# The Commonwealth of Massachusetts

**Group Insurance Commission** – **Office of the Comptroller**
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May 15, 2015

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

By email: Notice.comments@irscounsel.treas.gov

To whom it may concern,

In response to Notice 2015-16 from the Treasury and the IRS ("Notice"), this set of comments addresses federal regulations related to I.R.C. §4980I, the Excise Tax on High Cost Employer-Sponsored Health Coverage. The Group Insurance Commission, the Commonwealth of Massachusetts agency that manages health insurance for state and some municipal employees and retirees, drafted these comments with input and support from the Comptroller's office, the Commonwealth agency with primary responsibility for managing payroll and payroll taxes for the state as an employer.

The comments fall into three broad areas. First are comments on the structure of the excise tax. We understand that the IRS and Treasury are not in a position to change the statute, but we would be remiss if we were to comment on regulatory matters without reference to deeper concerns about the statute itself. Second are general comments on areas where we would like the regulations to bring greater clarity. Third are narrower comments on specific topics raised in the Notice.

## I. Section 4980I Penalizes Employers for Insuring Employees and Retirees in High-Cost Markets

Section 4980I is widely known as the Cadillac tax because ostensibly it targets overly rich benefits that by their design encourage wasteful health care expenditures. We acknowledge that the structure of health insurance in the United States contributes to the exceptionally high cost of American healthcare. However, the excessively high cost of American health care derives from a complex mix of factors, among them the inherently inflationary fee-for-service system and market failure in medicine.

Employers do make decisions about what benefits to offer in order to attract and retain a qualified workforce, but generally employers are not in a position to reduce the cost of health care unilaterally. We as employers participate in a dysfunctional market. Specifically, employers in Massachusetts participate in a local health care market that is among the most expensive in the nation. It is characterized by unusually high reliance on academic medical centers and other high-cost provider facilities. Purchasers are also constrained in their ability to trim benefits in situations where benefits are collectively bargained. Consolidation in the hospital sector has exacerbated these cost trends.

The passage of Chapter 224 of the Acts of 2012, An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation, is one example of the state's ongoing efforts to curb wasteful spending through bringing light to health care inflation, setting explicit targets for total growth in medical expenses, and supporting alternative payment mechanisms. Additionally, the GIC, directly and through its six carriers, has led the way in physician tiering, limited networks, and risk-based provider contracting.

Our carriers improve patient outcomes and reduce costs. They do so through disease management, case management, care management, discharge planning, support for primary care practices and referral systems, and a range of other such initiatives. Just this year, two of our biggest non-Medicare plans are changing from a Preferred Provider Organization (PPO) to Point of Service (POS) structure in order to take advantage of more favorable contracts, enhance the role of primary care, improve care coordination through referral requirements, and improve the exchange of critical data such as ER and hospital utilization between insurers and primary care practices.

The Cadillac tax recognizes none of this context. Instead, it rounds up all the pre-tax components of health care spending, including not only employer-sponsored insurance but also the various ancillary structures intended to encourage financial accountability by employees (HRAs,[1] health FSAs, and pretax portions of HSAs and Archer MSAs). After certain adjustments, none of which are geographic, it compares the cost of health care with a benchmark.

In short, the tax will track primarily to the price of health care in the relevant market, and not just in proportion to the wastefulness of the benefit design. The burden of managing those expenses belongs, at least in large part, with those who can do something about reducing the cost of the system – that is, providers.[2]

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[1] The application of the Cadillac tax to HRAs is not clear. The Notice on p. 7 indicates the HRAs are probably applicable coverage. Public perception of this important question seems split on the matter, with some HRAs expressly marketed as a way to reduce exposure to the excise tax, while other commentators explain confidently that HRAs are included in the calculation of the tax.

[2] Given their power to influence prices in the market, we would suggest that when providers are calculating liability for the Cadillac tax for their own benefited employees, they should be required to use billed charges to calculate costs of services rendered in-house. If billed charges are seen as outrageously misleading indicators of cost, an alternative would be for provider-employers to use arms-length rates, such as rates negotiated with their largest commercial payer.

Troublingly, the tax also will tend to penalize an employer's decision to cover retirees. The adjustment factors for retirees do not appear adequate to account for the differential cost of insuring non-Medicare eligible retirees.[3] We are aware of no federal policy intended to discourage employers from covering retirees – and the Early Retiree Reinsurance Program indicated that Congress is aware of the access problems facing early retirees, and supportive of employer-sponsored retiree insurance. But non-Medicare retirees are an expensive population to insure, and the few remaining employers who insure them should not be heavily taxed for that decision.

There are ways an employer can reduce exposure to the Cadillac tax, but there are some troubling policy implications. Limited networks, which exclude higher cost facilities, are effective in reducing costs, but limited networks alone will not solve the problem of high health care costs.[4] Increasing employee cost-sharing sharply (without offsetting these costs through FSAs, HSAs, and the like) reduces plan costs but leaves members exposed to financially ruinous bills.[5] Ending coverage for retirees reduces an employer's health costs but at the expense of retirees and with little to no effect on the cost of health care in the market.

## II. Regulations Should Provide Clear Guidance for Employers

Moving away from general concerns about the Cadillac tax, this section addresses areas where we believe regulatory guidance to employers would be helpful. Although these areas were referred to in the Notice, more information would be helpful.

### A. Health Flexible Spending Accounts (FSAs)

The aggregation of health insurance and FSA elections presents technical and conceptual problems. These concerns include the following:

- Health FSA elections are different in kind from insurance premiums, because they do not pool risk. Their value lies elsewhere – in the ability to set aside money on a pretax basis for predicted expenses.
- Health FSAs can be used for expenses, such as glasses, contact lenses, and dental services, that would not normally be covered by health insurance. It therefore does not

[3] The difference in cost in GIC plans in the plan year ending June 30, 2014 between active and retired members in non-Medicare individual plans was $3,000, or nearly twice the proposed self-only adjustment factor of $1,650. Similarly, the difference for family plans was $5,300, about 50% greater than the proposed other-than-self-only adjustment of $3,450.

[4] In our experience, uptake of limited network plans plateaus around 30-40% of active employees, while retirees enroll in limited network in far fewer numbers. Older and sicker individuals tend to prefer higher premiums to network restrictions, and, since we are a geographically concentrated employer, many retirees are not eligible if they spend a significant part of the year outside the plan service area.

[5] Studies have shown that medical bills are a leading cause of bankruptcy even among insured adults. See e.g. David U. Himmelstein, MD, et al., Medical Bankruptcy in the United States, 2007: Results of a National Study, The American Journal of Medicine, Volume 122, Issue 8, Pages 741–746 (Aug. 2009)

make sense to add health FSA elections to health plan expenses in order to get a total picture of health benefits.

- It is not clear how to determine what health FSA coverage is self-only versus other-than-self-only, as, per best practices within the FSA industry, family member or dependent member names are not tracked or required.
- Predicting voluntary elections differs conceptually from projecting utilization across a population. Relative to health expenses, FSA elections are less a function of health care utilization, and more a function of tax planning.

These problems are exacerbated where the benefits are administered quite separately, as they are for many of the employees we cover. The GIC administers health insurance for employees who have access to FSAs through their employer.[6] Employees covered by GIC plans may also have access to a spouse's FSA, but neither we nor the spouse's employer would be able to make that connection.

We recommend as follows:

- Disregard contributions to health FSAs if they are funded through employees' voluntary salary reductions.
- Permit government plans to disregard health FSAs when those plans are administered by entities other than the health plan sponsor.
- Count all FSA elections, if at all, as other-than-self-only coverage

**B. Blending/Adjustment factors**

The discussion in the Notice of disaggregation and how the various adjustment factors apply leaves a lot of uncertainty around calculating the cost of applicable coverage. In general, more guidance of what is and is not legal would be helpful, so that blending and adjustment do not proceed by guesswork, with the risk of substantial penalties:

- Can sub-groups of employees in risky professions be rated separately, and can the high-risk profession adjustment apply?

  *To give an example, Massachusetts's pension system divides employees into Groups 1, 2, 3, and 4. Groups 2, 3, and 4 are made up of employees in public safety and hazardous occupations, such as ambulance attendants, and mental health hospital attendants. Group 1 is all other employees. Could the GIC rate Groups 2-4 separately from Group 1?) (p. 23)*

- Can we add just enough clerical employees to the hazardous employees' group to maintain a slim majority of risky employees, and then apply the adjustment?

- Can we rate employees and retirees separately?

[6] For state employees, the GIC administers a range of non-pension benefits, including both health insurance and health FSAs. The GIC offers health insurance but not FSAs to participating municipal employees. Some municipal employers may administer health FSAs locally.

- Can we rate over-under (spouses where one but not the other spouse is Medicare eligible) couples separately from retirees with family coverage for non-Medicare plans, and from retirees with Medicare plans for themselves and their spouses?

- In determining who is a qualified retiree, what about over/under couples, where the retiree is not Medicare eligible, but the spouse is, or vice versa. Does retiree adjustment apply?

- Can the qualified retiree and the risky profession adjustments both apply? (p.22-23)

- How does the age/gender adjustment[7] work? (p.23) Will someone publish age/gender adjustment charts? How will the age/gender variation be translated into cost variation?

In short – in answer to the question on p. 23, yes, more guidance is needed.

**E. Projected costs (actuarial basis method)**
Again, more guidance would be helpful. Must rates tie to published full cost rates where they exist? Where costs are projected as ranges, is it acceptable to use the low end of ranges? Is there any true-up if the projections are substantially low?

In short, how should FSA elections be projected?

**D. Role of plan administrator / hierarchies of data**
An oddity of the Cadillac tax is the role of plan administrators in self-insured plans. The responsibility of plan administrators as opposed to plan sponsors appears to be rooted in the COBRA statute.[8] However, it creates complications in the Cadillac tax where the tax is on the aggregate value of the employer-sponsored coverage, potentially across multiple carve-outs and ancillary plans (HSAs, health FSAs, and the like).

Guidance would be appreciated on the degree of consistency expected across plans. Can carve-outs approach cost differently? For example, can a medical plan use the actuarial basis method while a related drug carve-out uses the past cost method? How does a plan administrator determine what share of excess benefits are associated with that particular plan? If data sharing becomes necessary, whose responsibility is it to assure that data sharing functions correctly?

**E. Health Reimbursement Arrangements (HRAs)**

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[7] See §4890I[b][3][C][iii][II].
[8] See e.g. I.R.C. § 4980(f)(4)(B)(ii) (calculation of COBRA premiums for self-insured plans); see also I.R.C. § 4980B(d)(2)(A) (determination of cost of employer-sponsored coverage for Cadillac tax to be "similar to" COBRA rules).

The Notice indicates on p. 7 that HRAs will likely count as applicable coverage. Clarity here is obviously important. Guidance would be helpful on whether HRAs count as applicable coverage, and, if they do, whether annual election or actual expenditure is the relevant figure.

**F. Miscellaneous**
We have the following miscellaneous suggestions:

1. EAPs. In response to the question on page 10: yes, Employee Assistance Programs (EAPs) should be excluded from applicable coverage. EAPs are not an insurance function; they are more of a service to employees. (p. 10)
2. Switching. Further guidance would be helpful on the limitation on switching between actuarial and past-cost method. What is a "significant difference" or a "significant change" in coverage or employees covered by a plan? (p 16)
3. Employer overhead. Clarify that reasonable overhead expenses means only the fee paid to a third party administrator (TPA) where applicable, and not an employer's costs in managing eligibility or the TPA contract where the employer has contracted with a TPA to administer a benefit. (p.17, 18).
4. Medicare. Employers should not be responsible for determining whether under-65 retirees may be Medicare eligible. An employer is generally not in a position to know whether a retiree is Medicare eligible. We recommend the regulations create a safe harbor presumption that retirees under the age of 65 are not Medicare eligible. (p. 22)

Thank you for the opportunity to comment and for your attention to our suggestions.

Yours sincerely,

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