the statute, it serves to reinforce this meaning.

Specific comments

Calculating cost for multiemployer plans. Notice 2015-16 reflects the statute by stating that all coverage under a multiemployer plan is treated as other-than-self-only (Sec. IV.A.2.(2)). Thus, disaggregation of self-only coverage is not required in the case of a multiemployer plan, because such plans do not provide self-only coverage for purposes of the excise tax. We recommend that regulations illustrate the treatment of multiemployer plans, such as through an example showing that multiemployer plans calculate costs using the other-than-self-only calculation rules and that the mandatory disaggregation rules for self-only coverage and other-than-self-only coverage proposed by Treasury in Notice 2015-16 do not apply because all multiemployer coverage must

[2] The two laws (PPACA and HCERA) are together referred to as the Affordable Care Act, or the ACA.
[3] *Technical Explanation of the Revenue Provisions of the Reconciliation Act of 2010, as Amended, in Combination with the Patient Protection and Affordable Care Act*, Joint Committee on Taxation, March 21, 2010, JCX-18-10.

be treated as other-than-self-only coverage. Plans would be permitted to calculate an aggregate cost, not separate costs for self-only coverage and other than self-only coverage.

Permissive aggregation within other-than-self-only coverage. In accordance with Notice 2015-16, plans using the other-than-self-only standard could permissively aggregate within other-than-self-only coverage. We agree with the Notice that § 4980I(d)(2)(A) does not require that the cost of coverage be determined separately based on the number of individuals who are receiving coverage in addition to the plan participant. Consequently, we support the permissive aggregation within other-than-self-only coverage set forth in the Notice, which would permit a plan to treat all employees who are enrolled in the same benefit package and who receive coverage for one or more individuals as similarly situated for purposes of determining the cost of applicable coverage for that group.

Aggregation by benefit package. Notice 2015-16 suggests a potential approach for purposes of determining the groups of similarly situated employees that would group employees enrolled in each particular benefit package provided by the employer. We recommend that aggregation by benefit package be permissive but not mandatory. If Treasury and IRS determine that aggregation by benefit package would be mandatory, we recommend that plans be permitted to combine costs for similar benefit packages (e.g., when regional or national plans offer one HMO or PPO option in each state or region so that all participants have the choice of a similar HMO or PPO). Similar plans could be considered those with similar plan designs or similar actuarial value. For self-funded plans, actuarial value could be determined, using rules similar to those used for minimum value purposes. For example, plans within a 5-10 percentage actuarial range would be considered similar benefit packages and costs for those benefit packages would be aggregated. Such an approach would ease administration.

Permissive disaggregation. Notice 2015-16 also proposes rules for permissive disaggregation that would allow but not require employers and plans to subdivide further the group of employees that would be treated as similarly situated. The Notice suggests that permissive disaggregation could be based on employment-related criteria, employees vs. retirees, geographic differences, etc. We recommend that any additional disaggregation factors should be permissive (not mandatory). In addition, we request clarification that costs for active employees may permissively be combined with retirees, but that this combination is not mandatory. Further discussion of determining cost for retirees is also provided below.

2. Health Reimbursement Arrangements (HRAs) -- Section IV.C.3.

Notice 2015-16: Section IV.C.3. states that an HRA will be considered applicable coverage under§ 4980I. Treasury and IRS are considering various methods to determine the cost of coverage under an HRA, including determining the cost of applicable coverage based on the amounts made "newly available" to a participant each year, without taking into account carry-over amounts of amounts prior to 2018. Treasury and IRS are also considering permitting cost determination by adding together all claims and administrative expenses for a particular period, and dividing that sum by the number of covered employees, and considering permitting or requiring an actuarial basis method. Treasury and IRS are also considering whether to include in the cost of coverage an HRA that can only be used to fund the employee contribution toward

coverage and HRA amounts that can fund coverage that is not applicable coverage. The Notice requests information on the extent to which HRAs are used to fund employee contributions and non-applicable coverage.

NCCMP Comments:

Multiemployer plans utilize HRAs in a number of different ways. For example, HRAs may be used to fully or partially fund the cost of coverage under the multiemployer health plan. HRAs may also be used for other health expenses and to cover benefits that are not applicable coverage (e.g., dental or vision coverage). HRAs that are part of multiemployer plans often, but do not always, provide for a carry-over from year to year. Some HRAs are designed to help defray costs only in retirement and cannot be accessed until retirement, even though amounts are credited (or earned) during active employment.

With respect to determining the cost of coverage under an HRA, NCCMP recommends the following:

- Plan sponsors should have flexibility with respect to the method used to determine the cost of coverage under an HRA. Such flexibility is important due to the various different ways in which HRAs may be used. Depending on how an HRA is structured, some methods, for example, such as looking at amounts newly made available, may tend to overstate the actual value of the coverage in a particular year.
    - Permitted options to determine cost should include: (1) looking at amounts newly made available each year, disregarding any carry-over amounts and amounts made newly available before 2018; (2) adding claims and administrative expenses and dividing by number of covered participants; and (3) determining costs on an actuarial basis method.
    - The cost of coverage should not include an HRA that can only be used to fund the employee contribution toward coverage (including any contribution for retiree coverage). Failure to exclude such amounts would result in double counting.

      If the HRA may be used toward the cost of coverage and other benefits, plan sponsors should be able to use any reasonable method, e.g., actuarial estimates, to allocate the cost of the HRA between the different benefits.
    - HRAs that may be used only at retirement should not be factored into the cost of active coverage even though amounts are contributed during active employment.
- The cost of coverage should not include an HRA that reimburses only for excepted benefits that are not subject to the excise tax.
    - If the HRA may be used toward the cost of excepted benefits and benefits that are applicable coverage, plan sponsors should be able to use any reasonable method, e.g., actuarial estimates, to allocate the cost of the HRA between the different benefits.

- Section 4980I calls for the tax to be calculated on a monthly basis. Many HRAs provide for contributions that are intended for an annual or longer period. In such cases, cost must be determined in a manner so as not to overstate the value for any particular period.

3. Dollar Limit Adjustments for High-Risk Professions -- Section V.C.2

Notice 2015-16: Section 4980I(b)(3)(C)(iv) provides that the threshold increases for an individual who participates in a plan sponsored by an employer the majority of whose employees covered by the plan are engaged in a high-risk profession or employed to repair or install electrical or telecommunication lines. The term includes an employee who is retired from a high-risk profession if they met the criteria for not less than 20 years.

The Notice requests comments on how to determine whether a majority of employees are engaged in a high-risk profession and what the term "plan" means in that context, and how an employer determines that an employee was engaged in a high-risk profession for at least 20 years.

NCCMP Comments:

Definition of high-risk professions.

Multiemployer plans provide both health and retirement benefits to participants whose work is high risk and meets the qualifications for the increased threshold under § 4980I. The primary job categories covered by multiemployer plans include individuals whose primary work is in categories listed in the statute -- s longshore work, individuals engaged in the construction, mining, agriculture, forestry and fishing industries, and individuals employed to repair or install electrical or telecommunications lines. Plan participants covered by multiemployer health plans that include workers in these job categories are entitled to the additional threshold.

In determining who qualifies as an individual under the statutory categories we suggest that plans be permitted to choose among different options, including an approach based on Bureau of Labor Statistics (BLS) categories and one based on the North American Industry Classification System (NAICS). Under the BLS approach, high-risk categories should be defined broadly so as to include, at a minimum, all occupations listed by the BLS, e.g., those categories listed in the 2010 Standard Occupational Classification (SOC) system under the categories of 45-0000 Farming, Fishing, and Forestry Occupations and 47-0000 Construction and Extraction Occupations.[4] Additionally, we believe that all jobs under the category "49-0000 Installation, Maintenance, and Repair Occupations" should also be included, in order to assure that the additional workers employed in construction or to repair or install electrical or telecommunications lines are covered. See § 4980I(a)(3)(C)(iv). Furthermore, additional BLS codes will be necessary to accommodate the inclusion of longshore work, which means any activity relating to the loading or unloading of cargo, the operation of cargo-related equipment (whether or not integral to the vessel), and the handling of mooring lines on the dock when the vessel is made fast or let go, in

[4] http://www.bls.gov/oes/current/oes_stru.htm#53-0000

the United States or the coastal waters thereof.[5] These could include, but are not limited to, 53-7121 Tank Car, Truck, and Ship Loaders.

As another option, a high risk individual would include an individual employed by an employer the primary activity of which falls within one of the enumerated industries, following commonly used industry codes such as those under the NAICS (e.g., the major groups for Sector 23-Construction; Sector 21—Mining, Quarrying, and Oil and Gas Extraction; and Section 11—Agriculture, Forestry, Fishing and Hunting) or the related Principal Activity Codes used by the IRS.

In addition to the BLS and NAICS classifications, we recommend that occupations may be considered high-risk if they meet generally accepted classifications of high-risk employment, to be determined by reference to a higher incident of injury than average.

The statutory list of employees who are engaged in a high risk profession is obviously deficient, in that it does not include many workers whose occupations are in fact high-risk. Most notably, workers in the manufacturing, transportation and warehousing, and performing arts, spectator sports and related industries are not specifically listed, but all have higher incidence rates of nonfatal occupational injuries and illnesses than average.[6] Every effort should be made by Treasury and IRS to assure that workers whose occupations are in fact high-risk occupations are entitled to the additional threshold, as their work results in higher health care claim costs.

Retirees.

High-risk employees also include retirees who are retired from the profession, if they satisfied the high-risk definition for a period of not less than 20 years during the employee's employment. We recommend that regulations permit the plan sponsor to determine whether the retiree has 20 years of service in the plan or industry by looking at plan coverage records or other verification of employment during that time period. We recommend that the plan sponsor be entitled to a rebuttable presumption that if the plan has provided coverage for 20 years or the plan otherwise receives verification of 20 years of employment in the industry satisfactory to the plan sponsor, then the retiree is entitled to the higher threshold. We do not recommend requiring the health plan sponsor to use retirement records, as some of these categories may not have had retirement plans (e.g. residential construction) and because those may be inaccurate or may not be available if the retirement plan uses a standard other than "20 years".

Majority of employees.

We recommend that the terminology of the statute that relates to a "majority" of employees of an employer be implemented using a majority of the workers in the multiemployer plan. Majority

[5] 8 U.S. Code § 1288(b).
[6] 2013 Survey of Occupational Injuries and Illnesses conducted by the U.S. Bureau of Labor Statistics, Department of Labor (December 2014) http://www.bls.gov/news.release/archives/osh_12042014.pdf

could be defined based on the same standards that plan sponsors use to aggregate or disaggregate plan participants for purposes of determining the cost of coverage.

4. Definition of Applicable Coverage - Section III

a. Limited Wraparound Benefits

Notice 2015-16: After Notice 2015-16 was issued, the Departments of Treasury, Labor, and Health and Human Services finalized regulations adding limited wraparound coverage that meets certain criteria to the list of excepted benefits.[7]

NCCMP Comments:

Treasury and IRS should exercise their authority under § 4908I(g) to exclude limited wraparound coverage that qualifies as an excepted benefit from applicable coverage. This would be consistent with the approach proposed in Notice 2015-16 with respect to other types of excepted benefits with respect to which administrative guidance has recently been issued, such as employee assistance programs (EAPs) and limited-scope vision and dental benefits.

b. On-Site Medical Clinics -- Section III.E.

Notice 2015-16: Treasury and IRS propose to exclude from the definition of applicable coverage on-site medical clinics that offer only de minimis medical care to employees. The Notice asks for comments on how "de minimis" should be determined and includes a number of possible approaches. Specifically, the Notice asks for comments on excluding on-site clinics that: (1) meet the criteria in the COBRA regulations (i.e., the care is available only to current employees and employees are not charged for use of the facility), and (2) provide the following services (a) first aid during working hours for a health condition, illness or injury that occurs during working hours (as provided in the COBRA regulations), and (b) other services (in addition to or in lieu of first aid), such as immunizations, injections of antigens provided by employees, a variety of aspirin and other nonprescription pain relievers, and treatment of injuries caused by accident at work (beyond first aid). The Notice also seeks comments on related issues.

NCCMP Comments:

NCCMP supports the exclusion of certain on-site medical clinics from the definition of applicable coverage. NCCMP recommends that the list of the types of care that may be provided should be expanded to include (in addition to the types of services listed in the Notice) other coverage of a type provided at typical on-site clinics, such as prescriptions for acute, minor conditions, wellness counseling, weight loss counseling, biometric screening, and routine annual exams.

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[7] Treas. Reg. § 54.9831-1(c)(3)(vii) (80 FR 13995, 14004) (March 18, 2015).

NCCMP recommends that plans be given the option to make the determination as to whether a clinic is applicable coverage based on the nature of the services provided or cost. We also note that determination of cost in the case of clinics raises a number of issues which deserve further consideration. At a minimum, however, cost should not include capital or start-up costs or costs not directly relating to medical services.

The COBRA requirement that the clinic provide services only to current employees is unduly restrictive based on typical practices; some plans operate clinics that are available to all plan participants and beneficiaries, including, for example, retirees. NCCMP believes that the nature of the services provided, rather than the classes of individuals eligible for the services is more relevant to determining whether the services provided are de minimis. Thus, NCCMP recommends that this element of the COBRA rules not apply here.

c. Health Savings Accounts – Section III.B and III.D

Notice 2015-16: The Notice states that employer contributions, including pre-tax salary reduction contributions, to health savings accounts (HSAs) will be taken into account for purposes of the 4980I tax. After-tax contributions to HSAs will not be taken into account.

NCCMP comments: NCCMP agrees that after-tax contributions to an HSA should not be taken into account under the excise tax, as there is no statutory basis for subjecting such contributions to the tax.

With respect to employer contributions to HSAs, however, NCCMP believes that the position in the Notice is overly broad and is not supported by the statute. The definition of "applicable employer-sponsored coverage" in § 4980I(d)(1) requires that the coverage in question must be a group health plan. Treasury and the IRS, along with the Department of Labor (DOL) and the Department of Health and Human Service (HHS), stated early in the ACA implementation process that HSAs generally are not group health plans and, thus, not subject to the ACA reforms, including the prohibition on annual limits on benefits.[8] The DOL has issued guidance in both 2004 and 2006 (FABs 2004-1 and 2006-2) describing situations in which an employer could cause the HSA to become a group plan subject to ERISA's group plan requirements. In most cases, however, employer involvement is limited so as not to trigger ERISA application. IRS and Treasury have generally followed DOL's rules in this regard. The sections of the statute referred to in the Notice, §4980I(c)(2)(B) and §4980I(d)(2)(C), do not change the definitional requirement that "applicable employer-sponsored coverage" must be a group health plan. Rather, these sections address application of §4980I only "if" an HSA is applicable employer-sponsored coverage, i.e., a group health plan. Based on the statutory provisions, NCCMP recommends that HSAs should be taken into account for purposes of the tax only if the HSA is a group health plan, determined under existing rules.

If an HSA is a group health plan, §4980I(d)(2)(C) provides that the cost of coverage is equal to the employer contributions. For this purpose, "employer contributions" should not include salary reduction contributions. In Code § 4980I(d)(2)(B), Congress made a clear distinction between employer contributions and employee pre-tax salary reductions. The lack of a similar reference

[8] See, for example, 75 Fed Reg 37188, at 37190 (June 28, 2010).

when referring to HSAs indicates that Congress did not intend to include salary reduction contributions to HSAs.

d. Limited Scope Dental and Vision Benefits – Section III.F.

Notice 2015-16: Treasury and IRS are considering proposing that self-funded dental and vision benefits that qualify as an excepted benefit are excluded from applicable coverage. This approach would provide consistency between the treatment of fully-insured excepted benefit dental and vision coverage and self-funded coverage.

NCCMP Comments:

NCCMP supports the exclusion from applicable coverage for self-insured dental/vision benefits that are excepted benefits.

5. Retirees: Determining Cost for Retirees; Dollar Limit Adjustments for Qualified Retirees – Sections IV.C.I. and V.C.1.

Notice 2015-16: Section 4980I contains two specific provisions relating to retirees. Section 4980I(d)(2) provides that a plan may elect to treat a retiree who has not attained age 65 and a retiree who has attained age 65 as similarly situated employees for purposes of determining the cost of applicable coverage. Section 4980I(b)(3)(C)(iv) increases the dollar threshold for qualified retirees, defined (in § 4980I(f)(2)) as retirees who have attained age 55 and are not entitled to or eligible for Medicare benefits. Notice 2015-16 reiterates these rules and asks specifically for comments on how an employer determines that an employee is not eligible for enrollment in Medicare.

NCCMP Comment – determining the cost of applicable coverage:

With respect to determining the cost of applicable coverage for plans that provide retiree coverage, NCCMP believes the best reading of § 4980I(d)(2) is that it is a clarification of a permissive rule. That is, calculating costs for different groups of retirees is clearly permitted, but not required, and does not preclude other options.

As part of permissive aggregation/disaggregation, NCCMP recommends that plans should have flexibility as to how to treat retirees. In particular, NCCMP recommends that the following options should be available in determining the cost of coverage:

- Plans may combine or separate pre- and post-age 65 retirees, at the option of the plan.
- Plans may combine pre- and post-age 65 retirees, even if the retirees are enrolled in different benefit packages, including in Medicare Advantage and Part D group plans.
    - This aggregation is clearly supported by the statute.
    - Notice 2015-16 indicates that Treasury and IRS are considering proposing that cost be determined separately for each benefit package. As discussed above, NCCMP recommends that plans be allowed to permissively disaggregate by benefit package.

- If Treasury and IRS do generally require disaggregation by benefit package, permissive aggregation for pre- and post-age 65 retirees is clearly permitted by § 4980I(d)(2). Because of Medicare rules, these groups of retirees will typically be in different benefit packages; thus, the statute would override any administrative rules that might be created with respect to disaggregation by benefit package.

- This approach will also ease administration, particularly for Medicare retirees who have spouses who are not eligible for Medicare and, thus, will be in different benefit packages.

- Plans may combine retirees with active employees for purposes of determining costs.

  - If a plan combines retirees with active employees, the plan may decide whether to combine all retirees, or only pre- or post-age 65 retirees with the active employees.

NCCMP Comments – adjustment to dollar threshold:

Section 4980I(b)(3)(C)(iv) provides that the increase in the dollar threshold applies to "an individual who is a qualified employee." Thus, under the statute, the increase applies regardless of whether pre- and post-age 65 retirees are aggregated for purposes of determining cost or aggregated with active employees (as discussed in the comment just above). Clarification that this is the case would be helpful.

6. **Determining Cost for Self-Insured Plans; Actuarial Basis vs. Past Cost Method – Section IV.C.2.**

Notice 2015-16: Comments are requested on two possible ways for self-insured plans to determine the cost of applicable coverage (both of which, in general, are options in setting COBRA rates):

- **The actuarial basis method**: The cost would be equal to a reasonable estimate of the cost of providing coverage under the plan for individuals in the group for the determination period, using reasonable actuarial principles and practices.

- **The past cost method**: This method determines the cost for a specific period and then applies a specific adjustment factor (the percentage increase or decrease in the implicit price deflator of the gross national product (GNP) over a certain period). Notice 2015-16 lists the costs that plans would take into account under this method: claims, premiums for stop-loss or reinsurance, administrative expenses, and reasonable overhead expenses allocated to the cost of administering the plan.

Notice 2015-16 also states that Treasury and IRS are considering requiring a plan to use the valuation method that it chooses for at least five years. The exception would be a prohibition on using the past cost method where there is a significant difference between periods in coverage

under (or employees covered by) the plan, in which case the plan would need to use the actuarial basis method for two years following the significant change.

NCCMP Comments:

Permitted methods and frequency of changing methods. To allow plan sponsors the greatest flexibility, NCCMP recommends that both methods be permitted and that plan sponsors be permitted to change between methods more frequently than every five years. Indeed, the NCCMP recommends that plan sponsors be allowed to change methods from year to year, as circumstances warrant. The one exception would be similar to the one discussed in Notice 2015-16: plan sponsors would not be allowed to use the past cost method in one year if there is a significant difference between periods in coverage under (or participants covered by) the plan. However, the prohibition on using the past cost method would apply only for that one year.

Inflation adjustments. One of the main concerns that NCCMP has about the excise tax is that the thresholds (e.g., the other-than-self-only threshold, set at $27,500 in 2018) will increase based on the Consumer Price Index (CPI-U) and not the much higher rate of medical inflation. Because the inflation adjustment for the thresholds is set in the statute, the only way to make plan costs and the applicable thresholds follow more parallel trajectories is to apply a comparable inflation adjustment on the cost side as is applied to the threshold. NCCMP suggests two ways to do this: either allow plan sponsors to use the implicit price deflator of the GNP under the actuarial basis method (as well as under the past cost method), or allow plan sponsors to apply the same index (CPI-U) to plan costs as is applied to the threshold when projecting costs.[9]

7. Determination Period – Section IV.D.

Notice 2015-16: The Notice seeks comments on two possible ways of calculating the potential excise tax: one based on a determination period that would permit liability to be known at the beginning of the taxable year generating the tax liability, or one that would use actual costs in the taxable year to determine liability after the end of the year.

NCCMP Comments:

To allow plan sponsors the greatest flexibility, plan sponsors should be permitted to determine costs in advance of the plan year (using the actuarial method or the past cost method), as well as after the plan year (based on actual costs), and determine tax liability (if any) based on the lower of the two.

The surest way to avoid excise tax liability is for plan sponsors to do careful estimates of their potential liability, well in advance and at regular intervals, and to make necessary, corresponding

[9] The reason that very few plan sponsors use the past cost method to determine COBRA rates is that historically the adjustment set out in § 4980B(f)(4)(B)(ii)(II) has been much lower than medical inflation. Using that adjustment when medical inflation is much higher will generally result in a COBRA rate that understates actual plan costs. As a result, while the NCCMP seeks this flexibility for purposes of the excise tax, this approach should not apply to actuarial projections of COBRA rates.

adjustments in plan design over time. Plan sponsors have a strong motivation to do this: the reality is that no plan sponsor wants to incur this tax. As a result, plan sponsors will rely on actuarial estimates of plan costs and make changes to the plan as needed. However, if it turns out that, despite reasonable actuarial estimates of plan costs, the plan incurs costs that are lower than expected, there is no reason why the plan sponsor should not be able to use those lower-than-expected actual costs to determine the tax liability (if any). The excise tax will already have had its intended effect: motivating plan sponsors to change the plan design to lower the overall cost of the plan. Assessing a tax when actual plan costs do not warrant a tax is not appropriate.

By contrast, it would not be appropriate to assess a tax (or a higher tax) when plan costs exceed reasonable projections. Some increases in plan costs can be restrained through careful plan design (e.g., using value-based programs to steer participants to high quality, lower-cost providers). However, even well designed plans will have higher costs when their participants (or their covered dependents) have serious health care problems. Assessing a tax when actual costs exceed reasonable projections would unfairly punish a plan based on the health status of its enrollees in that particular year.

8. Age and Gender Adjustments – Section IV.C.3.

Notice 2015-16: Section 4980I(b)(3)(C)(iii) provides for an increase in the dollar threshold if the age and gender characteristics of the employees of an employer exceed those of the national workforce. Notice 2015-16 requests comments 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.

NCCMP Comments:

Regulations should clarify that the age and gender adjustments apply to multiemployer plans based on the characteristics of the participants in the plan. Because the tax applies if the cost of the plan's coverage exceeds the allowed threshold, calculating any age and gender adjustments should similarly be made based on the plan characteristics. The plan will not have any information regarding the age and gender characteristics of the employees of contributing employers who are not participants in the plan.

NCCMP supports the creation of safe harbors for this purpose in order to make the adjustments more easily calculable. Each year the IRS should publish a standard table of age and gender factors that reasonably reflects morbidity cost by age and gender, along with a table of a standard national employee population. For the age adjustment, Treasury and IRS should construct the table in yearly increments so that, for example, a plan with an average age of 45 would get a higher adjustment than a plan with an average age of 44. The table needs to extend past age 65. This is particularly important for plans with a high number of active participants who are older than 65, because the plan will continue to pay primary to Medicare due to their employment status. Age would be determined as of a specific date (e.g., the midpoint of the plan year or of the taxable year).

Conclusion

NCCMP greatly appreciates the opportunity to comment in advance of rule-making on issues relating to multiemployer plans and the excise tax under § 4980I. Because plan participants will ultimately bear the burden of this tax, it is particularly important that it be implemented so as to reduce needless burdens. We look forward to commenting on additional issues as the guidance process continues. We are more than happy to discuss any questions you may have regarding these comments and related issues.

Respectfully submitted,

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