UNITE HERE HEALTH

Notice 2015-16

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LEGAL PROCESSING DIV.
PUBLICATION & REGULATIONS BRANCH

Submitted by e-mail to Notice.comments@irscounsel.treas.gov

May 15, 2015

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

Re: Notice 2015-16

Department of Treasury and IRS:

The following comments regarding the Excise Tax on High Cost Employer-Sponsored Health Coverage (Excise Tax; Notice 2015-16) by the Department of the Treasury and the Internal Revenue Service (the Departments) are submitted on behalf of Unite HERE Health (the Fund), which is responsible for the health care benefits and wellness of approximately 250,000 people in the United States. Our participants currently receive excellent health benefits that are well managed through nationally recognized quality and cost metrics. Our health professionals work diligently to provide evidence-based care for the particular needs of the hospitality employees covered by the Fund. Fund participants often work in high-stress and demanding hospitality jobs such as housekeeping and food service, and often face socioeconomic disparities that impact their health status. They often work in jobs that are not economically rewarding, and they have little ability to pay for the health benefits that they will not be afforded if their health care is reduced or eliminated as a result of the excise tax. In addition, it has never been their previous experience – or ours – that benefit decreases resulted in increased wages.

Our Fund is a nonprofit health fund solely dedicated to providing affordable, high quality health benefits to our Participants and their families. Our Plans have remained viable in the face of many challenges in the health care landscape. We are very proud of the care we have provided to our members for the last 40 years. We are now extremely concerned about the impact of the Affordable Care Act (ACA) on the stability of our plan and our ability to continue to provide the coverage on which so many currently rely.

We are particularly concerned about the potentially destructive impact of the Excise Tax under Code Section 4980I on employer-based coverage. While the stated goal of the ACA is the expansion of health care coverage to those without coverage, proponents at no time suggested that the goal of the ACA is also to reduce or eliminate care for those covered by employer-sponsored health coverage. Our concern is that the Excise Tax regulations will result in reduction or elimination of essential and affordable coverage that currently exists for millions of people through their employment-based insurance, including our participants.

IRS Notice 2015-16 solicits feedback from stakeholders on potential approaches to implementing the Excise Tax under § 4980I. The Notice calls out three major categories for consideration: (1) which health care coverage counts toward the Excise Tax; (2) how the cost of coverage is determined; and (3)

how the Excise Tax threshold would vary depending on covered population and tier of coverage elected. Our understanding is that additional comment solicitation is forthcoming.

The intent of the inclusion of the Excise Tax in the ACA was to (1) correct a "perceived" over-consumption of health care and (2) help finance other provisions of the ACA. It was expected to impact a few select plans (reported at the time to be 3%). While we must reiterate that we disagree with these general assumptions of the Excise Tax, our comments focus primarily on the first major category of the Notice –what coverage should count toward the Excise Tax. From the perspective of the Fund, the Departments should attempt to differentiate between health care coverage, health care facilities, and health care, and avoid taxing care and facilities that are devoted to reducing the cost of coverage.

I. Exemption of Fund and/or Employer Medical Clinics

Some employers and health funds are introducing a variety of value-based delivery designs, such as medical clinics. These clinics can control or reduce the cost of health coverage, improve the health of employees, enhance work place safety, and decrease employee health-related leave time. These clinic designs align with, rather than counteract, the intent of the Excise Tax (which, as we understand it, is at least partially intended to stem the trend of increasing medical costs). These designs should be encouraged rather than taxed at all. The Excise Tax on high cost plans (meaning coverage) should not apply to facilities, care activities, or other value based programs that provide savings and/or reduction in the trend of increasing health care coverage costs. This would be a better cost reduction solution than what is now happening to avoid the Excise Tax - pushing health care costs out of the plan onto families through high deductible plan designs that simply create unaffordable care.

The exclusion suggested by the Departments of worksite and employer-sponsored clinics (which under current guidance would be limited to those providing only de minimus care), should be reconsidered and expanded. Specifically, we request that the Departments consider allowing the start up and administrative costs related to medical clinics (as opposed to health benefit costs) be excluded from the Excise Tax.

- The construction costs related to creating more affordable health care options can be substantial, though not permanent. Imposing a 40% tax that includes the start up costs of these clinics will result in fewer direct care solutions, and will also reduce the amounts that remain available benefits.
- Imposing a 40% tax on programs that aim at reducing costs will also result in quicker degradation of member benefits – the programs will be reduced to avoid expending program costs, and the benefits will be reduced as the lack of cost control programs escalates costs.
- Taxing these clinics represents a competitive disadvantage to these clinics that will eliminate their sustainability. If clinics are taxed because they are part of a health plan, they will be eliminated, and patients will instead seek medical care at a non-Fund or non-employer facility that is not part of any particular health plan, and is therefore not subject to the tax.
- These clinics are currently being created because they are part of the health care cost solution- they reduce fragmentation, duplication, and waste .
- These clinics are already subject to state and federal property taxes, equipment taxes, payroll taxes, and sales taxes on supplies and equipment. Imposing an additional excise tax will further erode their sustainability.

- Work related care – clinics (whether on site or near site) should be able to provide services that are either specifically related to the requirements of the ACA, or related to care needed because of work, and this care should be excluded from the Excise Tax calculations. For example, we recommend that the following be excluded from the 'value' of coverage:
  - Immunizations, injections of antigens, aspirin and other pain relievers that result in workers remaining on the job.
  - Treatment for any injuries related to work.
  - Annual prevention exams mandated by the ACA for nongrandfathered health plans.
  - Screenings related to wellness.
  - Programs devoted to reducing health care costs when related to the provision of an ACA-compliant wellness benefit.
  - All other essential services mandated by the ACA.

II. Exemption of Implementation Costs Mandated by the ACA

The Excise Tax was created in 2010 prior to the subsequent implementation of the ACA. Since the passage of the ACA, many health care costs have increased purely as a result of other requirements. Plans that would not reach the excise tax limits prior to the ACA now might. Examples include transitional reinsurance fees, costs incurred as a result of lifting annual and lifetime limits, costs of free preventive care, costs of covering dependent adults, and administrative costs of employer and plan reporting – these all increase the premium for health care. Most of these costs, all mandated, are permanent and substantially contribute to the plan's cost for purposes of the Excise Tax. In addition, these ACA-mandated costs will add trend annually - cost trend on top of cost trend. This leaves plans with few options for managing plan cost outside of reducing or eliminating non-mandated health benefits. Eventually, only benefits that will be provided under the plans will be the mandated benefits, as other important benefits must be reduced or eliminated in order for the plans to remain under the Excise Tax limits.

Allowing plans to appropriately reduce costs through careful management and decision-making would be a preferred and longer-term solution for plans to reduce health care cost for purposes of the excise tax. Removing the ACA-mandated costs that did not exist when the Excise Tax passed from the Excise Tax calculations would provide plans with more flexibility in plan design and plan sustainability. We therefore ask that the ask that the Departments consider how to make adjustments for this unintended impact through safe harbors which allow mandated costs to be reduced, separated out, or in some other way adjusted. Otherwise, the health care system will face a situation where the costs created by the ACA are responsible for triggering the Excise Tax.

III. Safe Harbors to allow for Age and Gender and Actuarial Value Plans

Recognition of the need to allow for Age and Gender adjustments in the development of limits under which the Excise Tax is not triggered is appreciated by Unite HERE Health. We suggest

safe harbors that allow plans simplicity and flexibility in determining which methods best meet the situation of their particular enrollees. We further request age/gender adjustment tools that acknowledge and account for the range of age and gender due to health care cost disparities that may arise out of socioeconomic factors.

Additional Safe Harbors should be created for plans meeting the values established by the ACA. The ACA establishes and allows plans with an actuarial value of at least 60 percent, 70 percent, 80 percent, or 90 percent. Any such plan authorized by the ACA and meeting those actuarial values should be protected by a safe harbor. Such a safe harbor would address the inherent discrimination that is confronting employers in high cost locations and with high cost membership demographics under the current framework of the Excise Tax.

IV. Other Flexibility – Options Regarding Segregation and Desegragation

The ability to segregate or desegregate plans based on the factors most relevant to the experience of the membership in the plans is critical, and we urge that the Departments move forward with the careful construction of essential flexibility and options in each area. In particular, we believe the IRS should allow for an open-ended list of factors that might permit segregation/desegregation, as long as such factors are pursuant to bona fide business criteria. Such criteria might include factors such as geographic location, nature and/or status of employment, variety of employers, and similar factors.

V. Issues Facing Multiemployer Plans

Finally, we ask that the Departments acknowledge and address the complexity of multiemployer and collectively bargained plans when issuing regulations.

- First, we urge the Departments to ensure the statutory provision intended to address Multiemployer Plan structure through the 'other than self' costing be comprehensively included for Multiemployer Plan calculation and costing. This is an important element in operating our health plans now, and it would be destructive if diminished.
- Second, employers in our plans need flexibility around blending plans, since one plan often involves many employers and a variety of job classifications. It is essential our plans maintain the ability to consider each employer's unique plan makeup and membership enrollment. We support the comments of the National Coordinating Committee on Multiemployer Plans regarding the need for flexibility within our already complicated and varied plans.
- Finally, Unite HERE Health strongly encourages the Departments to allow a transition period for collectively bargained health plans. Multi-year, multi-employer collectively bargained contracts cannot be immediately changed to address new and complicated regulations. Some sections of the ACA have taken into account the longer ramp up time needed for collectively bargained health care, and we suggest that recognition be extended to the Excise Tax regulations. Benefit eliminations or reductions required by these new regulations will leave our Participants with health care gaps we have always filled. Stark reductions in health care to those on the edge of financial solvency will derail any success at reaching a middle class life. Our Participants are excluded by law or regulation

from the support offered by Medicaid and the exchange subsidies. This population will, instead, be left with high needs and no ability to pay for medical care no longer provided in their health plan.

We appreciate the opportunity to comment on the Department guidance, and look forward to continued opportunities to share our concerns about and suggestions for the application of the Excise Tax. We are also attaching for the record several studies which attempt to quantify and/or predict the impact of the Excise Tax on employment-sponsored health care. We acknowledge the value and importance of such efforts. Thank you.

For more information, please contact Bobbette Bond, Sr. Director of Health Policy, Unite HERE Health – bbond@culinaryhealthfund.org; 702-860-6089.