LEGAL PROCESSING DIVISION
PUBLICATION & REGULATIONS BRANCH

Notice 2015-16

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Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, D.C. 20044

To Whom It May Concern:

The Self-Insurance Institute of America, Inc. ("SIIA") respectively submits these comments in response to Notice 2015-16, which is intended to initiate and inform the process of developing regulatory guidance regarding the Excise Tax on High-Cost Employer-Sponsored Health Coverage (the "Excise Tax").

SIIA is a member-based association dedicated to protecting and promoting the business interests of companies involved in the self-insurance/alternative risk transfer marketplace. SIIA's membership includes self-insured employers, third party administrators, and stop-loss/reinsurance carriers, among other industry service providers.

Comments Relating to Notice 2015-16

1. *What Is the Excise Tax and What Type of Health Coverage Is Counted Toward the Tax?*

For taxable years beginning after December 31, 2017, employer-sponsored health care coverage that exceeds $10,200 for individuals and $27,500 for families would be subject to a 40% excise tax.[1] For purposes of determining whether the cost of the employer-sponsored coverage exceeds the dollar thresholds, the aggregate value of the *entire* package of health care coverage is taken into account.[2] This means that in addition to the premium costs of a major medical plan – and certain other types of health coverage such as, among others, employer

[1] Section 4980I(a), (b)(3)(C)(i), (c) of the Internal Revenue Code ("Code"). These dollar thresholds will be increased (1) on account of age and gender and (2) for retirees and individuals who work in "high-risk professions" or are employed to repair or install electrical or telecommunications lines. [Code section 4980I(b)(3)(C)(iii), (iv)]. Importantly, these thresholds are indexed to the Consumer Price Index ("CPI") plus one percent in 2019, and then beginning in 2020 and for years thereafter, these thresholds will only increase based on changes in CPI. [Code section 4980I(b)(3)(C)(v)]. In the case of a multiemployer plan, the "family" threshold applies regardless of whether a worker maintains single versus family coverage. In other words, the threshold for both single and family coverage offered under a multiemployer plan is $27,500 [Code section 4980I(b)(3)(B)(ii)].

[2] Code section 4980I(d)(1).

contributions to a Health Reimbursement Arrangement and employee contributions to a Health Savings Account ("HSA") made through a Code section 125 cafeteria plan – the value of coverage for on-site medical clinics providing more than de minimis medical care are *all* counted toward the calculation of the Excise Tax.[3]

2. *Should the Value of Coverage for On-Site Medical Clinics Providing More than De Minimis Medical Care Be Counted Toward the Excise Tax?*

No. SIIA recognizes Congress's desire to limit the tax preference for employer-sponsored health insurance, otherwise known as the "exclusion."[4] However, SIIA respectfully disagrees with the assertion that limiting the exclusion is an effective way of reducing health care spending. SIIA believes there are a number of other policies that may pursued that would "bend-the-cost-curve" downward without disadvantaging low- and middle-income workers (which will be the ultimate impact of the Excise Tax). One such policy pursuit is promoting the use of on-site medical clinics.

For example, on-site medical clinics provide an employee covered by an employer-sponsored health plan direct access to certain services that would otherwise require the employee to leave the work-site and, in some cases, over-utilize medical care. Specifically, data indicates that on-site medical clinics reduce the number of emergency room visits, which has a beneficial effect on health care spending. On-site medical clinics also provide earlier treatment of illnesses or injuries, and better management of chronic conditions. Again, services that contribute to the reduction of health care spending overall.

It would appear that in some cases, the Internal Revenue Service (the "Service") would consider on-site medical clinics as providing "significant benefits in the nature of medical care or treatment," as opposed to "providing only de minimis medical care." But, what does it mean to provide "significant benefits in the nature of medical care or treatment"? Neither the Service nor the other Federal Departments have clearly defined this standard.[5]

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[3] Code section 4980I(d)(1)(B)(i).

[4] The "exclusion" for employer-provided health insurance generally refers to Section 106 of the Internal Revenue Code ("Code"). Code section 106 provides that "employer" contributions used to pay for health insurance coverage under an "accident and health plan" are not taxable to an employee for income tax purposes. These employer contributions are also not taxable to an employee for FICA tax purposes. [*see* Code section 3121(a)(2)(B)].

[5] In Notice 2004-50, Q&A-10, the Internal Revenue Service (the "Service") provided that a program that does not provide "significant benefits in the nature of medical care or treatment" would not considered a "health plan" for purposes of Code section 223(c)(1). We recognize that the Service attempted to clarify this standard in Notice 2008-59, but the meaning of what constitutes "significant benefits in the nature of medical care or treatment" remains ambiguous. For example, the Department of Labor ("DOL") has also issued guidance in relation to employee assistance programs ("EAPs"), suggesting that an EAP that does not provide "significant benefits in the nature of medical care or treatment" would continue to be considered an "excepted benefit." [*see* DOL Technical Release 2013-02]. But, similar to the Service, the DOL did not define the meaning of this standard other than to say that "employers may use a reasonable, good faith interpretation of whether an EAP provides significant benefits in the nature of medical care or treatment." [*Id.*]. In addition, the Departments of Treasury, Health and Human Services, and Labor discuss the standard of providing "significant benefits in the nature of medical care or treatment" in final regulations amending the "excepted benefit" rules, but those regulations simply re-state the reasonable, good-faith interpretation standard in DOL Technical Release 2013-02. [79 Fed. Reg. 59130, 59132-33 (Oct. 1, 2014)].

SIIA argues that trying to develop such a bright-line test of (1) what it means to provide "de minimis medical services" and (2) what it means to provide "significant benefits in the nature of medical care or treatment" is extremely difficult and arbitrary. It appears that for purposes of the Excise Tax, the Department of Treasury ("Treasury") and the Service are looking to the COBRA regulations to develop some sort of standard based on what types of services should be considered "first aid," and what types of services are considered "in addition (or in lieu) of first aid."[6] Again, developing such a bright-line test is extremely difficult, and Treasury and the Service run the risk of developing rules that will have a chilling effect on offering on-site medical clinic-related services altogether.

Importantly, Section 9832 of the Internal Revenue Code ("Code") acknowledges the benefits that on-site medical clinics bring to the health care industry and excludes these programs – along with a small handful of other benefits – from existing health plan regulations (i.e., on-site medical clinics are considered "excepted benefits"). However, on-site medical clinics are generally the only "excepted benefit" potentially subject to the Excise Tax. Not only does including the value of on-site medical clinics in the calculation of the Excise Tax go against the overall goals of healthcare reform (i.e., increasing the quality of care, improving the overall health of the population, lowering spending, and creating access to care), it is inconsistent with how the Service is treating other "excepted benefits."

For these reasons, SIIA respectfully requests – for the purposes of the Excise Tax – that Treasury and the Service consider any medical services provided by an on-site medical clinic to be "de minimis medical care," which meets the standard set forth in the statute. Developing an arbitrary bright-line test will only confuse employees and employers, and such actions will adversely impact the utilization of on-site medical clinics, which – as discussed above – have been shown to decrease health care utilization, thereby reducing health care spending overall.

3. *Would Excluding the Value of Coverage for On-Site Medical Clinics Providing More than De Minimis Medical Care Be an "End-Run-Around" the Excise Tax?*

No. SIIA recognizes that during the drafting of the Excise Tax, policymakers were concerned that if the value of on-site medical clinics were excluded from its calculation, employers would try to "end-run-around" the Excise Tax by replacing major medical insurance coverage with medical services offered through an on-site clinic. However, the primary motivation of employers that offer on-site medical clinics is to reduce absenteeism, increase productivity, and lower health care utilization among employees. The primary motivation is *not* to replace medical services that can be performed at local hospitals, doctors' offices, and specialty care facilities, which are traditionally covered by a major medical health plan.

It is important to emphasize that this primary motivation would *not* change if the overall value of on-site medical clinics was removed from the calculation of the Excise Tax altogether. Actually, SIIA believes more employers would offer on-site medical care-related services as a result, which could contribute to the reduction in health care utilization, thereby "bending-the-cost-curve" downward. A result that the Service, the Federal Departments, and Congress are all trying to achieve.

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[6] Notice 2015-16, Part III, Section E.

B. Comments Relating to the Calculation and Assessment of the Excise Tax

SIIA understands that Treasury and the Service intend to issue future guidance that the describes and invites comments on potential approaches to a number of issues not addressed in Notice 2015-16, such as procedural issues relating to the calculation and assessment of the Excise Tax. However, in advance of the issuance of this guidance, we wanted to take a moment to highlight an issue of significant concern to our organization.

As pointed out in Part II, Section A of Notice 2015-16, the Excise Tax is imposed pro rata on (1) the insurance company in the case of a fully-insured health plan, (2) the administrator of any self-insured benefits, and (3) the employer in certain cases.[7] In the case of the administrator of self-insured benefits, SIIA suggests that Treasury and the Service consider the interpretation that the Department of Health and Human Services ("HHS") adopted when implementing the "reinsurance program" created under Section 1341 of the Patient Protection and Affordable Care Act ("ACA"). For example, the statutory language of ACA section 1341 provided that the assessment used to fund the reinsurance program would be payable by "third party administrators [("TPAs")] on behalf of group health plans."[8] HHS's implementing regulations clarified that the assessment in this case would generally be payable by "a self-insured group health plan," not the TPA.[9]

Developing a different standard would have placed significant burdens on TPAs that currently administer self-insured health plans on behalf of an employer. And, developing a different standard would have simply created "tax-within-a-tax," where TPAs and their employer customers would be at odds over the payment of reinsurance program assessment. A similar situation could arise in the context of the Excise Tax if a similar clarification is not made in forthcoming guidance.

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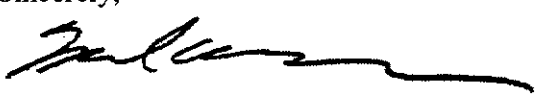
Thank you in advance for considering these comments. Please do not hesitate to contact me if you have questions, or if members of SIIA can serve as a resource on this very important issue.

Sincerely,



Mike Ferguson
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[7] *See also* Code section 4980I(c)(2).
[8] Section 1341(b)(1)(A) of the Patient Protection and Affordable Care Act.
[9] 45 C.F.R. section 153.20.