AMERICAN BENEFITS COUNCIL

December 22, 2014

Submitted electronically via http://www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9944-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: HHS Notice of Benefit and Payment Parameters for 2016 – Minimum Value Interpretation for Eligible Employer-Sponsored Plans

Dear Sir or Madam:

We write on behalf of the American Benefits Council ("Council") to provide comment in connection with the proposed rule published in the Federal Register on November 26, 2014, by the Department of Health and Human Services ("Department") entitled "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016" ("Proposed 2016 NBPP").

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.

The Proposed 2016 NBPP, in part, proposes to amend the definition of "minimum value" as set forth in existing Department regulations to require that plans also provide "substantial" coverage for inpatient hospital and physician services. While we understand the Treasury Department may be issuing its own proposed regulations regarding the same for purposes of determining an individual's eligibility for premium tax credits under Section 36B of the Internal Revenue Code of 1986, as amended

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("Code") and for purposes of the employer shared responsibility provisions of Code Section 4980H(b), we understand the Departments may be coordinating their rulemaking efforts. Accordingly, we believe it appropriate to comment with respect to your Department's Proposed 2016 NBPP as it relates to the "minimum value" determination.

The Council is <u>very</u> concerned about the Proposed 2016 NBPP as it relates to the definition of "minimum value" to the extent the same or a similar definition becomes applicable for purposes of Code sections 36B and 4980H ("New Proposed Definition"). As discussed below, we are concerned that the expanded definition, as proposed, is contrary to the statutory language of the Affordable Care Act ("ACA") as well as congressional intent. Moreover, we believe the rule, if adopted, would serve to further exacerbate employer concerns regarding the application of the 40 percent high-cost excise tax (i.e., the "Cadillac Tax") to their employer-sponsored plans. For these reasons, we <u>strongly</u> oppose the proposed expansion of the minimum value definition.

THE EXISTING MINIMUM VALUE DEFINITION ALREADY PUSHES THE BOUNDARIES OF THE STATUTORY LANGUAGE IN LOOKING BEYOND THE FOUR CORNERS OF THE PLAN IN DETERMINING MINIMUM VALUE STATUS.

The existing minimum value definition as set forth in final Department regulations issued on February 25, 2013 ("Existing HHS Regulatory Definition") effectively requires that a plan measure its minimum value status by reference to a third-party plan. The existing definition is also reflected in Proposed Treasury Regulation section 1.36B-6(c) (issued on May 3, 2013), which states 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) ("Existing Treasury Regulatory Definition"). As a result, to the extent that a given employer-sponsored plan does not cover a specific benefit otherwise reflected in the denominator, this will adversely affect a plan's minimum value status.

The Council believes the Existing HHS and Treasury Regulatory Definitions of minimum value already go well beyond the statutory language of Code section 36B(c)(2)(C)(ii) in requiring a plan to be considered relative to a third-party benchmark. Specifically, Code section 36B(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 provided <u>under the plan</u> is less than 60 percent of such costs***. (Emphasis added).

As evidenced by the above language, a plan provides minimum value if "the plan's share of the total allowed costs of benefits <u>provided under *the* plan</u> is less than 60

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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 Existing HHS and Treasury Regulatory Definitions 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").

The Existing HHS and Treasury Regulatory Definitions already push the boundaries of statutory construction. We are very concerned that the New Proposed Definition has even less statutory foundation. Moreover, given the very clear language of Code section 36B(c)(2)(C)(ii), we believe the New Proposed Definition contradicts the clear congressional intent as evidenced by the statutory language.

Under the Existing HHS and Treasury Regulatory Definitions, a plan is not required to cover any specific essential health benefits, as such term is defined in ACA section 1302(a). This is expressly acknowledged in the preamble to the Department's 2013 final regulation, which 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.)

This is similarly reflected in the preamble to Proposed Treas. Reg. §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.

While the employer community has been concerned about the "minimum value" definition as promulgated by the Departments (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), the Department's definition of minimum value did not expressly require an employer-sponsored plan to include any specific essential health benefits.

Under the New Proposed Definition as contained in the Proposed 2016 NBPP,

employer-sponsored plans would now be required to not only meet the existing minimum value standard, but also to provide "substantial" inpatient hospital and physician services. More specifically, 45 C.F.R. section 156.145(a), as proposed to be amended by the Proposed 2016 NBPP, would provide as follows:

> An employer-sponsored plan provides minimum value (MV) only if the percentage of the total allowed costs of benefits provided under the plan is greater than or equal to 60 percent, *and the benefits under the plan include substantial coverage of inpatient hospital services and physician services*. (Emphasis added.)

We believe the proposed expansion of the minimum value definition sends us further down a path unsupported by the clear language of the statute and congressional intent. We believe that the New Proposed Definition, if adopted, would establish an untenable precedent in that it would impose essential health benefit mandates on employer-sponsored group health plans in order for such plans to be considered to provide "minimum value."

The Council is also concerned that the precedent that would be established by such a proposed rule would lead to the Department engaging in future rulemaking to compel the offering of additional categories or types of essential (or other) health benefits.

In enacting Code section 36B as part of the ACA, Congress correctly understood the importance of ensuring that employers maintain flexibility to design their health plans as appropriate to best meet their employees' needs. As such, Congress adopted a "minimum value" definition in Code section 36B(c)(2)(C)(ii) that looks solely at the benefits offered within the plan itself. For this reason, as well as those discussed above, the Council strongly opposes the adoption of the New Proposed Definition as set forth in the Proposed 2016 NBPP.

THE PROPOSED DEFINITION SHOULD NOT BE ADOPTED AS IT WOULD FURTHER EXACERBATE EMPLOYER CONCERNS REGARDING THE 40 PERCENT HIGH-COST EXCISE TAX (I.E., "CADILLAC TAX").

We are also very concerned that the New Proposed Definition, if adopted, would exacerbate current employer concerns regarding the 40 percent high-cost excise tax "Cadillac tax" as set forth in Code section 4980I ("High-Cost Excise Tax").

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 High-Cost Excise Tax has substantial potential implications for employer-

sponsored group health plans and employees. This is because the Code provision appears to look not at the richness of benefits (*e.g.*, by using an actuarial value standard), but rather at the cost of the coverage for determining whether a plan triggers the tax. Many of our members have begun to model the effects of the High-Cost Excise Tax on their plans and are implementing changes to avoid triggering the tax. We are concerned that unless timely regulatory or legislative relief is provided, the tax may result in employees losing access to important and valuable health benefits coverage.

Significantly, the existing minimum value definition <u>already</u> has exacerbated the potential effect of the High-Cost Excise Tax on America's employers and employees. This is because, as noted above, the Existing HHS and Treasury Regulatory Definitions require a plan to look beyond its four corners in determining minimum value status. (This is in contrast to the statutory language requiring only that a plan cover 60 percent of any benefits actually covered under the plan itself, as discussed above.) 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 High-Cost Excise 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 the New Proposed Definition of minimum value would exacerbate the current situation for the employer community with respect to the High-Cost Excise Tax by imposing additional benefit requirements on employers with respect to their plans. We believe this result is inconsistent with Congressional intent and should be avoided. For this reason, as well those referenced above, the Council strongly opposes the adoption of the New Proposed Definition as set forth in the Proposed 2016 NBPP.

We recognize that the Departments of Health and Human Services and Treasury 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 the Departments' action is 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 and we urge the Departments to consider ways target this small minority without imposing additional benefit mandates upon large group and self-funded employer plans. To the extent the Departments feel compelled to amend the existing regulatory "minimum value" definition to require "substantial" coverage for inpatient hospital and physician services, the Council requests that the Departments promulgate 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 High-Cost

Excise Tax.

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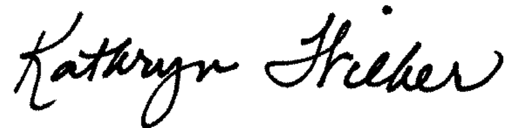
Thank you for considering these comments submitted in response to the Proposed 2016 NBPP. If you have any questions or would like to discuss these comments further, please contact us at (202) 289-6700.

Sincerely,



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