Notice 2015-16

California Public Employees' Retirement System
Executive Office
P.O. Box 942701
Sacramento, CA 94229-2701
TTY: (877) 249-7442
(916) 795-3825 phone · (916) 795-3410 fax
www.calpers.ca.gov

May 15, 2015

CC:PA:LPD:PR
(Notice 2015–16)
Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Subject: Notice 2015-16, Request for Comments Regarding IRC § 4980I

Thank you for the opportunity to allow the California Public Employees' Retirement System (CalPERS) to inform the process as the Internal Revenue Service (IRS) develops regulatory guidance regarding the excise tax on high cost employer-sponsored health coverage (excise tax), as established in the Affordable Care Act (ACA) and included in § 4980I of the Internal Revenue Code.[1] Since its passage in 2010, CalPERS has been a committed supporter of the ACA, with its promise to expand health care access to millions of Americans, promote quality care, and control costs. As an active health benefits purchaser, CalPERS is keenly interested in how the IRS will implement the details this tax, with its potential to impact most, if not all, of our health plan offerings over time.

Background

CalPERS is the largest public employer health benefits purchaser in California and the second largest employer purchaser in the nation after the federal government. We provide health benefits to approximately 1.4 million people, comprised of active and retired state, local government, and school employees and their families. Our health plan offerings include health maintenance organization (HMO), self-funded preferred provider organization (PPO), and exclusive provider organization plans. In 2015, CalPERS will spend more than $8 billion to provide health benefits to our members.

[1] See Notice 2015-16. http://www.irs.gov/irb/2015-10_IRB/ar11.html

CalPERS is a unique player in the public employer health care purchaser arena. As both a health care purchaser and a public employee retirement system, CalPERS has a vested interest in the health of our members, not only during their tenure as employees, but also throughout retirement. This long-term relationship with members, from employee to retiree, drives the comprehensive, quality health benefits that we provide. CalPERS does not consider our health plans "Cadillac," in the sense of providing extravagant and extraneous benefits to our members. Rather, we see our plan design as offering a level of coverage that, for more than half a century, has helped ensure that the employees who serve the people of California remain a part of the middle class by never being forced to choose between seeking necessary health care and experiencing a medical bankruptcy or other extreme health-related financial hardship—a level of coverage that is quickly eroding in the current employer-sponsored health care marketplace.

As a health benefits purchaser for over 1,200 public agencies, school districts, and the State of California, CalPERS is concerned that the excise tax will ultimately force our contracting employers to pass on even higher costs to their employees through increased cost sharing. In addition, CalPERS respectfully differs in opinion regarding the assumption that as a consequence of the tax, employers will make up the difference in reduced plan benefits with higher employee wages, with the net effect resulting in total benefit compensation remaining relatively constant.[2] For our contracting employers, CalPERS' annual rate process and any accompanying benefit design changes are largely decoupled from their collectively bargained salary negotiation process that occurs at the local level. Further, while the U.S. economy continues to move from its low point in the economic downturn, American wages are not keeping pace with the recovery.[3]

CalPERS has proactively developed strategies to control costs while preserving meaningful core benefits. We have worked hard to moderate rate increases by focusing on initiatives to increase competition and lower costs, such as:

- Supporting transparency in cost and quality reporting and increased financial disclosure, such as launching an online portal for PPO members to compare cost and quality ratings from multiple providers and hospitals before seeking services
- Initiating integrated health care projects (similar to an accountable care organization) that aligns quality and cost incentives for plans and providers while providing comprehensive care management for members with complex medical needs

---

[2]Congressional Budget Office. Statement of Douglas W. Elmendorf, Director, "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010" before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, 30 March 2011: 18, footnote 18. http://www.cbo.gov/sites/default/files/03-30-healthcarelegislation.pdf. For a summary of likely employer behavior, see: Jost, Timothy S. and White, Joseph, Cutting Health Care Spending: What is the Cost of an Excise Tax that Keeps People from Going to the Doctor? *Institute for America's Future*: 4. http://ourfuture.org/files/Jost-White_Excise_Tax.pdf

[3] Gould, Elise, "2014 Continues a 35-Year Trend of Broad-Based Wage Stagnation," *Economic Policy Institute*, Issue Brief #393, 19 February 2015: 2. http://s4.epi.org/files/pdf/stagnant-wages-in-2014.pdf

- Supporting national efforts to move away from fee-for-service payment models toward value-based systems consistent with the Administration's efforts
- Implementing a successful reference pricing program on hip and knee replacements that ensures an adequate network of high-quality providers for members
- Incentivizing generic prescription utilization over brand drugs
- Exploring a blended payment model to discourage non-medically necessary elective cesarean deliveries before 39 weeks and reward hospitals with lower cesarean rates
- Integrating wellness and disease management programs into our plan design
- Verifying dependent eligibility to ensure only eligible individuals are enrolled
- Risk adjusting our non-Medicare health plans to mitigate adverse selection
- Spurring health plan competition by opening CalPERS' procurement process to additional plans
- Exploring narrow provider network options when reasonably priced and adequate and appropriate access to physicians, specialists, and hospitals is ensured
- Establishing an integrated care program for high-cost members in rural areas

Preliminary Regulatory Considerations

Given the constraints in the law, as a health benefits purchaser and not an employer, CalPERS cannot as easily implement the excise tax rules that are geared primarily toward the employer community. As the IRS begins to contemplate the regulatory framework of the tax, we wish to preliminarily highlight a few areas for your consideration. These areas are only some of our concerns, and as the process develops, we would like the opportunity to provide further input. Ultimately, we feel that the tax will expose our members to financial harm.

1. Notice 2015-16, Section III: Definition of Applicable Coverage

We urge the IRS to continue its practice of providing tax advantages to employees through the use of flexible spending accounts, health savings accounts, and health reimbursement arrangements to help offset out-of-pocket costs by determining pre-tax contributions to these accounts do not constitute applicable coverage. The IRS should consider these savings vehicles as applicable coverage only when they are the exclusive health care funding mechanism available to employees, and not when used as a compliment to comprehensive employer-sponsored health coverage.

By clarifying that these savings vehicles are excluded from applicable coverage when employers offer comprehensive major medical coverage it allows health benefit purchasers, such as CalPERS, flexibility and administrative relief relative to the computation, allocation, and reporting of the tax. For CalPERS, the efforts necessary to educate, communicate, and coordinate with our over 1,200 contracting employers is complex in our normal course of business. Adding a new employer requirement to

accurately and timely provide CalPERS' health plans and the IRS notification about the individuals exceeding the threshold, as well as having our employers compute and allocate the amounts attributable to the private administrators of these other savings vehicles, adds an additional layer of complexity that would be administratively burdensome. In addition, if purchasers such as CalPERS and health plans have diligently negotiated to keep premiums below the excise tax thresholds, and we are unaware of any additional benefits provided by our contracting employers to their employees at the local level, our health plans should be held harmless relative to the payment of any pro rata portion of the excise tax incurred due to a benefit over which CalPERS and our health plans have no control.

2. Notice 2015-16, Section V, C, 1 and 3: Adjustments for Qualified Retirees; Age and Gender Adjustments

Although CalPERS is a health benefit purchaser for active employees and retirees, and their eligible dependents, we are also a public retirement system and as such, our member population may differ from other large purchasers whose populations include only active employees and their families. It is common knowledge that a health plan's demographics affect its risk pool and, therefore, its price. In 2013, the last year for which data was available, CalPERS' population in non-Medicare health plans (active employees/early retirees and their families) was 53 percent female and 47 percent male, with more than half of our membership older than age 35.[4] Public employee health plans in general tend to skew older and to include more women.[5] In addition, public sector plans show a higher prevalence of chronic conditions than private sector plans.[6]

Given the above information, CalPERS supports the tax threshold adjustment for qualified retirees provided in § 4980I(b)(3)(C)(iv). We recommend that the IRS permit early retiree attestation as one way for an employer to determine that an individual is not eligible for enrollment in the Medicare program. Similarly, regarding § 4980I(b)(3)(C)(iii), CalPERS supports generous safe harbors that adjust the dollar limit thresholds for employee populations with age and gender characteristics different from the national workforce.

3. Notice 2015-16, Section IV, C: Potential Approaches for Determining Cost of Applicable Coverage; Permissive Disaggregation

Health care is local, especially in California where we not only experience substantial price differentials between northern and southern California, but also amongst our often

[4] Data extracted in March and April 2015 using the Health Care Decision Support System (HCDSS)/Milliman MedInsight tool.
[5] According to 2010 findings from Truven Health Analytics, state and local governments insured a higher proportion of older workers and their dependents, and more women, than did the private sector. "State Employee Health Plan Spending—An examination of premiums, cost drivers, and policy approaches," The Pew Charitable Trust and the John D. and Catherine T. MacArthur Foundation. (August 2014): 11-12. http://www.pewtrusts.org/~/media/Assets/2014/08/StateEmployeeHealthCareReportSeptemberUpdate.pdf
[6] Ibid.,13

adjacently situated regions, such as the Bay Area and Sacramento regions. In addition, of the 58 counties in our very populous state, 34 of those counties are rural areas where our members often have limited health plan choice and may only have access to higher cost PPO plan products. Due to the extra high cost of health care in portions of California, we know that there are already standard plans—plans much less generous than what the "Cadillac" tax assumes—that would breach the cost thresholds. As a result, through no fault of an enrollee's plan choice or the plan's benefit design, a tax assessment would apply. As such, we ask the IRS to consider allowing maximum flexibility and a broad standard in determining groups of similarly situated individuals, including permissive disaggregation to include population, cost, and bona fide employment criteria, as well as geographic distinctions, such as our five CalPERS regions that serve 1.4 million covered lives.

4. Notice 2015-16, Section V, C: Dollar Limit Adjustments; Cost of Living

Section 4980I(b)(3)(v) allows for a cost-of-living adjustment based on the Consumer Price Index for Urban Consumers (CPI-U). It appears that the CPI-U includes a medical care component;[7] however, if after the 2018 application of the health cost adjustment percentage, the cost of health care rises faster than the CPI threshold adjustment plus one percent in 2019, and by the annual increase to the CPI thereafter, most employers' health benefits will move closer to, or exceed the threshold.[8] If the excise tax were in place today, based on CalPERS 2015 health plan rates using the single and family plan thresholds only, five plans in three of CalPERS regions would already exceed the thresholds. In addition, reports estimate that the excise tax will affect almost one-half of private plans by 2025, with three-quarters affected by 2029.[9] The ACA has allowed millions of Americans to enroll in affordable health coverage either individually or through an employer-sponsored plan; however, as the cost of health care continues to rise, employees and their families will bear the burden of higher premiums, reduced plan benefits, and increased out-of-pocket costs as employers shift costs to avoid the excise tax.

Despite employer efforts to reduce their tax exposure, reports show that continued medical inflation and regional health care price differences will make it difficult for employers to ultimately avoid the tax.[10] Projections show that, for years 2018-2024, CPI-U plus one percent will equate to approximately 3.4 percent per year.[11] CalPERS' 2014 average non-Medicare premium increase, unadjusted by geographic region, was 3.7 percent.[12]

---

[7] U.S. Department of Labor, Bureau of Labor Statistics. "Measuring Price Change for Medical Care in the CPI," http://www.bls.gov/cpi/cpifact4.htm

[8] Jost, Timothy S. and White, Joseph. Cutting Health Care Spending: What is the Cost of an Excise Tax that Keeps People from Going to the Doctor? *Institute for America's Future*: 2. http://ourfuture.org/files/Jost-White_Excise_Tax.pdf

[9] Herring, Bradley and Korin Lentz, Lisa. How Can We Bend the Cost Curve? What Can We Expect from the "Cadillac Tax" in 2018 and Beyond? *Inquiry:The Journal of Health Care Organization, Provision, and Financing*, vol. 48, (Winter 2011/2012): 334. http://inq.sagepub.com/content/48/4/322.full.pdf

[10] Troy, Tevi D. and Wilson, D. Mark. "The Impact of Health Care Excise Tax on U.S. Employees and Employers," *American Health Policy Institute*, (2014): 1. http://www.americanhealthpolicy.org/Content/documents/resources/Excise_Tax_11102014.pdf

[11] Ibid.,4.

[12] CalPERS Facts-at-a-Glance, http://www.calpers.ca.gov/eip-docs/about/facts/facts-at-a-glance.pdf

The CPI-U adjustment, while appreciated, will not keep our plans from being vulnerable to the tax. CalPERS is concerned that the CPI-U is an insufficient measurement to accurately reflect the nationwide increases in health care premiums, despite the ACA's and CalPERS' contributions toward bending the cost curve. CalPERS encourages the IRS to apply a percentage adjustment that more accurately reflects medical premium trend while remaining consistent with the intent of the ACA.

Conclusion

CalPERS and our health plan partners provide employees, retirees, and their dependents high-quality, comprehensive, and affordable employer-sponsored health coverage that exceeds basic minimum value standards, but is not excessively generous. We believe this level of coverage is consistent with the letter and spirit of the ACA and helps public employees remain a viable part of the American middle class. Despite our many concerns with the implementation of the excise tax on high cost employer-sponsored health coverage, CalPERS remains committed to continued collaboration with the federal government to help ensure the successful implementation of the ACA. Please contact me at ann.boynton@calpers.ca.gov, or 916-795-0404, if you have any questions or wish to discuss these issues further.

Regards,

ANN BOYNTON
Deputy Executive Officer
Benefit Programs Policy and Planning

cc: George Bostick
Mark Iwry
Vicki Judson
Stephen Tackney