AWC
ASSOCIATION OF WASHINGTON CITIES

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LEGAL PROCESSING DIVISION
PUBLICATION & REGULATIONS BRANCH

May 14, 2015

Notice 2015-16

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

RE: **IRS NOTICE 2015-16: HIGH COST HEALTH COVERAGE EXCISE TAX**

Dear Sir/Madam:

On behalf of the Association of Washington Cities ("AWC") and its 281 incorporated cities and towns, we are respectfully submitting comments to Notice 2015-16 regarding the Excise Tax on High Cost Employer-Sponsored Health Coverage ("excise tax").

**Background**

Founded in 1933, the AWC is a private, non-profit, non-partisan corporation that represents Washington's cities and towns before the state legislature, the state executive branch and with regulatory agencies. Membership is voluntary. The AWC proudly maintains 100% participation of Washington's 281 cities and towns. In addition to legislative representation, the AWC provides educational training, technical assistance and member programs, including a large employee benefits pool insuring 36,000 members.

**Our Concerns**

The AWC is very concerned about the undue financial burden that the excise tax may place on local government employers in Washington State. While the excise tax does not take effect until 2018, Washington municipalities are disproportionately impacted by the excise tax due to statutory requirements mandating benefit coverage for certain groups of employees or former employees, such as early and post 65 public safety personnel. These statutory requirements make it very difficult for local government employers to make benefit change that would allow them to fall below the threshold, thereby avoiding the tax.

In addition, local governments are still recovering from the economic recession, and have done so at a much slower rate than private sector employers. The AWC, and our national organization – the National League of Cities (NLC) – are concerned that a 40 percent excise tax on the value of high

cost plans, especially those benefits which are inescapable due to state mandated, will further impede the economic recovery that many local governments continue to face.

The AWC supports efforts to reduce the disproportionate impact of the excise tax on local governments and to minimize the administrative burden on employers in calculating the tax.

**Comments**

1. **Definition of Applicable Coverage [Section III]**

   **A. On-site Medical Clinics [Section III.E]**

   Code Section 4980I(d)(1) requires on-site medical clinics that are part of a "group health plan" to be included in the cost of "applicable employer-sponsored coverage" in determining the "excess benefit" subject to the excise tax. Our comments on this issue reflect our concern that the imposition of that tax on employer-sponsored on-site medical clinics may unduly impede the ability of employers to effectively manage their health care costs and assure the well-being and productivity of their employees.

   The significant investments that employers have made in their on-site medical clinics have enabled them to improve their employees' general health and well-being, while keeping employee healthcare costs down. Employer-sponsored on-site medical clinics also enhance employee productivity by improving job performance and reducing absenteeism. Today, many employers use medical clinics to provide preventive care (*e.g.,* blood pressure readings, cholesterol screenings, biometric screenings, immunizations and checkups that include conversations about diet, smoking cessation and physical activity), encourage health and wellness, and raise awareness of medical conditions before they become chronic. This care often is provided during working hours and below prevailing market rates.

   We want to stress that care at most employer-sponsored on-site medical clinics is *de minimis* medical care because such facilities do not have the staff, equipment or expertise necessary to treat employees that have significant health issues. On-site medical clinics don't employ specialty physicians, such as cardiologists, oncologists or urologists, nor do they offer complex imaging (*e.g.*, CT scans or MRIs) and they don't offer surgery or hospitalization. When faced with an individual who is in need of significant medical treatment, an employer-sponsored on-site medical clinic will serve as a referral conduit to link that individual with a specialist who can provide optimal care. As such, these clinics focus less on treatment, and more on prevention and wellness. As observed by the Department in Notice 2015-16, most employees are not likely to consider their employer-sponsored on-site medical clinic as part of their health coverage. We agree with that point and believe that such a clinic is an *employer* benefit that is

often offered as an *employee* benefit; from an employee standpoint, employer-sponsored on-site medical clinics are therefore at best a *de minimis* fringe benefit.

As stated in Code section 4980I(d)(2), the cost of employer-sponsored coverage subject to the high-value plan excise tax should be determined under rules which are *similar* (not identical) to those used to calculate COBRA premiums. The ACA therefore gives the Department the right to depart from its COBRA guidance with respect to on-site medical clinics.[1] We therefore urge the Department to adopt regulatory criteria that would minimize the impact of the excise tax on these clinics given the valuable role they play in managing healthcare costs and promoting healthy and productive employees - goals that go to the very heart of the ACA.

To best preserve the critical role played by employer-sponsored on-site medical clinics, we strongly recommend that the Department exempt "*de minimis* medical care" provided at on-site medical clinics, which should be defined to consist of:

- Preventive care (*e.g.*, blood pressure readings, cholesterol screenings, biometric screenings, immunizations and check-ups that include conversations about diet, smoking cessation and physical activity);
- Health and wellness programs that promote a healthy lifestyle; and
- The occasional treatment of minor medical ailments.

Like the Department, we have concerns about how to value care obtained at an employer-sponsored medical clinic. It is difficult and administratively burdensome for an employer to place a value on encounters that occur primarily because of convenience (rather than out of necessity) and that refers employees to external healthcare providers for treatment that is covered under the employer's health plan. To address these concerns, we recommend that the Department exclude from the cost of coverage all care obtained at an employer-sponsored medical clinic that is primarily devoted to *de minimis* medical care (*i.e.*, more than 50% of clinic visits or more than 50% of the total clinic operating expenses relate to *de minimis* medical care). Alternatively, we recommend that the Department view as *de minimis*, and exclude from the cost of coverage, up to $500 in annual care provided by an employer-sponsored medical clinic, which could be calculated by dividing the total cost to staff, supply and manage the clinic by the number of individuals who are eligible to use the clinic. This $500 exclusion would be consistent with the *de minimis* expense rules set forth in the final capitalization regulations (T.D. 9636), which were issued by the Department in September 2013.

We also recommend that the Department issue guidance that interprets the definition of "group health plan" for Code Section 4980I purposes differently than such term is interpreted for

[1] Treas. Reg. § 54.4980B-2 (Q&A #1) contains this guidance.

COBRA purposes. We suggest the Department interpret the term "group health plan" to include only those employer-sponsored on-site medical clinics that satisfy the following criteria:

- Access to the clinic is limited to current and former employees who are enrolled in the employer's health plans;
- Clinic services are included in the governing documentation for the plan (*e.g.*, plan document or summary plan description); and
- The majority of the healthcare services offered by the clinic are other than "*de minimis* medical care" (as such term is defined above).

We believe the foregoing recommendations balance the desire to tax the excess benefit in high-value health plans with the significant non-health plan-related benefits employers realize from owning and operating their own on-site medical clinics.

**B. Limited Scope Dental and Vision Benefits [Section III.F]**

We agree with the proposal to exclude from the cost of applicable coverage under Code Section 4980I self-insured limited scope dental and vision coverage that qualifies as an "excepted benefit". Excluding self-insured limited scope dental and vision coverage for 4980I purposes would be consistent with the treatment of such coverage under other provisions of the Affordable Care Act (*e.g.*, market reform provisions, transitional reinsurance fee, PCORI fee).

**C. Employee Assistance Programs (EAPs) [Section III.G]**

We also agree with the proposal to exclude from the cost of applicable coverage under Code Section 4980I EAPs that qualify as an "excepted benefit". Excluding EAPs for 4980I purposes would be consistent with the treatment of such programs under other provisions of the Affordable Care Act (*e.g.*, market reform provisions, transitional reinsurance fee, PCORI fee).

**2. <u>Determination of Cost of Applicable Coverage</u> [Section IV]**

**A. Potential Approaches for Determining Cost of Applicable Coverage [Section IV.C]**

**i. Similarly Situated Individuals [Section IV.C.1]**

**a. Aggregation by Benefit Package**

We support the approach proposed by the Department to divide similarly situated employees based on the type of benefit package in which they are enrolled, then subdividing that group based on the mandatory disaggregation rules, and allowing further subdivision based on the permissible disaggregation rules. This

seems like a viable starting point for active employees (but not retirees) and provides some administrative flexibility for employers.

**b. Permissive Aggregation within "Other Than Self-Only" Coverage**

We support the approach proposed by the Department to not require an employer to determine the cost of applicable coverage for employees receiving "other than self-only" coverage based on the number of individuals covered in addition to the employee (even if the actual cost of such coverage varied on this basis). This approach is consistent with the statute and provides administrative flexibility for employers.

**c. Permissive Disaggregation**

We support the approach proposed by the Department to permit further disaggregation of similarly situated individuals. To encourage administrative flexibility for employers, we encourage the Department to permit disaggregation based on a broad standard. The standard that comes to mind is the reasonability standard addressed in Treas. Reg. § 1.410(b)-4(b), which permits a facts and circumstances approach to determining reasonability and states that reasonable classifications generally include specified job categories, nature of compensation, geographic location, and similar *bona fide* business criteria. Permissive use of a broad disaggregation standard provides administrative flexibility for employers.

**d. Retirees**

The Department has asked whether additional guidance would be beneficial under Code Section 4980I(d)(2)(A), which provides that "the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries." This correctly suggests that a plan should be allowed to average the cost of employer-sponsored coverage for pre-Medicare retirees with the cost of similar coverage for retirees who are entitled to benefits under Medicare (where such employer-sponsored coverage may be limited to a Medicare supplement plan).

Allowing employers to offset the typical high costs of pre-Medicare retiree coverage with lower cost Medicare supplement plans increases the likelihood that employers will preserve pre-Medicare retiree coverage (which was the main goal of the ACA's Early Retiree Reinsurance Program) and provides relief to public employers who are legally required to offer retiree health coverage under constitutional and statutory mandates. (See Revised Code of Washington 41.26.150, mandating lifetime medical benefits for public safety personnel.)

Interpreting this language in a contrary manner is likely to wreak further havoc on the financially vulnerable budgets of state and local governments.

### ii. Self-Insured Methods [Section IV.C.2]

#### a. Past Cost Method (Costs Taken into Account) [Section IV.C.2.c.ii]

We encourage the Department to specify that the only factors that must be included under the past cost method are claims and premiums associated with stop-loss coverage and/or reinsurance (which directly relate to claims), because these are the principal cost drivers of a group health plan. We believe this approach would more closely align to the statutory phrase "***coverage** under any group health plan*" set forth under Code Section 4980I. Section 5000(b)(1) of the Code defines a "group health plan" as a plan that provides "health care." To our knowledge, the Internal Revenue Code does not define "health care," but the Department has acknowledged that for COBRA purposes, this term has the same meaning as the term "medical care" under Code Section 213(d) (*i.e.*, "amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, for the purpose of affecting any structure or function of the body").[2] Based on the meaning of this term under COBRA and the plain meaning of the phrase "coverage under," we believe the past cost method calculation should be limited to claims and stop-loss/reinsurance premiums to guard against catastrophic claims.

Furthermore, we strongly support the exclusion of administrative expenses (which, for COBRA purposes, have always been charged at the option of the employer) and not allocating overhead expenses (*e.g.*, compensation, rent, supplies, utilities) in favor of administrative simplicity. Including administrative expenses and allocating overhead expenses for individuals involved in health plan administration would be complicated, time consuming and burdensome for employers. Exclusion of these amounts is likely to have little bearing on the actual cost of any health plan.

Lastly, we strongly support the Department's proposal to exclude from the cost of applicable coverage (i) reserves for potential future costs; and (ii) claims that are subject to reimbursement under a stop-loss or reinsurance policy.

[2] See Treas. Reg. § 54.4980B-2 (Q&A #1).

**b. Actuarial Basis Method [Section IV.C.2.b]**

We support a self-insured plan's ability to make an actuarial estimate of the cost of providing coverage for a determination period using reasonable actuarial principles and practices. For administrative simplicity, we encourage the Department to specify that the only factors that must be included in an actuarial estimate are claims and premiums associated with stop-loss coverage and/or reinsurance. The rationale for our position is set forth in Section 2.A.ii.a, above.

With respect to requiring an accreditation process to make actuarial estimates, most, if not all, self-insured plans already have competent actuaries making actuarial estimates, so requiring formal accreditation seems to be unnecessary. The need for accreditation would be lessened if actuarial estimates only had to factor in claims and premiums associated with stop-loss coverage and/or reinsurance.

**iii. HRAs [Section IV.C.3]**

We encourage the Department to issue guidance permitting employers to determine the cost of coverage for HRAs by using either the contribution approach (based on the amounts made newly available to a participant each year) or the claims approach (adding together all claims, but not administrative, expenses attributable to the HRA for a particular period). This will provide employers with the greatest flexibility to determine the least complicated and administratively burdensome for their plan. Requiring one or the other method for determining the cost of coverage for HRAs may be more complicated and administratively burdensome for employers and could result in greater cost variability from year to year.

We also encourage the Department to permit the employer to exclude from the cost of applicable coverage contributions to and/or reimbursements from limited-purpose HRAs, which are used to reimburse for excepted benefits such as dental and vision and/or for employee contributions towards coverage.

Comments are requested on whether the potential approaches described for purposes of determining the cost of applicable HRA coverage under § 49801 should apply for purposes of determining the COBRA applicable HRA premium. We recommend that when a monthly HRA contribution amount is determined for a 12-month determination period, and is determined before the beginning of such period, the actual monthly HRA contribution amount should be the amount used for purposes of determining the COBRA applicable premium.

**3. Applicable Dollar Limit [Section V]**

**A. Dollar Limit Adjustments [Section V.C]**

**i. Adjustments for Qualified Retirees [Section V.C.1]**

We suggest that the Department issue guidance confirming that a "qualified retiree" is any individual who (1) is receiving health coverage by reason of being a retiree, (2) has attained age 55, and (3) is eligible to enroll in the Medicare program under title XVIII of the Social Security Act, but is not receiving Medicare benefits. As noted, many public employers are legally bound to offer legacy retiree benefits which provide primary coverage. Retirees of such employers are not required and have no incentive to enroll in Medicare (even if they are eligible). Our requested clarification of Code Section 4980I(f)(2)(C) would expressly allow these employers to utilize the higher applicable dollar limit, which is critical because legacy retiree benefits that are primary to Medicare are very costly for public employers and cannot be modified in most situations.

**ii. Adjustments for High-Risk Professions [Section V.C.2]**

We support the issuance of further guidance on what constitutes an "employee engaged in a high-risk profession." In determining whether the majority of employees covered by a plan are engaged in a high-risk profession, we suggest that the Department allow employers to have multiple "plans" as long as each plan can be justified using *bona fide* business criteria. For example, an employer should be allowed to have different plans for specified job categories, hourly and salaried employees, union personnel, and similar *bona fide* business criteria.

Thank you for considering our comments. If you have any questions or would like to discuss these comments further, please do not hesitate to contact our Legislative Advocate Candice Bock or our Director of Member Pooling Programs Carol Wilmes at (360) 753-4137, candiceb@awcnet.org, or carolw@awcnet.org.

Sincerely,

Luann Hopkins

Luann Hopkins
Chief Operating Officer/Interim CEO