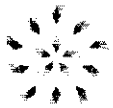
Notice 2015-16



PBGH
PACIFIC BUSINESS
GROUP ON HEALTH

575 Market St. Ste. 600
SAN FRANCISCO, CA 94105
PBGH.ORG

OFFICE: 415.281.8660
DIRECT LINE: 415.520.0927

May 15, 2015

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

Dear Ms. Levin:

Thank you for 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 ("Excise tax") under §4980I of the Internal Revenue Code. The Pacific Business Group on Health ("PBGH") is a non-profit organization that leverages the strength of its 60 members—who collectively spend $40 billion a year purchasing health care services for more than 10 million Americans—to drive improvements in quality and affordability across the U.S. health system.

Our members believe strongly that keeping employees and their families healthy is both the right thing to do and a wise business strategy. A key cornerstone of these efforts is providing tax-preferred employer-sponsored health insurance coverage along with an innovative suite of employer health and wellness initiatives, benefits long encouraged by policymakers and excluded from an employee's taxable income under §106 of the Internal Revenue Code. While rising health care costs present a major challenge to our members, they remain deeply committed to offering comprehensive health coverage and have an enduring stake in population health policies that affect employee wellness and productivity.

A key question facing policymakers is how to effectively catalyze the delivery system changes required to lower costs and improve value in our nation's health care system. The Excise tax is a unique cost control mechanism originally intended to discourage excessively generous employer-sponsored health insurance packages, thereby increasing incentives for the prudent and efficient use of care. The tax is not meant to work at cross purposes with the general concept of employer-sponsored insurance, undermine the overall movement toward consumer directed care, or hinder an employer's ability to offer cost effective strategies for improving the health and wellbeing of their 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, increase the cost of offering retiree coverage, or impede an employer's use of health and wellness incentives; and,

PBGH
PACIFIC BUSINESS
GROUP ON HEALTH

575 Market St. Ste. 600
SAN FRANCISCO, CA 94105
PBGH.ORG

OFFICE 415.281.8660
FAX NUMBER 415.520.0927

3. Fairly apply costs in a limited, simple, and transparent manner that does not require employers to incur additional expenses on complex actuarial analysis.

These principles support the important policy goal of placing downward pressure on costs at the provider level without eviscerating the employer-sponsored insurance market, undermining consumer-driven health care, or hampering employee wellness programs in the United States.

Definition of Applicable Coverage

First, the agency must promulgate a tight definition of "applicable coverage," or make fewer things count toward the threshold constituting excessively generous coverage. The IRS has already indicated it likely will not include self-insured dental and vision coverage or employee assistance programs (EAPs) in the definition of applicable coverage. PBGH and its members believe strongly this is the correct course of action. The agency should further 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.

PBGH members offer employees a host of benefits that improve employee health while ultimately lowering health care spending, including access to onsite and temporary medical clinics, wellness incentives, and low- or no-cost primary care services. 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 promulgate 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 several of our members have built cost-effective clinics on their campuses, some of our 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.

Determination of Cost of Applicable Coverage

Second, the agency's method for calculating the cost of coverage should be consistent with the original policy goal of discouraging excessively generous employer-sponsored insurance plans, rather than undermining movement toward more consumer directed care by limiting the tax preference for employee contributions to flexible spending accounts (FSAs), Archer medical savings accounts (MSAs), and health savings accounts (HSAs). Unfortunately, the IRS suggests in Notice 2015-16 that "applicable coverage" includes employee pre-tax contributions to FSAs, MSAs, and HSAs, presumably based on the

PBGH
PACIFIC BUSINESS
GROUP ON HEALTH

575 Market St. Ste. 600
SAN FRANCISCO, CA 94105
PBGH.ORG

OFFICE 415.281.8660
FACSIMILE 415.520.0927

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 should 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.

PBGH and its members were pleased to note that the IRS is continuing to encourage employer-sponsored retiree coverage by allowing the blending of pre- and post-65 retirees when calculating the cost of coverage for these groups. This is consistent with §4980I(d)(2)(A) of the law, which makes explicit that pre- and post-65 retirees may be treated as "similarly situated." The agency's interpretation will support the maintenance of employer-based retiree coverage by allowing companies to average the cost of providing coverage to retirees over and under the age of 65, thereby lowering the probability that these relatively expensive groups will trigger excise tax liability.

Applicable Dollar Limit

Third, 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 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. Our members will separately pursue a statutory change so that the qualified retiree adjustment is also available to pre-55 retirees.

It is crucially important that any methodology for applying costs propagated by the agency be simple, transparent, and equitable. For example, utilizing the federal age curve and demographic averages promulgated by the Bureau of Labor Statistics and determining a simple age adjustment factor would

PBGH
PACIFIC BUSINESS
GROUP ON HEALTH

575 Market St. Ste. 600
SAN FRANCISCO, CA 94105
PH: 415.281.8660
FAX: 415.520.0927

mitigate the need for employers to contract for complex—and expensive—actuarial analysis. Similarly, using standard definitions from the North American Industry Classification System (NAICS) would provide a straightforward, neutral, and widely-used source for communicating more information about which groups the agency considers to be engaged in high risk professions.

Other Considerations

Finally, we appreciate the deliberate and collaborative process the IRS has signaled for the implementation of regulations surrounding §4980I. It is crucially important, however, for the agency to speed up the regulatory process. The Excise tax portion of the Affordable Care Act goes into effect on January 1, 2018, less than three years from today. In the context of the traditional health benefits cycle, this is not far in the offing. Businesses of all sizes have already begun projecting employee benefit costs and preparing for implementation of the tax—we all need significant lead time to plan for upcoming benefit cycles.

Thank you for the opportunity to provide comments to the agency as it implements this section of the Affordable Care Act. We trust that the IRS will issue regulations consistent with the original intent of the lawmakers, which was to limit the tax preference for excessively generous employer-sponsored health insurance policies. Drifting from that narrowly tailored policy goal will have an undesirable impact on employers' ability to offer comprehensive coverage to their employees, undermine the movement toward more consumer directed health care, and limit innovative approaches to health and wellness that are reducing—rather than driving—national health expenditures.

Please contact me should you require any additional information or clarification.

Sincerely,

William Kramer
Executive Director for National Health Policy
Pacific Business Group on Health