Notice 2015-16

HealthSCOPE
BENEFITS

27 Corporate Hill Drive
Little Rock, AR 72205

May 4, 2015

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

Re: HealthSCOPE Benefits requests exclusion of wellness incentives from applicable coverage definition

Dear Sir or Madam:

On behalf of HealthSCOPE Benefits ("HealthSCOPE"), as both an employer plan sponsor, and a third party administrator, of self-funded group health plans, we are writing to express concern about the definition of applicable coverage as set forth in IRS Notice 2015-16. Specifically, HealthSCOPE believes that employer contributions for wellness incentives as well as the use of on-site clinics should be expressly excluded from the definition of applicable coverage that a plan would use to calculate the cost of coverage that could result in the imposition of the excise tax commonly referred to as the "Cadillac Tax." The basis of our belief is that employers and other sponsors of self-funded group health plans need flexibility in plan design to encourage employees to engage in healthy activities as well as assist plans with controlling increases in their annual healthcare spend.

Support for our belief is found in regulations promulgated previously by the IRS jointly with the Department of Health and Human Services ("HHS") and the Department of Labor ("DOL") (collectively referred to as "the Departments"). In 2013 the Departments issued final HIPAA wellness regulations that aimed to promote wellness through employee incentives. *In the general overview of the regulations, the Departments* state, "wellness programs have the potential to contribute importantly to promoting health and preventing disease." At that time, the Departments recognized the *importance that incentives such as employer contributions to account-based plans (e.g.,* Health Reimbursement Accounts, health Flexible Spending Accounts) can play. Indeed this was one primary goal of final HIPAA wellness regulations, as evidenced by the

statement: "these final regulations continue to provide plans and issuers flexibility and encourage innovation."

The purpose of these wellness incentives is to promote employee choices that lead to positive health outcomes, which would in turn reduce future healthcare spending by the employer. This goal is vital to promoting the continued viability of self-funded group health plans in this country.

The broad definition of applicable coverage appears to include employer contributions to HSAs, FSAs, and HRAs for wellness incentives. Specifically, we are concerned with employer contributions to HSAs, FSAs, and HRAs (or any other reduction in employee cost-sharing) for completing certain participation or activity-based tasks associated with wellness programs. A few examples include biometric screenings, tobacco cessation, and yearly physicals.

Under the proposed guidance set forth in Notice 2015-16, the definition of applicable coverage, and the rules for calculating the cost of coverage, could plausibly be read as contributing to the threshold amount for excess benefits. This would result in the imposition of an excise tax on an employer that would otherwise not have to pay the tax if its wellness programs were terminated. Unfortunately, this would discourage plans with employer contributions designed to reduce employee cost-sharing from implementing wellness programs for fear of having to pay the 40 percent excise tax.

While other incentives can be used, in our opinion, monetary rewards are among the most effective methods for employers to incentivize employees to participate in the wellness programs.

Second, we are concerned with the inclusion of free or reduced on-site clinics in the definition of applicable coverage. Notwithstanding the logistical difficulties of calculating the cost of coverage in this instance, these clinics play an essential role in helping employers control costs through the use of carefully contracted rates and early intervention before disease states progress. These clinics also support existing preventive care programs by providing convenient physical and wellness screenings for employees who may otherwise not visit another primary care physician. In fact, many of our clients' health plan members use the on-site clinic as a primary care facility; it truly may be the only ongoing relationship they have with a provider. If the cost of coverage for on-site clinics is included in the definition of applicable coverage, we are concerned that many employers will elect to shut down their clinics rather than be subject to the excise tax.

As a third party administrator, we have unique insights into self-funded health plans across the country. This regulation, in its current form, could discourage plan sponsors of self-funded plans from using wellness incentives or providing on-site care in the future. Moreover, we believe that the regulation, in its current form, may frustrate the purpose of regulations promulgated by the ACA to ensure continued access to coverage

through, in part, a sustainable, comprehensive employer-sponsored group health plan at an affordable cost.

For these reasons, we ask that in the final regulations, you exclude benefits received from the use of on-site medical clinics and employer wellness contributions to HSAs, FSAs, and HRAs from the total amount used to determine if the threshold amount has been met to qualify as an "excess benefit."

Sincerely,

Mary Catherine Person
President