Notice 2015-16

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VIA EMAIL: Notice.comments@irscounsel.treas.gov.

May 15, 2015

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

Re: Excise Tax on High Cost Employer-Sponsored Health Coverage (IRS Notice 2015-16)

Dear Ms. Levin:

The Pharmaceutical Research and Manufacturers of America (PhRMA) appreciates the opportunity to comment on the Internal Revenue Service and Treasury's (collectively, "IRS") recent notice (the Notice) regarding the Excise Tax on High Cost Employer-Sponsored Health Coverage (the Excise Tax). PhRMA is a voluntary, non-profit organization representing the nation's leading research-based pharmaceutical and biotechnology companies, which are devoted to discovering new medicines that allow patients to lead longer, healthier, more productive lives.

PhRMA members are not only the nation's leading research-based pharmaceutical and biotechnology companies, they are also employers who understand the value that offering high quality benefits to their employees can have both in terms of quality of life for their employees and dependents as well as for the success of their businesses. Our members have invested significant resources ensuring that benefits packages are affordable to employees while ensuring access to medically necessary care, effective treatment, and wellness initiatives.

The Excise Tax likely will have an impact on not just high-cost, or "Cadillac" benefit structures, but also more modest plans.[1] PhRMA believes this is particularly likely in areas of the country with higher labor and underlying health-care costs, such as the northeastern seaboard where a number of member companies' U.S. operations are headquartered. PhRMA is concerned that the Excise Tax eventually could incentivize employers to cut their benefits far beyond simply ensuring that overly generous benefits do not contribute to the overuse of medical services. Indeed, if not implemented through prudent regulations, the Excise Tax could lead to benefit cuts that will severely limit access to medically necessary treatments and lifesaving medications and technologies.

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[1] Towers Watson, *Nearly Half of U.S. Employers Expected to Hit the Health Care "Cadillac" Tax in 2018 with 82% Triggering the Tax by 2023* (Sept. 23, 2014), http://www.towerswatson.com/en-US/Press/2014/09/nearly-half-us-employers-to-hit-health-care-cadillac-tax-in-2018-with-82-percent-by-2023.

Given the statutory methodology chosen for indexing the thresholds for inflation, if not properly implemented, the Excise Tax has the potential to create a "race to the bottom" where employers may reduce the richness of the benefits they offer on a regular basis until they reach the thresholds and are incentivized to drop coverage to avoid this significant liability. We urge the IRS to limit the detrimental impact that the Excise Tax likely will have on employer-sponsored coverage.

Specifically, to help control costs in the long run and ensure that the Excise Tax is fully consistent with the goals of the Affordable Care Act (ACA), we ask the IRS to:

- Define the term "Applicable Coverage" to exclude employee benefits designed to promote the general health and welfare of employees from the definition;
- Provide employers with the maximum amount of flexibility to determine the cost of Applicable Coverage across their populations;
- Allow geographic adjustments to the applicable dollar limit;
- Consider the possibility of other methods for determining the cost of Applicable Coverage; and
- Exclude health plan administrative costs from the Applicable Coverage premium calculation.

I. Definition of Applicable Coverage

The Internal Revenue Code (Code) currently defines Applicable Coverage to mean, "with respect to any employee, coverage under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under section 106, or would be so excludable if it were employer-provided coverage..."[2] Additionally, the Code specifically addresses the treatment of certain types of coverage under the Excise Tax, such as Health FSAs, Archer MSAs, HSAs, and others.

The definition of Applicable Coverage is a crucial element in determining an employer's potential liability under the Excise Tax. The purpose of the Excise Tax was to promote price sensitivity in employee benefit plans by limiting excessively rich benefit structures such as "Cadillac Plans." It was not intended to limit the availability of programs designed to improve public health. Thus, PhRMA asks the IRS to define the term "Applicable Coverage" so that this item only includes major medical coverage and those types of coverage specifically enumerated in the law. The definition should not include other programs designed to improve public health more generally.

a. On-Site Medical Clinics Treating Injury or Illness Presented at Work Should Be Excluded from the Definition of Applicable Coverage

[2] Internal Revenue Code § 4980I(d)(1)(A).

According to the Notice, the Excise Tax specifically addresses coverage for on-site medical clinics and proposes a potential approach that would exclude certain on-site medical clinics that provide only *de minimis* medical care from the definition of Applicable Coverage. PhRMA supports the exclusion of *de minimis* coverage from the definition of Applicable Coverage but urges the IRS also to exclude from its definition of Applicable Coverage any treatment of any health condition or illness that is presented by a worker during business hours.

The IRS approach described in the Notice provides that on-site clinics "that meet the criteria described in the COBRA regulations and provide certain [de minimis] services in addition to (or in lieu of) first aid (for example: (1) immunizations; (2) injections of antigens (for example, for allergy injections) provided by employees; (3) provision of a variety of aspirin and other non-prescription pain relievers; and (4) treatment of injuries caused by accidents at work (beyond first aid)) would be excluded from the definition of Applicable Coverage.

On-site clinics have been addressed in the context of regulations promulgated under the Consolidated Omnibus Budget Reconciliation Act (COBRA) for determining whether an on-site clinic would constitute a group health plan. According to those COBRA rules, "[t]he provision of health care at a facility that is located on the premises of an employer or employee organization does not constitute a group health plan if – (1) The health care consists primarily of first aid that is provided during the employer's working hours for treatment of a health condition, illness, or injury that occurs during those working hours; (2) The health care is available only to current employees; and (3) Employees are not charged for the use of the facility."[3]

Consistent with this COBRA framework, PhRMA believes that the definition of *de minimis* care should include treatment of any health condition, illness, or injury that occurs during working hours. The definition of Applicable Coverage contemplates group health plan coverage. The COBRA regulations contemplate a pathway where on-site clinics can treat health conditions and illness and not be considered group health plan coverage. Thus, the IRS has precedent for excluding from Applicable Coverage the services provided by an on-site clinic to treat any illness or health condition that an employee presents while at work without the coverage being included as Applicable Coverage.

From a practical standpoint, PhRMA supports the promotion of on-site medical clinics as a cost effective, accessible, and quality method for delivering certain health services. On-site clinics provide a convenient way for workers to access critical primary care and screening services, for example. This access to care, in turn, lowers health care costs by warning workers of health risks before they become costly chronic illnesses subject to group health plan coverage. Inhibiting this pathway to care could remove critical access which would increase the cost of group health plan coverage and, thus, would be inconsistent with the goals of the ACA. PhRMA is concerned

[3] 26 C.F.R. § 54.4980B-2.

that proposals that limit their member companies' ability to provide on-site services to employees could result in poorer health outcomes.

b. Excepted Benefit Employee Assistance Programs (EAPs) Should Not Be Included in the Definition of Applicable Coverage

The Notice states that the IRS is considering whether to propose that EAPs that qualify as excepted benefits would be excluded from the definition of Applicable Coverage. PhRMA supports the proposal to exclude excepted benefit EAPs from the definition of Applicable Coverage. However, PhRMA believes the IRS should exclude all programs designed to promote health – such as employee wellness programs – from the definition of Applicable Coverage.

Recently, the Departments promulgated rules that added EAPs meeting certain criteria to the list of excepted benefits to ensure that employers would be able to continue offering these important programs to employees.[4] Those regulations provide that, for an EAP to constitute excepted benefits, the EAP must satisfy four requirements. Significantly, the regulations state that an EAP cannot provide significant benefits in the nature of medical care,[5] and its benefits cannot be coordinated with the benefits under another group health plan.

The definition of Applicable Coverage refers to coverage under a group health plan. By definition, the benefit offered through an excepted benefit EAP does not provide coverage for medical care that is coordinated through a group health plan. Thus, PhRMA's position is that it is inappropriate for the IRS to include excepted benefit EAPs in the definition of Applicable Coverage.

PhRMA members offer a wide range of EAPs that may offer benefits such as substance abuse, mental health counseling or referral services, as well as financial and legal services. PhRMA believes that these programs have a positive impact on the overall health of their workforces and play an important role in population health more broadly.

Similarly, PhRMA members also offer wellness and disease management programs, including screening activities, to detect for a variety of health conditions. These programs provide valuable access to care and ensure that employees are taking the appropriate steps to stay healthy and manage disease. These programs also play an important role in containing costs as they incentivize employees to seek care for health risk factors before they manifest into more costly

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[4] 79 Fed. Reg. 59130 (Oct. 1, 2014).

[5] "For this purpose, the amount, scope, and duration of covered services are taken into account. For example, an EAP that provides only limited, short term outpatient counseling for substance use disorder services (without covering inpatient, residential, partial residential or intensive outpatient care) without requiring prior authorization or review for medical necessity does not provide significant benefits in the nature of medical care." 79 Fed. Reg. 59130, 59133.

disease conditions. Thus, in the upcoming regulations, we urge the IRS to allow employers to continue to offer wellness and disease management programs outside the definition of Applicable Coverage.

Also of significance to PhRMA members are physical programs. PhRMA believes that these programs are another important component of providing comprehensive and thorough preventive services to employees, allowing employees to seek care before conditions progress to serious illnesses that are more costly to treat. Therefore, PhRMA believes that the IRS should not include physical programs in the definition of Applicable Coverage.

c. Employee Contributions to Health Savings Accounts ("HSAs") and Certain Other Tax-Favored Health Plans Should Not Be Included in the Definition of Applicable Coverage

According to the Notice, "Treasury and IRS anticipate that future proposed regulations will provide that (1) employer contributions to HSAs and Archer MSAs, including salary reduction contributions to HSAs, are included in applicable coverage, and (2) employee after-tax contributions to HSAs and Archer MSAs are excluded from applicable coverage." While PhRMA agrees that employee after-tax contributions should not be included in the definition of Applicable Coverage, PhRMA does not believe that employee pre-tax contributions to HSAs and Archer MSAs should be included in the definition of Applicable Coverage.

The Code provides that for HSAs and Archer MSAs, the cost of Applicable Coverage "shall be equal to the amount of employer contributions under the arrangement."[6] Consequently, any employee contributions to an HSA or Archer MSA, whether pre-tax or after-tax, are not employer contributions and, thus, should not be included in the definition of Applicable Coverage. Including these contributions in the definition of Applicable Coverage may have the adverse effect of more employers structuring pre-tax contributions to HSAs and Archer MSAs as post-tax contributions, eroding FICA tax savings for employers and employees and discouraging participation. Additionally, excluding these contributions is wholly consistent with the goals of the Excise Tax. These contributions are made with employees' own money and thus employees have an incentive to spend this money wisely and only contribute to these accounts to the extent necessary. Thus, excluding these contributions from Applicable Coverage would not contribute to overuse of health care services. Along these same lines, PhRMA believes that employee contributions to Health FSAs should also be excluded from the definition of Applicable Coverage.

PhRMA also supports excluding HSA-qualified high deductible health plans (HDHPs) from the definition of Applicable Coverage. These HDHPs are intended to increase cost sensitivity and curtail health care spending, aligning their purpose with that of the Excise Tax. Therefore,

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[6] Internal Revenue Code § 4980I(d)(2)(C).

PhRMA strongly believes that the IRS should exclude HSA-compatible HDHPs from the definition of Applicable Coverage.

II. Determination of the Cost of Applicable Coverage

The Code provides that the cost of Applicable Coverage is generally determined under rules similar to those used for determining the COBRA applicable premium. Under COBRA, the applicable premium is based on the average cost of providing coverage for those covered under the plan who are "similarly situated," rather than the cost of providing coverage based on each individual's characteristics.

Under the proposed approach outlined in the Notice, groups of similarly situated individuals would be determined by: (1) taking all employees covered by a particular benefit package (*e.g.* PPO, HMO, High-Deductible Plan); (2) dividing that group based on "mandatory disaggregation" rules, which will likely include dividing based on whether an employee is enrolled in self-only or other-than-self-only coverage (*e.g.*, self+one or family coverage); and (3) further dividing groups based on "permissive disaggregation" rules.

Accurately determining the cost of Applicable Coverage is a vital issue as that amount is compared to the year's dollar threshold to determine how much tax is owed. PhRMA recognizes that the Code requires at least some harmonization between the rules governing how to determine the cost of Applicable Coverage for purposes of the Excise Tax and those governing how to determine the COBRA applicable premium. PhRMA appreciates the IRS's proposal to allow permissive disaggregation of similarly situated employees, and PhRMA supports rules that would maximize employers' flexibility to accurately delineate groups of similarly situated individuals. Specifically, PhRMA supports an approach that would: (1) allow employers the flexibility to choose between a broad or specific standard for permissive disaggregation; and (2) include, among other criteria, geographic distinctions as a specific standard upon which employers may disaggregate.

a. Employers Should Have Flexibility to Choose Between a Broad or Specific Standard

As outlined in the Notice, a broad standard for permissive disaggregation would allow employers to disaggregate groups based on *bona fide* employment-related criteria, such as the nature of compensation, specified job categories, and collective bargaining status. A specific standard would allow employers to disaggregate based on categories like current and former employees, geographic distinctions, or tiers of coverage.

PhRMA believes that the IRS should promulgate rules that offer employers the maximum amount of flexibility to determine the cost of Applicable Coverage across their populations. To that extent, PhRMA supports giving employers the choice between a broad standard and a specific standard. Wide differences exist among employee populations, and giving employers this flexibility would allow them to individually determine how to most accurately delineate groups of similarly situated individuals. For example, although using a specific standard may be

more administratively burdensome for a particular employer, that employer may nonetheless wish to use the specific standard because the enumerated broad standards do not effectively capture the differences among its employees.

b. Geographic Distinctions Should Be Included as a Specific Standard

According to the Notice, if the IRS were to implement a specific standard approach to permissive disaggregation, geographic distinctions would be a potential specific standard upon which employers could disaggregate similarly situated employees. For example, employers would be permitted to disaggregate based on differences in employees' residences or business locations.

In conjunction with the flexibility to choose between a broad or specific standard discussed above, PhRMA supports including geographic distinctions as a specific standard. As corroborated by a substantial body of research, geographic variations are highly correlated with costs, including those for health coverage.[7] Allowing employers to account for geographic variations when disaggregating groups of similarly situated employees would help employers more accurately determine the cost of Applicable Coverage.

III. Geographic Variations in the Applicable Dollar Limit

Section 4980I(b)(3) of the Code provides two baseline annual dollar limits for 2018 – $10,200 for self-only coverage and $27,500 for other-than-self-only coverage. The Code also specifically provides for adjustments to these figures for 2018 based on a "health cost adjustment percentage" and for taxable years after 2018 based on changes in the cost of living. These amounts are also adjusted for qualified retirees, high-risk professions, and certain age and gender characteristics under the Code.

PhRMA strongly urges the IRS to consider implementing adjustments to the applicable dollar limit based on geographical variations. As discussed previously in this comment letter, geographic variations are significantly correlated with underlying geographic differences in health care costs. Therefore, applying a national dollar limit would have uneven results in certain areas where plan costs are not reflective of overly generous benefits. Allowing adjustments to the applicable dollar limit based on geographic variations in costs of living would help the Excise Tax more precisely target plans with overly generous benefits.

IV. Possibility of Other Methods for Determining the Cost of Applicable Coverage

The statute states that the cost of Applicable Coverage "shall be determined under rules similar to the rules of section 4980B(f)(4)." Section 4980B(f)(4) articulates the methodology for

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[7] *See, e.g.*, Urban Institute, *Geographic Variation in the Cost of Living: Implications for the Poverty Guidelines and Program Eligibility* (June 2013), *available at* http://aspe.hhs.gov/hsp/14/GeographicVariation/UrbanGeographicVariation.pdf.

determining the COBRA applicable premium, which is based on the cost of applicable coverage provided to similarly situated employees of the employer.

The Notice raises the question of whether the cost of Applicable Coverage for an employee could be determined by reference to coverage available elsewhere based on actuarial values, metal levels (bronze, silver, etc.), or other metrics. PhRMA strongly supports further consideration of alternative methods to determine the cost of Applicable Coverage, including one that is based on actuarial values, noting that the statute requires use of rules "similar to" but not identical to determinations under COBRA.

PhRMA is concerned that certain plans that are determined to be high-cost under the IRS's currently-proposed approach (i.e., determining the cost of Applicable Coverage in a manner similar to that used to determine the COBRA applicable premium) will not necessarily reflect overly generous benefits, especially since the dollar threshold is not adjusted for key factors that affect underlying medical costs. Instead, certain high-cost plans may be high-cost because of other factors, such as geographic variations in costs. A relatively modest plan in a high-cost area could reach the Excise Tax threshold while a more generous plan in an area with lower health care costs would not. As the Excise Tax is intended to curtail plans that are seen as overly generous, basing the cost of Applicable Coverage on actuarial values may be a more accurate proxy for capturing high-cost benefits than by using COBRA applicable premium rules.

Using an actuarial standard would still leave plans with ample incentives to control health care costs and manage their provider networks in a way that provides the best value for their employees. An actuarial standard would ensure that cost sharing averages a certain level for employees – thereby allowing the IRS to set a threshold that would provide that employer-sponsored plans could not be so generous as to reimburse for all covered expenses above the level set by the actuarial value threshold. Notably, a simple dollar threshold would not provide this same assurance, as it could allow for overly generous plans in low cost regions at the same time modest plans reach the Applicable Coverage threshold in higher cost regions. Under an actuarial standard, employers would have a strong incentive to spend their benefit dollars wisely within the actuarial value limits. We have already seen employers using innovative techniques to steer employees to high-value and high-quality providers.[8] Those innovations will likely

[8] For example, in 2011, the California Public Employees' Retirement System (CalPERS) capped what it would pay for hip or knee replacements after finding that hospital prices for the same surgery could vary widely with no appreciable differences in quality. CalPERS saved approximately $2.8 million in 2011 from this "reference pricing" program according to one analysis. James C. Robinson and Timothy T. Brown, *Increases in Consumer Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices for Orthopedic Surgery*, 32 Health Affairs, no. 8, 2013, at 1392-97, *available at* http://content.healthaffairs.org/content/32/8/1392.full.html. Other major employers, such as The Boeing Company, have partnered directly with providers to provide certain types of care in exchange for fixed-price bills. Carol M. Ostrom, *Boeing to Send Some Insured Workers to Cleveland for Cardiac Care*, The Seattle Times (Oct. 18, 2012), *available at* http://www.seattletimes.com/seattle-news/boeing-to-send-some-insured-workers-to-cleveland-for-cardiac-care/.

continue to spread as employers look for ways to control their health costs while also providing benefits that help maintain the health of their workforce.

V. Excluding Health Plan Administrative Costs from Premium Calculations

Finally, we urge IRS to consider that use of the COBRA premium calculation method in determining the cost of Applicable Coverage would capture health plan administrative costs and quality initiatives, which do not directly relate to the payment of medical benefits. A number of innovative plan administration and quality-promoting activities are consistent with the Excise Tax's goal of encouraging appropriate, and not excessive, use of medical services by covered employees. Accordingly, it would seem prudent for the IRS to consider excluding administrative costs and quality improvement initiatives from the premium calculation used to determine the cost of Applicable Coverage. There is limited, if any, opportunity for employer abuse of this policy in light of existing oversight of health plan medical loss ratios (MLR). The National Association of Insurance Commissioner's definition of MLR excludes administrative costs and quality initiatives among other items from the calculation of direct medical benefits. The existing MLR calculation methods should help to inform proposed IRS policy on calculating the cost of Applicable Coverage.

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PhRMA appreciates IRS' consideration of our comments. We stand ready to assist with any of the issues raised in our letter. Please contact Lisa Joldersma or Maya Bermingham with any questions.

Sincerely,

/s/

Lisa Joldersma
Vice President, Policy and Research

Maya Bermingham
Vice President and Senior Counsel