Notice 2015-16

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May 13, 2015

Notice 2015-16
Room 5203
Internal Revenue Service
P.O. Box 7604
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Washington, D.C. 20044

Copies to:
Senator Lamar Alexander, Tennessee
Senator Bob Corker, Tennessee
Congresswoman Marsha Blackburn, Tennessee
Congressman Jim Cooper, Tennessee
Former Senate Majority Leader Bill Frist, MD

This letter has also been emailed to Notice.comments@irscounsel.treas.gov.

To Whom It May Concern,

We (CareHere, LLC), respectively submit these comments in response to Notice 2015-16, which is intended to initiate and inform the process of developing regulatory guidance regarding the Excise Tax on High-Cost Employer-Sponsored Health Coverage (the "Excise Tax").

We specialize in providing on-site healthcare through employers by making healthcare and wellness easier, better and more affordable. Our program is not an insurance program, but helps employers reduce the 'fee-for-service' costs by offering this employee choice (voluntary) option on a pass-through cost basis paid by our employer/client.

Comments Relating to Notice 2015-16

1. *What Is the Excise Tax and What Type of Health Coverage Is Counted Toward the Tax?*

Beginning January 1, 2018, employer-sponsored health care coverage that exceeds $10,200 for individuals and $27,500 for families would be subject to a 40% excise tax.[1] For purposes of determining whether the cost of the employer-sponsored coverage exceeds the dollar thresholds, the aggregate value of the entire package of health care coverage is taken into account.[2] This means that in addition to the premium costs of a major medical plan – and

[1] Section 4980I(a), (b)(3)(C)(i), (c) of the Internal Revenue Code (Code). These dollar thresholds will be increased (1) on account of age and gender and (2) for retirees and individuals who work in "high-risk professions" or are employed to repair or install electrical or telecommunications lines. [Code section 4980I(b)(3)(C)(iii), (iv)]. Importantly, these thresholds are indexed to the Consumer Price Index ("CPI") plus one percent in 2019, and then beginning in 2020 and for years thereafter, these thresholds will only increase based on changes in CPI. [Code section 4980I(b)(3)(C)(v)]. In the case of a multiemployer plan, the "family" threshold applies regardless of whether a worker maintains single versus family coverage. In other words, the threshold for both single and family coverage offered under a multiemployer plan is $27,500 [Code section 4980I(b)(3)(B)(ii)].

[2] Code section 4980I(d)(1).

certain other types of health coverage such as, among others, employer contributions to a Health Reimbursement Arrangement and employee contributions to a Health Savings Account ("HSA") made through a Code section 125 cafeteria plan – the value of coverage for on-site medical clinics providing more than de minimis medical care are all counted toward the calculation of the Excise Tax. [3]

2. *Should the Value of Coverage for On-Site Medical Clinics Providing More than De Minimis Medical Care Be Counted Toward the Excise Tax?*

No. We recognize Congress's desire to limit the tax preference for employer-sponsored health insurance, otherwise known as the "exclusion."[4] However, we respectfully disagree with the assertion that limiting the exclusion is an effective way of reducing health care spending. We believe there are a number of other policies that may be pursued that would "bend-the-cost-curve" downward without disadvantaging non-executive-level workers (which will be the ultimate impact of the Excise Tax). One such policy pursuit is promoting the use of on-site medical clinics.

For example, on-site medical clinics provide an employee and dependents covered by an employer-sponsored health plan direct access to certain services that would otherwise require the employee to leave the work-site and, in some cases, over-utilize medical care. Specifically, data indicates that on-site medical clinics reduce the number of emergency room and urgent care visits, which result in a beneficial effect on health care spending. On-site medical clinics also provide earlier treatment of illnesses or injuries, and better management of chronic conditions. Again, services that contribute to the reduction of health care spending overall.

It would appear that in some cases, the Internal Revenue Service (the "Service") would consider on-site medical clinics as providing "significant benefits in the nature of medical care or treatment," as opposed to "providing only de minimis medical care." But, what does it mean to provide "significant benefits in the nature of medical care or treatment"? Neither the Service nor the other Federal Departments have clearly defined this standard.[5]

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[3] Code section 4980I(d)(1)(B)(i).

[4] The "exclusion" for employer-provided health insurance generally refers to Section 106 of the Internal Revenue Code ("Code"). Code section 106 provides that "employer" contributions used to pay for health insurance coverage under an "accident and health plan" are not taxable to an employee for income tax purposes. These employer contributions are also not taxable to an employee for FICA tax purposes. [see Code section 3121(a)(2)(B)].

[5] In Notice 2004-50, Q&A-10, the Internal Revenue Service (the "Service") provided that a program that does not provide "significant benefits in the nature of medical care or treatment" would not considered a "health plan" for purposes of Code section 223(c)(1). However, the Service did not define the meaning of this standard. The Department of Labor ("DOL") has also issued guidance in relation to employee assistance programs ("EAPs"), suggesting that an EAP that does not provide "significant benefits in the nature of medical care or treatment" would continue to be considered an "excepted benefit." [see DOL Technical Release 2013-02]. But, similar to the Service, the DOL did not define the meaning of this standard other than to say that "employers may use a reasonable, good faith interpretation of whether an EAP provides significant benefits in the nature of medical care or treatment." [Id.]. In addition, the Departments of Treasury, Health and Human Services, and Labor discuss the standard of providing "significant benefits in the nature of medical care or treatment" in final regulations amending the

We argue that trying to develop such a bright-line test of (1) what it means to provide "de minimis medical services" and (2) what it means to provide "significant benefits in the nature of medical care or treatment" is extremely difficult and arbitrary. It appears that for purposes of the Excise Tax, the Department of Treasury and the Service are looking to the COBRA regulations to develop a standard based on what types of services should be considered "first aid," and what types of services are considered "in addition (or in lieu) of first aid."[6] Again, developing such a bright-line test is extremely difficult, and Treasury and the Service run the risk of developing rules that will have a chilling effect on offering on-site medical clinic-related services altogether, the very service that helps to reduce costs for employer and covered members of the health plan.

In addition, The Internal Revenue Code (§ 9832) acknowledges the value on-site medical clinics bring to the overall goal of healthcare reform and exclude the programs – along with a small handful of other benefits – from existing health plan regulations. However, presently, on-site clinics are the only such exempt benefit potentially subject to the tax.

Not only does including on-site clinics as a benefit potentially subject to the excise tax go against the overall goals of healthcare reform – increasing the quality of care, improving the overall health of the population, lowering spending, and removing barriers to care – it's inconsistent with how the IRS is treating other exempt benefits.

Generally, on-site clinics contribute to less than 1 to 3 percent toward the aggregate cost of employer-sponsored coverage that exceeds the threshold to trigger the excise tax. Employers with on-site clinics view them as significant cost-control measure that should remain in place to assist efforts in remaining below the cost level that triggers the tax.

Including on-site medical clinics in the calculation of benefits subject to the tax goes against the triple-aim of healthcare reform – increasing the quality of care, improving the overall health of our population and lowering healthcare plan spending. In fact, these clinics are a proven solution to reduce and contain costs while further removing barriers of access, as well as improving medical and prescription compliance

For these reasons, we respectfully request – for the purposes of the Excise Tax – that Treasury and the Service consider any medical services provided by an on-site medical clinic to be "de minimis medical care," which meets the standard set forth in the statute. Developing an arbitrary bright-line test will only further confuse employees and employers in an already complex and confusing regulatory process, and such actions will adversely impact the utilization of on-site medical clinics, which – as discussed above – have been shown to decrease health care utilization, thereby reducing health care spending overall.

"excepted benefit" rules, but those regulations simply re-state the reasonable, good-faith interpretation standard in DOL Technical Release 2013-02. [79 Fed. Reg. 59130, 59132-33 (Oct. 1, 2014)].

[6] Notice 2015-16, Part III, Section E.

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3. *Would Excluding the Value of Coverage for On-Site Medical Clinics Providing More than De Minimis Medical Care Be an "End-Run Around" the Excise Tax?*

No. We recognize that during the drafting of the Excise Tax, policymakers were concerned that if the value of on-site medical clinics were excluded from its calculation, employers would try to "end-run around" the Excise Tax by offering, among other things, primary care physician and/or prescription drug dispensation services through the on-site clinic – in lieu of offering employees the ability to obtain these services from local hospital providers and/or physician groups, which stand as services that would be counted toward the Tax. However, the primary motivation of employers that offer on-site medical clinics is to reduce absenteeism, increase productivity, and lower health care utilization among employees. The primary motivation is not to replace primary care and/or other medical services that can be performed at local hospitals, doctors' offices, and specialty care facilities.

It is important to emphasize that this primary motivation would not change if the overall value of on-site medical clinics was removed from the calculation of the Excise Tax altogether. Actually, we believe more employers would offer on-site medical care-related services as a result, which could contribute to the reduction in health care utilization, thereby "bending-the-cost-curve" downward, a result that the Service, the Federal Departments, and Congress are all trying to achieve.

Thank you in advance for considering these comments. Please do not hesitate to contact me if you have questions on this very important issue.

Sincerely,

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