

Notice 2015-16

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Howard A. Burde, Esquire
Howard Burde Health Law, LLC
2320 Haverford Road, Suite 240
Ardmore, PA 19003
e-mail: Howard@BurdeLaw.com
website: www.BurdeLaw.com
(o) 610-616-3357
(c) 215-292-1246
(f) 866-591-9531

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

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Notice.comments@IRSCounsel.treas.gov

Karen Levin, Esquire
Office of Associate Chief Counsel
Courier's Desk
Internal Revenue Service
1111 Constitution Avenue, NW
Washington DC 20044

RE: Notice 2015-16

Dear Ms. Levin,

Please be advised that I represent a leading provider of on-site wellness and clinic services on behalf of employers and unions. On behalf of that provider of on-site wellness and clinic services, I am submitting this response to Notice 2015-16 (the "Notice") regarding calculation of "applicable coverage" under Section 49801 of the Internal Revenue Code.

Background

As you know, the Notice seeks feedback regarding the calculation of the cost of "applicable coverage" as that term is used in Section 49801 of the Internal Revenue Code. Specifically, the Internal Revenue Service ("IRS") seeks information to help it determine which benefits may be included in the calculation of applicable coverage and how such benefits should be valued. If applicable coverage exceeds the annual limitation in the year 2018, then the excess value will be subject to a non-refundable and non-deductible 40 percent excise tax.

The provider of on-site clinic services is particularly interested in responding to Section III.E of the Notice regarding the treatment of on-site medical clinic. We understand that Section 49801(d)(1)(B)(i) of the Code specifically does not exclude from the calculation of applicable coverage the value of on-site medical clinics.

The Notice anticipates that applicable coverage will not include on-site medical clinics that offer only *de minimus* medical care to employees as defined by the COBRA regulations. The Notice also seeks comments on the calculation of value of clinics that may offer additional services in addition to first aid “for a health condition, illness, or injury that occurs during working hours.” For example, such services might include, but should not be limited to “(1) immunizations; (2) injections of antigens (for example for allergy injections) provided by employees; (3) provision of aspirin and other nonprescription pain relievers; and (4) treatment of injuries caused by accidents at work (beyond first aid).”

To summarize, the IRS and Treasury Department seek comments on whether the standard for exclusion of benefits from the calculation of applicable coverage should be based on the nature and scope of benefits, the dollar amount assigned to such benefits, or some combination of the two.

Discussion

While the IRS’s focus on excluding the value of on-site clinics is welcome, the approach should reflect the full scope of on-site clinic services. The Notice focuses on the acute care services in the COBRA language as well as additional services. However, the Affordable Care Act contains additional provisions incentivizing wellness programs and the IRS, Department of Health and Human Services (HHS) and Department of Labor Employee Benefits Security Administration (EBSA) published joint regulations, effective January 1, 2014 regarding wellness programs (the “Wellness Regulations” see, e.g. 26 CFR Part 54, 29 CFR Part 2590, and 45 CFR Part 146). Additionally, The Medicare program specifically covers Annual Wellness Visits which would not be considered acute care but which would promote the general well-being of individuals covered by applicable coverage.

Logically, the proposed rulemaking anticipated by the Notice should exclude the value of those types of programs and services specifically incentivized or mandated by the Affordable Care Act and the Medicare program, in addition to those that fall within or are similar to those in the expanded definition of *de minimus* clinic services.

Proposal

The provider of on-site wellness and clinic services proposes the following approach to determining both the services and the value of such services to be excluded from the calculation of applicable coverage:

1. Excluded Services. The proposed exclusion of, “for example, (1) immunizations; (2) injections of antigens (for example for allergy injections) provided by employees; (3) provision of aspirin and other nonprescription pain relievers; and (4) treatment of injuries caused by accidents at work (beyond first aid)” provides a useful but incomplete starting point and raises the question of what similar services should likewise be excluded. For example, if injections of antigens would be excluded, logically, administration of any preventative drug for a chronic condition should likewise be excluded. Administration of non-prescription pain relievers should include any non-prescription drug or analgesic.

Consistent with the COBRA definition, treatment of injuries or conditions which occur on-site, should include any condition which might be manifest at work, regardless of whether work is the cause, such as headaches or other treatable chronic conditions.

The provider of on-site wellness and clinic services proposes using either a visit code or time value estimation to capture the value of services to be excluded from the calculation of applicable coverage. For example, if a visit at an on-site clinic were to be coded as 99201, 99202, 99203 (for workplace accidents or illness), 99211, 99212, or 99213 (for workplace accidents or illness) then the value of such visits would not be included in the calculation of applicable coverage.

If an on-site clinic does not code its encounters, then another approach would be to have the clinic determine the percentage of time spent on excluded versus included services and then multiply that percentage by the cost per member per year to determine the value of on-site acute care clinic services to be excluded from the calculation of applicable coverage.

2. Wellness Services. The issue raised by the integration of wellness services and clinic services is how to value each for the purpose of excluding the entire value of the wellness services. Under the Affordable Care Act, and the implementing Wellness Regulations, incentives for wellness programs may allow rewards of up to 30 percent of the cost of health coverage (50 percent for tobacco cessation programs). To the extent an on-site clinic provides wellness services, it would be contradictory and counter-productive to include the value of wellness services in the calculation of applicable coverage thereby disincentivizing the provision of wellness services. Therefore, the value of any wellness services provided to a member should be excluded from the calculation of applicable coverage. For example, the actual amount paid by the plan on a per member basis could be excluded from such calculation.

Additionally, the Medicare program provides an annual wellness visit benefit which could be applied as a proxy for the value of certain wellness services provided in the on-site clinic context. For example, the Medicare Annual Wellness Visit ("AWV") is coded as G0438 for the initial visit and G0439 for each subsequent annual visit. To the extent that the on-site clinic provides the equivalent of an AWV, the value of such visits as expressed in the amounts paid for G0438 and G0439 should be excluded from the calculation of the applicable coverage.

3. Beneficiaries. Since many employer and union based plans offer benefits of on-site clinics to both members and beneficiaries, to the extent on-site services are excluded from the calculation of applicable coverage and are available not simply to members, but also to family members and dependents of members, the value of such services for family members and dependents should likewise be excluded.

We appreciate the opportunity to offer these comments in response to the Notice. If the IRS would like additional information regarding on-site clinic and wellness services, please let me know.

Respectfully Submitted,



Howard A. Burde