AMERICAN BENEFITS COUNCIL

November 2, 2015

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CC:PA:LPD:PR (REG–143800–14)
Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Minimum Value of Eligible Employer-Sponsored Health Plans

Dear Sir or Madam:

We write on behalf of the American Benefits Council ("Council") to provide comment in connection with the Supplemental Notice of Proposed Rulemaking published in the Federal Register on September 1, 2015, by the Internal Revenue Service and the Department of the Treasury (collectively, the "Service") entitled "Minimum Value of Eligible Employer-Sponsored Health Plans" ("Supplemental NPRM").

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to health and retirement plans that cover more than 100 million Americans.

Notice 2014-69 announced the intent of the Service and the Department of Health and Human Services ("HHS") to propose regulations providing that plans that fail to provide substantial coverage for inpatient hospitalization or physician services do not provide minimum value. In this regard, HHS issued a proposed regulation on November 26, 2014, stating that an eligible employer-sponsored plan provides minimum value only if, in addition to covering at least 60 percent of the total allowed costs of benefits provided under the plan, the plan benefits include substantial coverage

of inpatient hospitalization and physician services. HHS's proposed regulation was finalized on February 27, 2015 ("HHS 2015 Final Rule").

The Supplemental NPRM fulfills the Service's announced intent to propose regulations on the issue, and it incorporates the substance of the HHS 2015 Final Rule. It partially withdraws and replaces portions of the proposed rule that the Service previously published on May 3, 2013 ("2013 Proposed Rule").

As discussed below, the Council believes that the Supplemental NPRM goes well beyond the bounds of the statute and does not accord with congressional intent by mandating a specific benefit be covered under employer-sponsored group health plans. The Council also believes that the Supplemental NPRM, if finalized, would exacerbate the effect of the 40 percent high-cost excise tax (the "40 Percent Tax") on employer-sponsored plans. The Council submitted comments[1] to HHS prior to the finalization of the HHS 2015 Final Rule expressing similar strong concerns.

The Supplemental NPRM creates a "slippery slope" by mandating specific coverage employers must offer.

The minimum value definition contained in Proposed Treasury Regulation Section 1.36B-6(c) (which was published as part of the Service's 2013 Proposed Rule and not withdrawn by the Supplemental NPRM) provides that an employer must compare the aggregate expected claims costs under its plan (i.e., the numerator) against that of a typical self-funded employer-sponsored plan (i.e., the denominator). This is very similar to the minimum value definition published by HHS in a final rule issued on February 25, 2013 ("HHS 2013 Final Rule"). The HHS 2013 Final Rule effectively requires that a plan measure its minimum value status by reference to a third-party plan. Thus, not covering a specific benefit otherwise reflected in the denominator by reason of the reference to a third-party plan will adversely affect an employer-sponsored plan's minimum value status.

The Council believes that these existing definitions of minimum value already go well beyond the statutory language of Internal Revenue Code ("Code") Section 36B(c)(2)(C)(ii) in requiring a plan to be considered relative to a third-party benchmark. Specifically, Code Section 36B(c)(2)(C)(ii) states:

> (ii) Coverage must provide minimum value. Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in Section 5000A(f)(2)) ***and the plan's share of the total allowed costs of benefits <u>provided under the plan</u> is less than 60 percent of such costs***. (Emphasis added).

[1] See Council Letter dated December 22, 2014, available at http://www.americanbenefitscouncil.org/pub/e615c09e-c048-1588-d771-d5f5854ccead.

As evidenced by the above language, a plan provides minimum value if "the plan's share of the total allowed costs of benefits *provided under the plan* is less than 60 percent of such costs" (emphasis added). Thus, the statute on its face does not compel, or even suggest, that minimum value is determined by reference to a third-party benchmark.

Notwithstanding the clear and unambiguous language of the statute, as noted above, the Service's 2013 Proposed Rule and the HHS 2013 Final Rule require plans to be compared not within their four corners but by reference to those benefits typically covered by a self-funded employer-sponsored plan (*see* 45 C.F.R. Section 156.145(c) (stating that "[t]he standard population for MV must reflect the population covered by self-insured group health plans"); Prop. Treas. Reg. Section 1.36B-6(b) (stating that "[t]he MV standard population is based on the population covered by typical self-insured group health plans").

These existing definitions already push the boundaries of statutory construction. We are very concerned that the definitions set forth in the Supplemental NPRM and already finalized by HHS in the HHS 2015 Final Rule have even less statutory foundation than the existing definitions. Moreover, given the very clear language of Code Section 36B(c)(2)(C)(ii), we believe the definition in the Supplemental NPRM contradicts the clear congressional intent as evidenced by the statutory language.

Under the existing definitions, an employer-sponsored self-insured or insured large group plan is not required to cover any specific essential health benefits (EHBs), as such term is defined in Section 1302(a) of the Affordable Care Act ("ACA"). This is expressly acknowledged in the preamble to Proposed Treasury Regulation Section 1.36B-6, which states:

> The proposed regulations do not require employer-sponsored self-insured and insured large group plans to cover every EHB category or conform their plans to an EHB benchmark that applies to qualified health plans.

Similarly, the preamble to HHS's 2013 Final Rule states:

> While employer-sponsored group health plans are not required to offer EHB unless they are health plans offered in the small group market subject to PHS Act Section 2707(a), employer-sponsored group health plans that seek to offer minimum value must offer 60 percent of the total allowed cost of benefits. (78 Fed. Reg. at 12,852, Feb. 25, 2013.)

While the employer community has been concerned about the "minimum value" definition as promulgated by the Service and HHS (i.e., because it seems to deviate from the clear statutory language of Code Section 36B(c)(2)(C)(ii) in requiring a plan to determine minimum value status by reference to a third-party plan), neither the HHS

2013 Final Rule nor the Service's 2013 Proposed Rule expressly required an employer-sponsored plan to include any specific essential health benefits.

Under the definition set forth in the Supplemental NPRM and the HHS 2015 Final Rule, however, employer-sponsored plans would be required to not only meet the existing minimum value standard, but *also* to provide "substantial" inpatient hospital and physician services – *a specific mandated benefit*. More specifically, Treasury Regulation Section 1.36B-6(a) would provide as follows:

(a) In general. An eligible employer-sponsored plan provides minimum value (MV) only if –

> (1) The plan's share of the total allowed costs of benefits provided to an employee (the MV percentage) is at least 60 percent; and
>
> (2) *The plan provides substantial coverage of inpatient hospital services and physician services.* (Emphasis added).

The proposed expansion of the minimum value definition is unsupported by the clear language of the statute and in conflict with congressional intent. In addition, it creates precedent for imposing health benefit mandates on employer-sponsored group health plans via the minimum value rules. This precedent would lead to a slippery slope whereby the Service and HHS may find it appropriate to engage in future rulemaking to impose other requirements, including essential health benefit requirements, not expressly applicable to employer-sponsored self-insured or large group health plans, which would be contrary to the statutory language of the Code and the ACA as well as the intent of Congress.

Accordingly, the Council strongly urges the Service to not finalize the Supplemental NPRM. To the extent the Service finds it necessary to finalize the Supplemental NPRM, the Council believes it is critical that the Service and HHS make clear that the change to the definition of minimum value to require "substantial coverage for inpatient hospital services and for physician services" is not intended to signal or in any way create a precedent for additional specific benefit requirements.

The proposed definition would further exacerbate employer concerns regarding the 40 percent tax.

We are also very concerned that the definition set forth in the Supplemental NPRM would exacerbate the impact of the 40 Percent Tax on employer-sponsored coverage. Beginning in 2018, Code Section 4980I imposes a 40 percent nondeductible excise tax on certain providers of health coverage (generally employers, issuers and plan administrators, as applicable) with respect to employer-sponsored coverage that

exceeds certain dollar thresholds (for 2018, generally $10,200 for self-only coverage and $27,500 for other coverage, subject to certain adjustments).

The 40 Percent Tax has substantial potential implications for employer-sponsored group health plans and employees. This is because the Code provision does not look to the richness of benefits (*e.g.*, by using an actuarial value standard), but rather to the cost of the coverage for determining whether a plan triggers the tax.

Significantly, the existing minimum value definition *already* has exacerbated the potential effect of the 40 Percent Tax on America's employers and employees. This is because, as noted above, the Service's 2013 Proposed Rule and the HHS 2013 Final Rule require a plan to look beyond its four corners in determining minimum value status. As a result, plans have been put in the untenable position of one day being unable to comply with both the minimum value requirements of the employer shared responsibility provision of Code Section 4980H (and avoiding the assessable payments otherwise owed thereunder) and the 40 Percent Tax (and avoiding the 40 percent nondeductible excise tax) – thus necessitating that the employer pay at least one of these costly excise taxes.

The Council is concerned that expanding the definition of "minimum value" as set forth in the Supplemental NPRM would exacerbate the current situation for the employer community with respect to the 40 Percent Tax by imposing additional benefit requirements on employers with respect to their plans and could result in higher costs of coverage. We believe this result is inconsistent with Congressional intent and should be avoided. For this reason, as well as those referenced above, the Council strongly opposes the finalization of the Supplemental NPRM (and continues to oppose the HHS 2015 Final Rule).

We recognize that the Service and HHS may have policy interests in ensuring that individuals have access to important federal premium tax credits and cost-sharing reductions notwithstanding enrollment in/coverage by a plan that provides for very limited medical benefits and/or little to no meaningful inpatient hospital or physician services.

As an organization representing principally Fortune 500 companies, our members typically offer "substantial" coverage for inpatient hospital and physician services. The Council also recognizes that the Supplemental NPRM and the HHS 2015 Final Rule are likely targeted at a minority of entities who may seek to provide very limited medical benefits with little to no inpatient hospital or physician services. We urge the Service and HHS to consider ways to target this small minority without imposing additional benefit mandates upon large group and self-funded employer plans.

To the extent the Service and HHS feel compelled to require "substantial" coverage for inpatient hospital and physician services, the Council requests that the Service and

HHS issue a rule that will not further restrict an employer's ability to modify its plan coverage as needed to both (i) be found to provide minimum value, and (ii) avoid application of the 40 Percent Tax.

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Thank you for considering these comments submitted in response to the Supplemental NPRM. If you have any questions or would like to discuss these comments further, please contact us at (202) 289-6700.

Sincerely,

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