Notice 2015-16

Pittsburgh
Business Group
ON HEALTH

P.O. Box 208 Ambridge, PA 15003 info@pbghpa.com www.pbghpa.com 724-251-0230

May 15, 2015

Attention: IRS Notice 2015-16

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

Via notice.comments@irscounsel.treas.gov / Subject: Notice 2015-16

To Whom It May Concern:

The Pittsburgh Business Group on Health (PBGH) welcomes the opportunity to provide comments in response to the Internal Revenue Service's recent regulatory guidance (Notice 2015-16) regarding the excise tax on high cost employer-sponsored health coverage under §4980I of the Internal Revenue Code.

PBGH and its 113 employer and associate members are committed to reducing health care costs while increasing quality of care, access, and health care and benefit transparency relative to both care and cost.

PBGH is one of the country's premier employer-led coalitions and is aimed at serving as western Pennsylvania's only advocate and voice for large and small organizations representing various business segments, including private and public employers, government and academia. Our employer members represent more than 500,000 lives and generate more than $5.2 billion in health care spending alone.

The excise tax provision, while one of the final pieces of health care reform to be implemented, will be one of the heaviest burdens to bear for both employers and employees. The excise tax will threaten and erode the employer's ability to adopt tested and proven strategies aimed at achieving better quality care, reducing cost, and driving long-term efficacy, and we hope you will consider the barriers laid out within this letter.

We understand the challenge facing policymakers: how to effectuate the delivery system changes required to reduce costs and improve value in our nation's health care system.

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The "Cadillac" tax is a unique cost-control mechanism, which narrowly targets excessively generous employer-sponsored health insurance packages, thereby increasing incentives for the prudent and efficient use of care. The tax is not intended to work, however across the market and among all employers the same way, effectively undermining the overall movement toward consumer directed care or hindering an employer's ability to offer cost-effective strategies for improving the health and wellbeing of its workforce.

The regulatory implementation of §4980I must serve these narrowly tailored objectives. To that end, the IRS should incorporate three overarching principles when considering the issues outlined in Notice 2015-16:

1. Promulgate a tight definition of "applicable coverage" so that only excessively generous, "gold plated" employer health insurance coverage is penalized;
2. Calculate costs in a way that does not discourage employee contributions to consumer-directed health care accounts, or impede an employer's use of health and wellness incentives; and,
3. Fairly apply costs in a manner consistent with the lawmakers' original intent by ensuring upward adjustments are only offered in the limited number of specific exceptions codified in current law.

Promulgate a tight definition of "applicable 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. 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.

Since its inception, PBGH employer-members have focused on improving the health of their workforce, reducing overall cost of care, and driving quality initiatives among brokers, insurers, and providers.

Additionally, PBGH seeks to ensure the continued exclusion of employee assistance programs from applicable coverage. This type of support is not only essential for control of various forms of mental health, but when not offered, can trigger lack of compliance with other medical care, chronic condition management, and ultimately the ability to maintain employment.

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Moreover, PBGH asks policymakers to consider advocating that all on-site clinics, regardless of whether they provide di minimis services or full services, be excluded from applicable coverage. The experience of our employer members is that the inclusion of these costs when determining the cost of applicable coverage for an employer of any size could be substantial. In that regard, a broad definition may not truly benefit all employers who have taken creative steps to manage employee health and its related cost.

Nationally, the evidence suggests 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 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.

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.

<u>Calculate costs in a way that does not discourage employee contributions</u>

Like our larger sister organization, the National Business Coalition on Health (NBCH), our regional employer network also has strong concerns about 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

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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.

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.

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Fairly apply costs in a manner consistent with the lawmakers' original intent

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.

PBGH members believe 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.

PBGH's employer-members appreciate your continued thoughtful consideration of our comments on the proposed regulations. If you have any questions about these comments or wish to discuss further, please contact me directly at 724-251-0230 or via email at jessica.brooks@pbghpa.com.

You can also learn more about PBGH at www.pbghpa.com.

Sincerely,

Jessica L. Brooks

Jessica Brooks
CEO & Executive Director
Pittsburgh Business Group on Health

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