Notice 2015-16

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May 14, 2015

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

Attention: IRS Notice 2015-16

Submit electronically via notice.comments@irscounsel.treas.gov/ Subject: Notice 2015-16

To Whom It May Concern:

The Maine Health Management Coalition would like to express its appreciation for the opportunity to submit comments in response to the Internal Revenue Service's recent regulatory guidance (Notice 2015-16) relative to the excise tax on high cost employer-sponsored health coverage under §49801 of the Internal Revenue Code. The Maine Health Management Coalition (MHMC) is a multi-stakeholder, purchaser led non-profit membership organization. The mission of the MHMC is to work collaboratively to improve health and maximize the value of health care services for all Maine residents. MHMC has a membership of 70 organizations representing approximately 200,000 employees. The MHMC purchaser members include large private employers in the retail and manufacturing sectors as well as large public sector employers and plan sponsors.

The MHMC has a history of multi-stakeholder collaboration to improve population health, increase quality of care while reducing health care costs. Plan sponsors have implemented a series of innovative benefit design strategies in an effort improve the value of health care services. MHMC member organizations have been leaders in advancing public reporting of provider performance, introducing tiered networks and implementing new payment initiatives. Despite the adoption of innovative strategies Maine employers/plan sponsors continue to be confronted with cost increases that exceed regular inflation. The excise tax scheduled for 2018 poses a daunting challenge for employers attempting to contain costs at the same time efforts have been accelerated to expand risk-based contracts with health systems. We respectfully request that the IRS consider the issues that we identify in this communication.

The impending excise tax has, and will continue to, dominate employers' strategic planning for the next several years as they struggle to effectively catalyze changes in the delivery system which are necessary to reduce overall health care costs. As noted by many of the MHMC members, the excise tax is a unique lever that focuses on overly generous employer-sponsored health coverage prompting incentives for more efficient use of expenditures. What has significantly challenged employers has been the uncertainty of the regulatory parameters governing the excise tax. The MHMC and its members applaud the work of the IRS and the Treasury Department in soliciting comments. We would, however, urge that the regulatory process be accelerated to the greatest extent possible. The ongoing challenge of

analyzing benefit options, assessing actuarial value, and developing budget responses cannot be concluded until the guidance is finalized.

Defining applicable coverage:

The MHMC urges the agency to tighten the definition of "applicable coverage," ensuring this will only impact plans with excessively generous coverage. Casting too wide of a net on various types of coverage mechanisms will thwart the efforts of employers to contain cost, and result in a large scale cost shift to employees which may impede access to appropriate care. The agency should therefore exercise the regulatory authority granted under §4980I to exclude the many cost effective and innovative activities employers are engaged in to improve employee health and wellness.

In the past decade, employers have made great strides to improve the health of their workforce, reducing overall cost of care, and controlling for quality, by adopting new models for on-site medical services. The evidence suggests that employers with more than 1,000 employees or arrangements where multiple employers share clinics, can experience a complete return on investment and decrease overall health plan costs by more than 20% after 3 years. The IRS has indicated that it will exclude onsite medical clinics providing de minimis coverage—while excluding all onsite medical coverage would require a statutory change, the agency should implement as broad a definition of de minimis as possible, given that onsite medical clinics providing first aid, immunizations, and other forms of routine, non-intensive care are lowering, rather than driving, unnecessary utilization. MHMC would recommend all onsite or near site clinics be excluded. If this is not possible, a broad definition of de minimis is key.

A broad definition of de minimis onsite medical coverage would include both the many forms of high value preventive care offered at clinics and the many innovative ways employers are using onsite care at large and small worksites. While many employers have built cost-effective clinics on their campuses, some smaller employers contract a single nurse to give onsite immunizations or provide routine care in a medical van on a periodic basis. The IRS should define de minimis coverage in a way that does not distinguish between the efforts of large and small employers pursuing strategies that increase the receipt of high-value primary care. A new trend in near site employer clinics, or shared clinics, should also be excluded, as it is on track to provide high value, lower cost care.

Additionally, Treasury and IRS are commended for initial exclusion of employee assistance programs (EAP) from applicable coverage, and we ask on behalf of our plan sponsor members that EAPs remain excluded. This type of support is not only essential for control of various forms of behavioral health, but when not offered, can trigger lack of compliance with other medical care, chronic condition management, and ultimately may affect the individual's ability to maintain employment.

The MHMC and its self-funded plan sponsors would argue that there is no policy basis for distinguishing between insured and self-insured stand-alone dental and vision benefits for purposes of the excise tax. Self-funded stand-alone dental and vision coverage should also be excluded from the excise tax.

Calculating costs:

MHMC and our plan sponsors have strong concern with the cost calculation set forth in Notice 2015-16, specifically with limiting the tax preference for employee contributions to flexible spending accounts (FSAs), Archer medical savings accounts (MSAs), and health savings accounts (HSAs). This notice set forth as part of applicable coverage to include employee pre-tax contributions to FSAs, MSAs, and HSAs, presumably based on the assumption that employer contributions to those accounts are excluded from income under §106 and §4980I(d)(1)(C) does not differentiate between employer and employee contributions

Policymakers clearly did not intend to end the tax benefit associated with employee FSA, MSA, and HSA contributions, and included very explicit language for calculating the cost of coverage toward the threshold in §4980I(d)(2)(B)(i). This section plainly states that determining the cost of coverage in an FSA shall include only the "employer contributions under any salary reduction election." Similarly, calculating the cost of coverage for Archer MSAs and HSAs should only include "the amount of employer contributions," viz., not employee contributions. The IRS is urged to issue clarification that employee contributions to these accounts will continue to receive their traditional tax preference. We would argue that employee HSA contributions (and any other applicable employee contributions) via payroll deduction should not be included in the excise tax calculations.

The agency should also support the stated goals of lawmakers and the position of this and prior administrations when it comes to the treatment of Health Reimbursement Accounts (HRAs). Excluding employer contributions to HRAs would preempt the possibility of double-taxation if employees used HRA funds toward the cost of applicable coverage. Excluding employer contributions is also consistent with a longstanding policy favoring wellness initiatives, activities recognized as reducing—rather than driving—health care spending. Many employers use HRAs to provide employees with wellness incentives, and including wellness payments in the cost calculation would have the unintended effect of discouraging the proliferation of those programs.

When costs and application of tax are considered, the current model of the tax applying without regard to plan design, individual plan provisions, geographic locations, and population demographics, must be revisited. It is imperative that the final regulations allow for variations and reflect differences due to factors largely out of the control of employers, while focusing on "excessively generous" benefit designs.

Applying costs:

The IRS addressed the issue of "applying cost" in Notice 2015-16. As with other sections, the agency should apply cost in a manner consistent with the original intent of the statute, which includes an additional allowance only in a limited number of specific instances. MHMC and its members believe that costs should be applied equally to all groups except those explicitly provided for in §4980I(b)(3)(C)(iv)—qualified retirees, those engaged in high-risk professions, and groups with significant deviations from the age and gender balance of the national workforce.

The MHMC would strongly urge the agency to consider a geographic adjuster to account for significant geographic cost differences. Maine is a rural state with considerable price and utilization variation. Ongoing analyses of price variation for a market-basket of common procedures/services have revealed a

60% variation from the least costly to the highest cost hospitals. The variation is predominantly a geographic distinction. This variation, an aging population (second oldest state), and a relatively high chronic disease burden reflective of an older population have combined to produce per capita costs in the commercially insured population that are among the nation's highest. Despite sustained efforts by plans sponsors, Maine has remained a high per capita cost state. We would argue that failure to adjust for this geographic factor may result in many Maine employers being at risk of exceeding the base thresholds, not because of excessively generous benefit coverage, but as a result of Maine's high per capita costs.

MHMC and its member organizations appreciate your thoughtful consideration of these comments on the proposed regulations. If you have any questions about these comments or wish to discuss further, please contact Frank Johnson, Director of System and Payment Reform, at fjohnson@mehmc.org.

Sincerely,

Frank A. Johnson
Director of System and Payment Reform
Maine Health Management Coalition