



April 8, 2015

CC:PA:LPD:PR (Notice 2015-16)

Room 2503

Internal Revenue Service

PO Box 7604

Ben Franklin Station

Washington, DC 20044

On behalf of the Health Care Cost Management Corporation of Alaska (HCCMCA), we are providing comments regarding the potential excise tax regulations provided in Notice 2015-16. The HCCMCA is a non-profit coalition of more than 40 health plans providing coverage for approximately 180,000 people in Alaska and the Pacific Northwest.

The HCCMCA was formed to find ways to help member health plans control health care costs. Despite our best efforts and significant successes health care costs continue to rise in the Pacific Northwest, and health care costs in Alaska are among the highest in the US. As a result, the excise tax will have a more adverse impact on our participants than it will have in other parts of the country.

Notice 2015-16 requested comments on a variety of issues:

Section III. Types of Coverage Excluded from Applicable Coverage:

- *E. Medical clinics sponsored by an Employer or Self-Funded Health Plan.* The notice discussed potential approaches to on-site medical clinics. We encourage you to expand the exclusion for on-site medical clinics to encompass off-site/near-site clinics sponsored or funded by employers or self-funded health plans. Such clinics provide cost effective ways to provide basic medical care (including basic preventive care, immunizations, and treatment of accidents and minor illnesses). As observed in the Notice, such clinics may also provide services for work-related injuries. Because of the size of employers in our region and the geographic spread, we have found it is more cost effective to maintain off-site clinics that can treat employees and dependents of a group of employers, rather than maintaining clinics at each worksite.

Further, the Notice discusses the possibility of expanding the scope of services for clinics excluded from applicable coverage. We support the expansion of allowable services to include basic preventive care and treatment of minor illness/injury, for both employees and for dependents.

We suggest the standard be based on the nature and scope of benefits. To the extent a clinic provides both applicable coverage and excluded coverage, we encourage an approach

which would allow a health plan to break out the value of the elements of applicable coverage separately. Because of the reasons stated above, however, we believe it will be difficult to price clinic elements and encourage IRS and Treasury to adopt a broad exclusion for these clinics instead.

- *F. Limited Scope Dental and Vision Benefits.* We encourage the approach considered by Treasury and the IRS to exclude self-insured limited scope dental and vision coverage that qualifies as an excepted benefit from applicable coverage. This is consistent with the treatment of insured stand-alone dental and vision benefits and allows self-insured plans the ability to continue these benefits on a self-funded basis and not incur the additional costs associated with insuring these coverages.
- *G. Employee Assistance Programs (EAPs).* The Departments recognized that EAPs provide support services, which are supplemental to other health coverage and are therefore considered excepted benefits. EAPs typically provide services not covered by a typical health plan, including family counseling, advice on parenting and eldercare, help with workplace stress or workplace issues, financial counseling, etc. Furthermore, employers commonly provide these benefits to a broader base of employees than are covered by the health plan. Employers contributing to multiemployer trust funds may also provide EAP benefits independent of coverage under the Trust, and it would be prohibitive to attempt to coordinate the value. We encourage Treasury and the IRS to consider EAP services to be excepted benefits in order to be consistent with the determination by the Departments and to encourage employer to continue to provide these services. In the event EAPs are included as applicable coverage, we believe many employers will cease providing these programs to employees.

Section IV. Determining the Cost of Applicable Coverage

- *C.1. Permissive Aggregation within Other-Than-Self-Only Coverage.* We encourage Treasury and the IRS to allow, but not require, disaggregation by subdividing the group. If a specific standard for permissive disaggregation is allowed by the number of individuals or by family unit (Employee + Spouse, Employee + Child(ren), Employee + Spouse+ Child(ren)), we encourage Treasury and IRS to provide an escalator in the excise tax thresholds, because the cost of coverage will vary by the number of individuals or by family unit.

We support allowing a specific standard by geographic area. If this specific standard is permitted, we encourage Treasury and IRS to provide a geographic differential for the excise tax thresholds, as the costs of health care differs from one state or metropolitan area to another. This geographical differential is critical in areas like Alaska, which has health care costs which average 70% more than the 5 nearest peer states. By 2018, Treasury will have access to multiple years of significant state specific health insurance cost data based on policies sold through state and federal marketplaces.

We also support allowing a broader standard (such as a bona fide employment-related criteria) for permissive disaggregation in order to accommodate the needs of particular groups, however, we also recognize that it may not be possible to modify the tax thresholds when a broad standard is adopted, thus limiting the utility of the disaggregation.

- *C.2. Self-Insured Methods*

- a. *Changing between Methods.* We encourage Treasury and IRS not to limit the plan's ability to change between methods of calculation. As observed in the Notice, a health plan may implement plan changes or experience enrollment variability, which precludes the use of the past cost method in a given year. As such, the past cost method option will not be feasible if a plan is required to be locked into one method or the other for more than one year at a time or if required to prove a "significant difference" allowing a switch away from the past cost method. While we recognize the concern about the possibility of abuse if plans were allowed to switch between methods, we believe the impact from year to year will be small because both the actuarial method and the past cost method essentially use the plan's claims experience to determine the rate.
- b. *Actuarial Basis Method.* We encourage Treasury and the IRS to specify a list of factors that must be satisfied to make an actuarial determination of the cost of applicable coverage. This list of factors could also apply for the purposes of determining the COBRA premium. We do not believe the regulations should require accreditation of individuals making actuarial estimates. It is common for health plans to calculate the COBRA premium themselves or rely upon their administrators, brokers or consultants to provide this calculation. For small health plans in particular, the requirement to use a licensed actuary would increase the plan's cost as additional plan professionals would have to be engaged, at additional cost.
- c. *Past Cost Method.* The measurement period approach outlined in the Notice appears reasonable. In regard to the costs included in the past cost method, we provide the following comments:
 - i. We would encourage Treasury and the IRS to allow the plan the option to elect to use either claims incurred or claims adjudicated during the measurement period. Employers typically track paid claims, while claims administrators and insurers often track both. Stop loss contracts are based on claims incurred in a particular period and paid in another period, which will overlap but may include either run-in or run-out, depending on the contract. For that reason, it would be preferable to allow either approach, as long as the approach remains consistent from year to year absent bona fide business reasons for a change. If a claims adjudicated/paid approach is adopted, there will be no need for a run-out period. If a claims-incurred basis is adopted, the majority of claims are captured in the 3 months following the end of the period, but it is possible to see claims as late as 12 months later. For that reason, we encourage Treasury and IRS to allow the plans flexibility on that point.
 - ii. With respect to overhead expenses, we believe it is very rare for an employer to break out or track internal overhead expenses (e.g., salary, rent, supplies and utilities) related to administering the health plan. Particularly for smaller employers, employees in the Human Resources and Finance departments have wide-ranging job duties and are rarely devoted to the health plan in a way that can be easily calculated or that is consistent from one year to the next. We believe you should adopt the presumption that for self-insured plans with a

third party administrator, reasonable overhead expenses are reflected in the third party administrator fee.

- *C.3 HRAs.* We believe the Notice correctly identified the key issue in valuing HRAs: if the value is based on either the total contribution newly available to participants or the total amount available to participants, the HRA will be overvalued. The carryover provision is an important part of the HRA plan design, as it encourages participants to be better health care consumers, thus lowering the underlying health plan utilization. Therefore, we encourage Treasury and IRS to permit employers to determine the cost of coverage by adding together the claims and administrative expenses attributable to the HRAs for a particular period and dividing that sum by the number of employees covered for that period. Because the plan design of the HRA offered by the employer may change in the future (due to changes in the employer contribution, permitted uses or the details of the carryover provisions), we also encourage the use of the actuarial method basis be permitted.
- *D. Determination Period.* The Notice requested comments regarding whether a determination period must be elected in advance or whether it may be feasible to determine the cost of applicable coverage based on using actual costs, retrospectively. We encourage IRS and Treasury to allow self-funded health plans to utilize an actual cost approach as an option, at the discretion of the plan. Self-funded health plans do not experience the cost certainty that insured plans enjoy. The actual costs for a self-funded plan may increase or decrease as a result of market forces, changes in the employee population, large claims, mid-year benefit changes, etc. If such changes result in a reduction in actual costs compared to the amount projected under either the actuarial cost basis or the past cost basis, the health plan should be able to benefit from such mid-year cost reductions when calculating the applicable excise tax (if any).

Section V. Applicable Dollar Limit

- *B. Potential Approach for Application of Dollar Limit to Employees with both Self-Only and Other-Than-Self-Only Applicable Coverage.* Because the calculations are likely to be complex, we encourage IRS and Treasury to allow options for employers and health plans in this situation. The first potential approach outlined in the Notice may be easier for some employers to administer, as they assign the dollar limit based on the employee's medical plan election. However, some employers or health plans may be disadvantaged by this approach. Therefore, we encourage IRS and Treasury to consider as an option the approach outlined in the Notice which would allow a composite limit determined by prorating the dollar limits for each employee based on the ratio of the cost of the self-only coverage and the cost of the other-than-self-only coverage provided to the employee.

It is unclear to us how the calculation will be applied or the excise tax (if any) will be paid when some applicable coverages are insured and others are self-funded or when multiple insurers or administrators are used. It is unlikely that multiple insurers or administrators will be able to effectively coordinate the applicable calculation and reporting or ultimate tax payment (if applicable). For that reason, we encourage the IRS and Treasury to consider allowing the limits to apply separately to each coverage (e.g., medical, HRA, FSA, etc.).

We also encourage the IRS and Treasury to continue to allow self-only coverage under a multiemployer plan to be treated as other-than-self-only coverage. Because of the way multiemployer coverage is funded and administered, we believe this is a reasonable accommodation.

- *C. Dollar Limit Adjustments*

- Adjustments for High-Risk Professions.* We encourage Treasury and IRS to interpret the term “plan” in this context to mean the employer as a whole or a sub-group of employees by job classification or by bargaining unit. For example, many public sector employers employ firefighters, law enforcement officers, paramedics, first responders, etc., but those individuals do not make up the majority of their population. Those employers may benefit from allowing a more permissive interpretation.
- Age and Gender Adjustments.* We believe it would be desirable to develop safe harbors to adjust the dollar limit thresholds for this adjustment.
- Geographic Differentials.* We encourage Treasury and IRS to apply geographic differentials to the dollar limit thresholds. Health care costs vary dramatically by state. It costs significantly more to provide services to a population in Alaska than it does to provide the same services to an equivalent population in Minnesota or Kentucky. According to the Kaiser Family Foundation, the premium for the lowest cost Bronze plan in 2015 for a 40 year old non-smoker in Anchorage, Alaska was approximately 2.6 times higher than the cost of the benchmark plan in Phoenix, AZ or Nashville, TN, and almost 3 times higher than the cost of the benchmark plan in Louisville, KY, Minneapolis, MN, or Albuquerque, NM.

VI. Possibility of Other Methods of Determining Cost of Applicable Coverage

We would welcome alternative approaches to determining the cost of applicable coverage. The Notice provided mentioned by way of example that two self-insured plans may have the same actuarial value but may spend more (or less) to provide those benefits. Many of the factors that influence the ultimate cost of coverage are outside the control of the health plan. The population may be healthier or less healthy based on environmental issues. The cost of care in the area may be higher due to the plan’s geographic area. The plan may be lucky – or unlucky – in a given year. For those reasons, an approach in which the cost of applicable coverage is based on a plan’s actuarial value may be considered, and would be consistent with the statute.

Thank you for your consideration.

Sincerely,

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