



April 9, 2015

Office of Associate Chief Counsel, Tax Exempt and Government Entities
CC:PA:LPD:PR (Notice 2015-16)
Room 5203, Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Re: IRS Notice 2015-16 Excise tax on High Cost Employer-Sponsored Health Coverage

Via Email: Notice.comments@irsconsult.treas.gov

To Whom it May Concern;

On behalf of Charlotte County, a local government that employs 1,382 full-time employees and extends quality health care coverage to 1,272 plan enrollees including those employed by our constitutional officers and partnering governmental entities, we appreciate the opportunity to comment on the Internal Revenue Service's Notice 2015-16 regarding the excise tax on high cost employer sponsored health coverage.

The comments below constitute our thoughts and feedback for consideration in implementation of the excise tax on high cost employer sponsored health coverage as solicited in the notice:

1. Definition of Applicable Coverage

We do not believe that employee contributions to Flexible Spending Accounts (FSA) should be included in the definition of Applicable Coverage (AC). The inclusion of these accounts may encourage employers to cease offering these tax favored accounts that are necessary to promote well-being and assist employees in meeting out of pocket medical costs. For example, dental care is essential to good health, particularly good heart health. Dental plans currently have limited coverage maximums, yet dental costs are increasing. Many employees are able to spread the cost of much needed services through payroll deductions throughout the year, and reduce the effective cost due to the tax free contribution status, making these much needed services more affordable. Further FSA accounts come in two types, employer provided and employee provided. A large majority of public sector FSA's are employee funded with a cap that has been lowered in recent years to \$2,500. The employee election may vary and the employer has no control over these employee elections, so inclusion in the value of Applicable Coverage would be an uncertainty over which the employer has no control (other than to not allow medical FSA election programs to employees), but could put them at risk for a penalty. Employer funded FSA accounts utilized to fund wellness programs should also

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be excluded from the definition of Applicable Coverage, especially when these accounts are used as an incentive for wellness programs. It has been a long term commitment of employers to obtain employee engagement and many have used employer funded FSA accounts as wellness program incentives to succeed. Including these Employer FSA funds, especially contributed toward wellness, would jeopardize the progress employers have made with their employee population toward a healthier lifestyle, which is an important contributor in controlling costs.

Employer funded Health Reimbursement Account (HRA) contributions should be included at a predetermined charted safe harbor percentage rate. It would be burdensome to track per participant costs on an after the fact basis. It would be unfair to include potential contributions. It is important to note that HRA's promote consumerism and are necessary coupled with high deductible plans to offer affordable plan options. An example of how to handle HRA's might be to allow either an actuarial projection on the percentage of costs that will be utilized, or allow employees to use the prior year utilization percentage rate as a safe harbor. The preference would be to keep HRA accounts out of the definition for Applicable Coverage noting that employer funded HRA's, like FSA's, are often used for wellness incentives, and adding these to the formula might discourage employers from encouraging, and employees from participating in, wellness, which has gained in momentum.

Employer health centers should be excluded from Applicable Coverage. Services rendered at an employer provided clinic are often part of a comprehensive workforce wellness strategy and often see workers compensation injured employees. If an employee benefit plan percentage is necessary to be included, safe harbors must be selected for planning and administrative ease. At a minimum, administrative, facility operations, and startup costs should be removed when calculating the value for AC. Only medical personnel and dispensary costs should be included, as the other costs represent fixed costs and employers are not in the business of providing medical care; rather, they are facilitating access.

Broker and consultant compensation should be able to be removed when calculating the cost of Applicable Coverage. These service costs are separately available and represent service costs rather than medical expenditures. Brokers and consultants have become increasingly important to employers to control costs through plan negotiation and design, and to help navigate compliance as the provision of employer sponsored plans has resulted in: 1) more available products in the (sophisticated) health insurance marketplace; 2) increased filing/payment/reporting requirements to the federal agencies for which education and assistance is necessary; 3) increased reporting requirements to include the W-2, PCORI, Transitional Reinsurance Fee, and 1094/1095 for example; 4) increased compliance requirements for employers with various mandates that continue to be released, including for example: annual and lifetime maximums, women's wellness, out of pocket maximum definitions, maximum deductibles; 5) assistance being needed for employees with regard to access to care and services, and claims as plan designs become more sophisticated in the goal of controlling costs; and 6) employee education is necessary as consumer driven health care plan enrollment rises, new products and plan designs are implemented, and reporting of health coverage and other legislative changes (cafeteria plan changes, FSA max changes, DOMA changes) need to be communicated effectively from knowledgeable professionals. Also, it should also be noted that in the public sector, employers may not have the availability to add a separate budget line item to their

approved budget; therefore, not allowing broker and consultant compensation to be removed from Applicable Coverage could unfairly penalize these employers.

The cost of AC should not include “workplace benefit” type plans such as hospital indemnity and critical illness, which are tax free under IRC section 106 and are generally plans elected by, and paid for, by employees. These plans help employees to offset the risk of unexpected or extraordinary medical expenses and offer a buffer against the accumulation of medical debt. As deductibles rise, out of pocket maximums rise, and employees need the availability of these products to meet their needs. Employers are unaware of the elections employees will make when designing their employer sponsored programs and working within cost guidelines, so adding these products to the value of AC is uncertain and indeterminable. Additionally, adding these to AC could result in the employer not offering these workplace benefit coverages, which could place employers in an adversarial position with employees.

2. Determination of Cost of Applicable Coverage

The language of the Cadillac tax with regard to employer provided coverage should include:

- a. Cost of **employer sponsored** group medical and group prescription plan costs defined as the cost to purchase/provide coverage that includes: a) Essential Health Benefit Plan; and/or b) Minimum Value Coverage; or c) minimum essential coverage only when a or b is not offered. “Group” worksite products should be excluded when the employee purchases the coverage (these offer guarantee issues are of benefit to employees to purchase when group sponsored). Individual worksite products should be excluded. Broker/consultant compensation should be excluded. Health Industry Fee, Transitional reinsurance fee, PCORI fee, and any other state or local taxes and surcharges should also be excluded when determining the value of coverage to add to AC
- b. Cost of **employer sponsored** clinic medical care costs ideally should not be included. If determined to be includable, the AC additional value should be calculated as including only direct medical care costs such as physician costs, medical supply, and prescription drug supply costs. Admin, consulting, and occupancy costs of clinic should be excluded.
- c. CDH accounts (FSA, HRA, HSA) should only be included if the amounts to be provided are: 1) employer paid; 2) determinable in advance; and 3) not earned through a wellness or health improvement incentive program.

3. Determining the Applicable Dollar Limit

- a. Applicable of a LOCAL COST FACTOR. Health coverage is priced based on many factors, which include employee population zip code. When calculating AC, there needs to be a STATE and a LOCAL adjustment factor. Insurance is regulated by the state, hence the state factor as the first adjustment factor. For example, Florida has a large Medicaid and Medicare population and has not expanded Medicaid. Additionally, there needs to be local cost adjustment factors within states. This results in higher cost of care in the state to insured individuals as transferred into higher health premiums. It is unfair to have the same uniform limits apply to citizens of higher cost states, as to citizens living in lower cost states. Various areas, due to geography, limited access, low competition, high cost of living, or other factors have more costly medical care costs and resulting premium costs. An example of this is Key West in Florida. It is also important to note that medical inflation far exceeds COLA or other

traditional inflation factors, so any application of a “National” inflation factor would be unfair to residents of high cost states. A state, and local inflation rate are both necessary to create parity.

- b. Exemption for governmental plans (notably where retiree coverage at same costs and plan design is mandated by governmental authority). In Florida, public sector entities are required by Statute to offer retiring employees enrollment at the same cost as employees in the employer sponsored group health plan. As such, plan costs are higher for employees due to the cost of: 1) increased average age; and 2) increased claims cost of older aged participants. Accordingly, state and local government plans should ideally be exempt from the Cadillac tax, and if not, be able to apply higher limits due to these aged individuals.
 - c. Application of an AGE FACTOR BASED ON AVERAGE POPULATION AGE. Health insurance rates are partly calculated by, and costs rise with, age. State and local governments have a disadvantage with regard to cost as they tend to have long term employees, resulting in a higher average age. The application of a factor for average population age (retirees have been proposed) to the Applicable Dollar Limit would provide more equity for employers with aging workforces and would mitigate the risk of age discrimination that may become an ancillary risk of this tax. Therefore, calculation of the AGE and GENDER Adjustment under Section 4980I9(b)(3)(C) (iii) needs to include the entire risk pool (employees and retirees) and the factor should rise proportionately with average age. Example, a factor multiple for 45 should be much different than 35.
 - d. Allowance of High Risk higher limits to be applied to the applicable population in state and local governmental plans. The way the language is presently written, it appears that the plan would primarily have to cover high risk employees (such as fire and police) to be able to apply the higher ADL to these individuals. This is unfair to state and local governmental entities (and related entities such as special taxing districts) who provide coverage to these individuals as part of a greater population of employees. Removing these employees into a separate program or plan could have adverse effects on some employers. The state or local governmental entity should be allowed to benefit from the higher ADL for this population of employees by being able to proportionately increase the overall ADL for the group. Example: 400 employees, 100 are fire and police. Assume all have single coverage. Calculation example is: $((300*10,200 + 100*11,850))/400=(3,060,000+1,185,000)/400=10,612.50$ ADL per employee for this group.
 - e. We agree that EAP should be excepted benefits, like dental and vision benefits, and specifically not included in AC.
4. Other Methods of Determining Applicable Dollar Limit

We have presented our thoughts on the calculation in our comments above. We encourage the federal government to always remember that “insurance is local.” Selling insurance across state lines will not change the cost of health insurance to individuals in those states, as their coverage will still be priced the same as a house – by location. The application of broad or federal level adjustments such as COLA are not representative of inflation in health care or on a state or local level. These type of adjustments are unfair to those in high cost states/areas, and an advantage for those in low cost states/areas. It is important to find and provide equity and equality if this tax is going to be imposed nationally in an environment where insurance is priced locally.

Thank you for your consideration of these important issues. Charlotte County has been, and will continue to be, a good steward of our financial resources. We have been innovative in providing high quality healthcare for our employees, while promoting and incentivizing wellness. Additionally, public sector employees have long understood that strong health care benefits are often granted in lieu of lower pay. This excise tax will hit public sector employers and workers the hardest, including Charlotte County. We encourage the Administration to fully consider the consequences of the excise tax on high-cost health insurance plans within the Affordable Care Act, as its measures will create an increase in out-of-pocket costs or result in a reduction of healthcare benefits for employees and their families.

Sincerely,



William G. Truex, Chairman
Charlotte County Board of
County Commissioners

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cc: The Honorable Senator Marco Rubio
The Honorable Senator Bill Nelson
The Honorable Congressman Tom Rooney
Charlotte County Board of County Commissioners
Charlotte County Administrator, Ray Sandrock
Deputy County Administrator, Kelly Shoemaker
Charlotte County Attorney, Janette Knowlton