

Submitted electronically to:
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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: Notice 2015-16

Dear Ladies and Gentlemen:

Crossover Health welcomes the opportunity to comment on Notice 2015-16 concerning certain aspects of the implementation of the excise tax on high cost employer-sponsored health coverage. We appreciate the initial efforts of the Department of Treasury (Treasury) and Internal Revenue Service (IRS) relating to the potential approaches described in Notice 2015-16 with respect to imposition of the excise tax under section 4980I of the Internal Revenue Code (Code).

Crossover Health's Interest in the Affordable Care Act

Crossover Health is a leading worksite health company dedicated to improving the quality and cost of employee healthcare. With over 5 years of experience, Crossover Health manages more than 10 worksite-based health and wellness centers across the country. The company serves some of the nation's leading employers, including many in the Fortune 500. Crossover Health provides organizations and their employees with a range of on-site health services, including primary care, acute episodic illness and physical medicine.

Code Section 4980I and the Treatment of On-site Medical Clinics

Code section 4980I generally includes on-site medical clinics within the definition of applicable coverage for purposes of the excise tax on high cost employer-sponsored health coverage. Treasury and IRS indicate they anticipate promulgating regulations that exclude on-site medical clinics from the definition of applicable coverage under certain circumstances, most notably, when such clinics offer only de minimis medical care to employees. Treasury and IRS note that such an exception would be consistent with the technical explanation of the law prepared by the Joint Committee on Taxation. In addition, Treasury and IRS state that such an interpretation has the added benefit of avoiding the burdensome calculation related to determining the incremental additional cost of such coverage.

As further support for an exclusion of certain benefits offered to employees at on-site medical clinics, Treasury and IRS note that regulations promulgated under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provide a useful

comparison. Specifically, Treasury and IRS note that health care provided to employees free of charge at on-site facilities is not considered to constitute a group health plan for purpose of COBRA coverage if certain requirements relating to the nature of the care (primarily first aid) and the timing of the illness or injury (during work hours) are satisfied.

Crossover Health is pleased to respond to the request for comments relating to how Treasury and IRS should treat medical care in the case of on-site medical clinics and, in the case of care provided by on-site medical clinics that is applicable coverage, how to determine the cost of such care.

On-site Medical Clinics Provide Foundational Support for True Health Care Reform

Since the passage of the Affordable Care Act, great attention has been focused on how to expand access to health care to all Americans, while reengineering the health care delivery system to provide consistent quality care at the lowest cost. Mindful of these goals, an increasing number of employers have turned to on-site clinics to improve their employees' access to health care, productivity and health outcomes, in addition to supporting the traditional occupational health services designed to manage work-site illnesses and injuries. Since the enactment of the ACA, employers have adopted on-site medical clinics at an accelerated pace, reflecting not only a concerted effort to pro-actively respond to the relentless increase in health care costs, but also a shift in focus to health care quality, efficacy and prevention.

The expanded repertoire of non-occupational services offered by today's on-site clinics provide a vehicle for driving effective health care delivery. Employers increasingly understand that to achieve reduced costs and absenteeism, improved productivity and a higher quality of care, requires a shift in emphasis from the piecemeal, highly specialized care of the past, to a renewed focus on collaborative, primary care and prevention.

Modern worksite clinics offer a broad array of service options, affording employers the opportunity to tailor programs to the unique needs of their workforce. On-site medical clinic services can vary widely depending upon industry characteristics, workforce demographics and geographic considerations. Many employers opt for on-site patient-centered medical homes (PCMH), which is a centralized care delivery model whereby patient treatment is organized at the on-site facility to enhance the patient experience, generally by ensuring improved care coordination, patient (and, when appropriate, family) engagement and accessibility to care.

In addition to sites designed around the PCMH model, worksite clinics also offer services on a selective basis, including traditional occupational health, primary care, health promotion and prevention, and select specialty care services such as pharmacy, physical therapy, laboratory, dental, vision, and radiology services.

Wellness and prevention programs offered at on-site medical clinics today often go beyond the mere promotion of health awareness, providing, for example, medical care such as physical examinations, biometric screenings, flu shots, nutrition coaching and counseling, disease management and education.

Consistent with the goals of the ACA, delivery of these services at on-site clinics assist employers in reducing the cost of care and improving both the quality and access to such care. The legislative history of the ACA is replete with references to the importance of health promotion and disease prevention. Excluding medical care in the case of on-site medical clinics from the definition of applicable coverage for purposes of calculating the 4980I excise tax will incentivize employers to continue to utilize these transformative vehicles of change that are essential in today's health care delivery system. In contradistinction, casting a wide net and including the panoply of services provided by on-site medical services will have the reverse effect on employers' efforts to promote wellness and disease prevention.

Comments Relating to the Treatment of On-site Medical Clinics

Crossover Health agrees with Treasury and IRS that, for purposes of assessing the excise tax under Code section 4980I, calculating the incremental additional cost of coverage provided by on-site medical clinics is a burden best excluded from the determination of the aggregate cost of applicable employer-sponsored coverage. The exponential growth of worksite medical facilities reflects the expanded and pivotal role they currently play in employer-based health and welfare benefits programs. Requiring forward thinking employers who adopt on-site medical facilities to cost out each of the services provided at their clinics would represent a giant step backwards to the outdated, fragmented approach to health care delivery. Sophisticated sponsors of health and welfare benefits programs understand that the health care cost curve can be bent most effectively by tapping in to the savings of coordinated care, which requires integrated eligibility, utilization and digital technologies. Treasury and IRS are correct to avoid the perils of fragmentation inherent in requiring employers to undertake the burdensome task of calculating the implemental additional cost of coverage provided via on-site medical clinics.

It is no coincidence that there has been widespread adoption and development of on-site medical clinics since the passage of the ACA. The ACA's desire to bend the health care cost curve, as well as its focus on patient centered care, boost the merits of the worksite clinic platform. On-site medical clinics are a critical component in many employers' efforts to control cost and improve health outcomes for their employees; in many ways, they are the first line of defense for employers in the battle against rising health care costs and the attendant diminished productivity associated with poor health outcomes.

While the number of Americans without health care continues to decline, implementation challenges have slowed the progress of realizing the full goals of national health care reform. Many states continue to struggle with Medicaid

expansion, all stakeholders (employers, providers and patients) are grappling with high health care costs, and pending litigation threatens the viability of subsidies available through state- based exchanges. Employer-sponsored health and welfare benefits plans and programs historically have been the vehicle by which the majority of Americans have had access to health care. Inclusion of on-site medical clinics in the value of applicable employer- sponsored coverage for purposes of calculating the Code section 4980I excise tax significantly would undermine the employer sponsored health care delivery system.

Given the ongoing questions surrounding key provisions of health care reform and the growing demands placed on employers to comply with the statute's complex rules and regulations, the employer-sponsored model -- which is the bedrock foundation for the American health care delivery system -- must be supported vigorously if the goals of health care reform truly are to be achieved. Maintaining the stability of the employer-sponsored market is critical to bending the health care cost curve, the polestar of the statute. Any interpretation of the scope of applicable employer- sponsored coverage for purposes of imposing the 4980I excise tax should be mindful not to exacerbate the strains presently placed on the employer-sponsored model. Failure to heed this warning likely will lead to significant reductions in health care services provided by employer-sponsored plans and programs, and, in some instances, wholesale abandonment of such plans and programs.

For these reason, and as a threshold matter, Crossover Health respectfully requests that Treasury and IRS exercise their discretionary authority to provide an enforcement delay in implementing the imposition of the excise tax until the year 2020.¹ A delay will allow additional time for all agencies with interpretive and enforcement authority relating to the regulation of on-site medical clinics to analyze the empirical data underlying the arguments referenced above and below. Most notably, a delay in enforcement most assuredly also will delay the steady march towards benefits cutbacks, many of which already are underway and, without a course correction, more will follow.

Crossover Health also respectfully recommends Treasury and IRS ultimately promulgate rules reflecting the dynamic referenced above and, for purposes of the excise tax under Code section 4980I, treat any medical services provided by on-site medical clinics to be "de minimis medical care," which meets the standard set forth in the statute. In doing so, Treasury and IRS not only will provide much needed support to the employer-sponsored health care model which is integral to the

¹ Treasury and IRS previously have exercised discretion to grant administrative flexibility with respect to certain provisions under the ACA. See e.g., the delay relating to imposition of the employer mandate penalty, the delay relating to the imposition of the penalty for failure to transition to the SHOP exchanges, and the delay relating to compliance with the statute's W-2 reporting requirements.

delivery of health care to millions of Americans, but also preserve employers' ability to use one of the most effective tools in their toolbox for cutting the cost of care, while improving both the quality and access to such care.

If, however, Treasury and IRS determine they must set a standard which attributes some portion of the costs of on-site medical care to the costs of applicable employer-sponsored coverage, Crossover Health respectfully requests Treasury and IRS consider a standard which is based on a specific dollar limit, denominated as a percentage of an employer's national average of aggregate cost of applicable coverage.

Federal health care programs long have acknowledged the variation of health care costs depending upon the geographic location where the care is provided, and have addressed these variations by utilizing a national average to regulate payments. For example, the Medicare physician fee schedule determines the cost of services by a formula that considers the relative value of the service, a geographic adjustment factor for the service that reflects the variation in pricing in different areas of the country, and an annual conversion factor which is a dollar amount used to translate the relative value into a fee service. These geographic adjustments are based on indices that compare a particular location with a national average.²

Given the similar variations in the cost of services provided by on-site medical clinics across the country, best practice dictates that, for purposes of calculating the 4980I excise tax, the value of on-site medical clinic services must be assessed on a nation-wide basis. To do otherwise, would result in a hodge-podge of regional calculations that unfairly may disadvantage the rank and file workers of America, who most likely will bear the brunt of employer actions to avoid imposition of the statute's excise tax. It is these non-executive level workers in America who have a veritable Damocles sword hanging over their on-site medical clinic services.

Crossover Health supports the broadest interpretation of the nature and scope of worksite clinic services excludable from applicable coverage. Nonetheless, reliance upon a benefit specific safe harbor approach – one in which certain on-site medical clinic services are excluded consistent with either the group health plan exclusion criteria described in the COBRA regulations, or the “significant benefits” test criteria found in the rules relating to HSA eligibility and the Department of Labor's

² The Centers for Medicare and Medicaid Services (CMS) must develop a geographic practice cost sales index (GPCI) for each payment locality to reflect geographic variation in the three components of a procedure's relative value unit: (1) practice expense (which includes an index of the relative cost for employee wages, relative cost of office rents, measure of costs for equipment and supplies, and cost share weights); (2) malpractice costs; and (3) physician work. CMS then multiplies the relative value unit for each of the three components times the GPCI for that component in calculating the payment amount. CMS must update the GPCI every three years and phase in any changes over two years.

“excepted benefits” guidance regarding employee assistance programs – would unnecessarily undermine the significant progress made by employers who have embraced worksite medical clinics. An ever-increasing number of employers have established on-site clinics as the focal point for their health and welfare benefits programs, committing significant resources to build the necessary infrastructure and processes to optimize health care delivery to their employees. Employers are willing to make such investments because on-site medical clinics have proven to be transformative vehicles for true health care reform.

Treasury and IRS should facilitate the continued expansion of on-site medical clinics by fashioning a rule regarding the treatment of medical care in the case of clinics that reflects the meaningful role they play in reducing “excess benefits,” as contemplated in Code section 49801(b). A standard which relies upon a specified dollar limit, denominated as a percentage of an employer’s nation-wide average aggregate cost of applicable coverage, will continue to enable employers to drive meaningful health care delivery reform through the creative use of on-site medical clinics.

Crossover Health recommends 10% as the appropriate percentage limitation for the cost of on-site medical clinic services that may be excluded from an employer’s nationwide average aggregate cost of applicable health care coverage. Adopting such a standard has the dual benefit of easing the administrative burden associated with calculating the incremental cost of coverage provided via on-site medical clinics, and providing certainty for employers wishing to maintain these critical components in the ongoing battle to reduce costs while improving the quality of care.