Notice 2015-16

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Willis

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

Via e-mail: Notice.comments@irscounsel.treas.gov

May 5, 2015

Dear Sir or Madam,

This letter responds to the request for comments in Notice 2015-16 (the "Notice") concerning the regulatory guidance that is anticipated regarding the excise tax (the "Excise Tax") on high cost employer-sponsored health coverage under §4980I of the Internal Revenue Code as added by the Patient Protection and Affordable Care Act ("PPACA"). The Excise Tax will be assessed, beginning in 2018, on cost of applicable employer-sponsored coverage ("Applicable Coverage") in excess of $10,200 for employee-only coverage and $27,500 for family coverage.[1]

Willis North America Inc. works with over 20,000 employers in the US who collectively provide group medical plans to over 9 million employees and their dependents. In that capacity we have been working with our clients with respect to compliance with the various mandates and new requirements that apply to employer sponsored group medical plans under PPACA. Many of the mandates cause significant administrative and management complexity without adding significantly to the value of the benefits provided. That is certainly true with regard to the Excise Tax on high value plans. It undermines the employer-sponsored health plans that are used by a majority of non-elderly Americans -- without adding any meaningful value to those plans or to the provision of health care generally.

[1] Those amounts will be indexed in future years but those increases are not tied to medical inflation but to the Consumer Price Index (plus 1% in 2019 and at the CPI in 2020 and beyond). Medical inflation has generally been about double the inflation rate of the CPI. Assuming that historical precedent continues, at some point the vast majority, if not all, employer plans will be subject to the excise tax.

Importantly, the PPACA was intended to build on and complement the employer plan system, not replace it. Indeed, applicable large employers are penalized if they do not sponsor plans that meet certain minimum requirements. The Excise Tax is contradictory to the purpose of the statute to retain employer sponsored plans. Employers remain the major providers of health care coverage for over 150 million non-elderly Americans (depending on the survey it might even be more). Therefore, Willis urges, on behalf of our clients and their employees, that Treasury give the greatest consideration possible to interpretations that will facilitate retention of employer-sponsored plans. In that way, Congressional intent behind PPACA will be fully realized.

Taking too restrictive an approach to the excise tax would lead to high marginal costs in those cases where the 40% Excise Tax is imposed. We consistently hear from our clients, and it comports with commons sense, that few, if any, expect to continue significant employer subsidies coupled with payment of the penalty tax. Virtually every employer expects to scale back the coverage offered, abandon all plan options whose cost exceeds the dollar threshold, or in the worst case scenario, terminate their plans and pay the shared responsibility penalty rather than pay such an extreme tax.[2]

In that regard we note the following and ask that you consider these issues as part of the regulatory process:

Definition of Applicable Coverage

The proposals and guidance to date have very broad definitions of Applicable Coverage for the determination of the Excise Tax. The proposed definition includes several plan design initiatives that have been developed by the marketplace to reduce the overall cost of health care and to keep members of those plans healthier. Ironically, the proposals to date would include the cost of those initiatives as part of the cost of the underlying group medical plan. Doing so would punish those employers who include those new plan designs in their plans. That would again undermine the very purpose of including those designs while driving up the cost of health care. While some of those definitions might be part of the statutory language, we urge Treasury to adopt enough flexibility to permit those programs to be incorporated without penalizing employers who choose to make use of the programs to provide cost-effective medical plans.

Wellness Programs

Wellness programs have proven to be an effective means, along with other incentives, for plan participants and their families to manage their health care expenditures. Clinical results show substantial health improvement which, over time, cannot help but improve all Americans' standard of living, not to mention alleviate health care cost expenditures.

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[2] See what different audiences think with respect to the increased tax revenues at an ABA conference
http://benefits.bna.com/bprc/2226/split_display.adp?fedfid=68357891&vname=pbdnotallissues&split=0

More importantly, wellness programs have also been found to be effective for helping plans control their costs.[3] Therefore, while an argument could be made that wellness programs are a part of the medical plan and includable in the cost of the benefits we would urge Treasury to carve them out of the overall cost and thereby reduce the applicability of the Excise Tax.

Moreover, wellness programs that are part of a medical plan should have the same treatment as those that are not. There should not be better tax treatment for a wellness program that is not part of the underlying group medical plan. We believe it would be counterproductive to create an incentive for employers to remove successful wellness programs from the health plan simply and solely to avoid the high cost health plan tax.

In addition, the PPACA specifically encouraged expansion of wellness programs via the use of incentives in health plans. All of those plans that are currently in place have to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA"). Therefore, there is already a strong statutory and regulatory process to make sure the wellness programs comply with federal standards and there is no need to add an additional layer of regulatory complexity to their design by forcing them to be carved out of the medical plans.

Since wellness programs are not part of the specific statutory language regarding the excise tax and were specifically encouraged by provisions included in PPACA, it would be contradictory to the statute to limit their availability by including them in the definition of Applicable Coverage. Willis urges Treasury to exclude HIPAA-compliant wellness program costs from the definition of Applicable Coverage (whether or not they are part of a health plan).

On-Site Medical Clinics

Employers continue to search for methods of keeping their employees healthier and more engaged with respect to lifestyle and health choices. PPACA refers to on-site medical clinics and the Notice indicates that on-site medical clinics that provide *de minimis* levels of medical care to employees can be excluded from the cost of Applicable Coverage.

Willis agrees that the cost of on-site medical clinics should continue to be excluded from the cost of Applicable Coverage. That would be conditioned on the factors of identified in the Notice, regarding the scope of care to include, 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 nonprescription pain relievers; and (4) treatment of injuries caused by accidents at work (beyond first aid). . . ."

In addition, however, to make the clinics more effective, Willis believes restricting the exclusion of on-site medical clinics to only include active employees adds complexity

[3] Rand Corp. study on the effectiveness of workplace wellness programs on participant health outcomes http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR254/RAND_RR254.pdf

and would be counterproductive. Instead, Willis proposes including only the care provided to dependents and retirees that is paid by the employer.

Willis further believes, as a condition of the exclusion, that the care cost nothing to the employees and dependents is also counterproductive. Providing the care at no cost would undermine the effectiveness of the clinics as that "free" care would be perceived as lacking in value. However, by including the costs that are paid by the employer, the employers would have the flexibility to make those determinations based on their individual circumstances.

Finally, Willis suggests that if the clinic is run by an independent entity and the only support from the employer is the use of the space at the employer's place of business at zero or reduced rent that the clinic be excluded entirely from the definition of Applicable Coverage.

Account-Based Health Plans – Medical Savings Accounts (MSAs), Flexible Spending Accounts (FSAs), Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs)

The Notice indicates that salary reduction FSAs and HSAs will likely be included as Applicable Coverage. However, Willis urges that Treasury reconsider and exclude salary deferrals to HSAs based on the clear direction from Congress to treat those amounts differently for purposes of the high cost health plan tax. Congress clearly included salary deferral contributions to health FSAs in the statutory language. And, just as clearly, Congress did not include salary deferral contributions to HSAs. This is also reflected in the Joint Tax Committee summary of the Excise Tax.

We agree with Congress. The tax treatment for High Cost Health Plan purposes should not vary for contributions to an HSA based on whether they were made via salary deferrals using a cafeteria plan structure or as above the line contributions. For example, we do not believe Congress intended to include in the cost determination for the Excise Tax the value of pre-tax contributions for active employees, while excluding the above-the-line tax deductible contributions made by retirees. Similarly, it seems clear to us, and to the Joint Committee on Taxation, that the use of the term "employer contributions" referred to actual employer contributions to an HSA or MSA – and was not intended to include the "employer contributions" resulting from salary deferral elections (as contributions to a MSA are not permitted under a cafeteria plan).

Moreover, implicit in the Notice is the view that HSA contributions made with after-tax funds to an HSA maintained separately, but which has the same bottom-line impact on the tax incidence to the individual (because it would remain deductible) should be treated differently. That just raises more complexity and administrative burden to the individual and the system without any concomitant substantive change.

Consumer directed health plans, specifically HSA-qualifying High Deductible Health Plans, have been increasingly used by employers to help give the ultimate health care

consumers -- the employees and their dependents -- more control over financing their health care costs. Consistent with the intent of the High Cost Health Plan tax, the increased deductibles reduce the value of the underlying group medical coverage.[4]

Finally, unlike an FSA or HRA, funding in an HSA is not certain to be applied to defray medical costs. That is because the funds can be used for any purpose. However, if the funds are not used for qualifying medical expenses the HSA-holder must include the distribution as taxable income and pay a penalty. As a result, it may ultimately be taxed as ordinary income – making the application of the Excise Tax less of a reduction in the tax preference accorded to health coverage and more of a penalty on savings.

High Deductible Health Plans coupled with HSAs will not be successful at moderating the cost of coverage or facilitating a change in health behaviors unless employees save, unless they contribute their own money, and unless that money can accumulate. Similarly, taxing such amounts in the year they are contributed will chill efforts to save for future years, as employees become older, as their medical expenses tend to rise with age, and as the lack of savings is likely to trigger increased calls to enhance Medicare and other public/taxpayer supported health coverage.

The Excise Tax was intended to reduce the value of very rich medical plans permitting the employers to make those plans less rich but still assist employees with methods of supplementing that coverage to afford the coverage that they need. In the event that the account-based options are included in the definition of Applicable Coverage, the fear is that the employers will continue to have larger and larger deductibles apply to the medical coverage with no ability to assist employees with the cost of coverage under the deductible level. That would be devastating to those lower paid employees who would not be able to afford to pay for coverage out of pocket. The higher paid employees likely would be able to continue to have coverage and fund the expenses. The ironic result from this would be that inclusion of these accounts as part of Applicable Coverage would result in less robust coverage for the low paid while the higher paid would be hardly affected at all.

Willis has taken the opportunity to address the most pressing issues that have been raised. In addition, Willis is part of industry groups (most notably, the American Benefits Council and the Council of Insurance Agents and Brokers) that are also commenting on the proposals in the Notice. We enthusiastically support those comments as well.

Thank you for the opportunity to comment on the proposals relative to the Excise Tax. Please feel free to contact me if you have additional questions.

Sincerely,

James Blaney

[4] See one study on the effectiveness of CDHPs http://www.ebri.org/pdf/briefspdf/EBRI_IB_012-13.No393.CEHCS.pdf