



UPMC HEALTH PLAN

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CC:PA:LPD:PR (Notice 2015-52)
Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Submitted electronically via: notice.comments@irs.counsel.tres.gov

Re: Section 49801 – Excise Tax on High Cost Employer-Sponsored Health Coverage – IRS Notice 2015-52 & Notice 2015-16

Dear Sir/Madame:

UPMC, on behalf of both the UPMC Provider System and the UPMC Insurance Services Division (UPMC ISD), is pleased to submit the following comments in response to IRS Notice 2015-52 and Notice 2015-16 that offer initial guidance regarding the Excise Tax on high cost employer-sponsored health coverage (“Excise Tax”) as imposed by the Patient Protection and Affordable Care Act (ACA) through Internal Revenue Code (“IRC” or “Code”) section 49801.

UPMC is an integrated payer-provider system with more than 20 licensed hospitals, 500 doctors’ offices and outpatient sites, 3,500 employed physicians, and a suite of health insurance and health management companies. UPMC is also the largest employer in Pennsylvania, with more than 62,000 employees. UPMC has consistently provided those employees (and their families) a comprehensive benefits package that supports a culture of wellness and good health and is proud to be a five-time recipient of the National Business Group on Health’s “Best Employers for Health Lifestyles” Platinum award.

The UPMC ISD offers a wide range of commercial, Medicare and Medicaid products to consumers in Pennsylvania, West Virginia, and Ohio. The ISD’s many regulated entities include

its flagship company, UPMC Health Plan, which has grown consistently since beginning its operation in 1997 and today proudly serves more than 10,500 employers in Pennsylvania. The ISD's UPMC Health Coverage and UPMC Benefit Management Services were two (2) of eleven (11) commercial plans nationwide to receive the highest possible 5 out of 5 rating in the National Committee on Quality Assurance's (NCQA) Private Health Insurance Ratings, 2015-16. UPMC Health Network, UPMC Health Benefits, UPMC Health Options, UPMC *for You* (a physical health Managed Care Organization (MCO), Community Care Behavioral Health Organization (a behavioral health MCO), and UPMC WorkPartners round out the regulated entities making up the Division.

General Comments

We thank the IRS for providing UPMC, the UPMC ISD, other insurance carriers and a wide-range of stakeholders the opportunity to comment on both IRS Notices in advance of the proposed rulemaking. As a sponsor of a self-funded group health plan and a health insurance issuer, the manner in which the Excise Tax is implemented is of great concern to both UPMC and the UPMC ISD, respectively. Accordingly, we are pleased the IRS has extended to us and other stakeholders the opportunity to provide comments even before the formal rulemaking process begins. Because we have concerns about a number of proposals made by the IRS, we think this iterative process will serve everyone well.

We note that while the Excise Tax is designed to mitigate the increasing costs of healthcare by essentially controlling the costs paid by employers and employees for health coverage, it fails to address the true drivers and underlying factors influencing these rising costs. In fact, as proposed, the Excise Tax may unwittingly increase the cost of coverage going forward. The Congressional Budget Office (CBO) estimates that the Excise Tax could cost coverage providers and employers nearly \$5 billion dollars in 2018 and nearly \$80 billion dollars between 2013-2023. To avoid this tax, some employers will either direct their employees into low-cost benefit options, limit plan designs that are most vulnerable to the tax (including increasingly popular HSAs and FSAs) or drop coverage all together. This is a consequence that benefits no one, most notably not those in need of comprehensive care. In the long run, our concern is that the Excise Tax may imperil two of the ACA's primary policy goals – improving health care quality and lowering health care costs.

Additionally, the Excise Tax as proposed fails to account for the long-standing trajectory of the costs of healthcare. Specifically, the dollar limit per employee will be adjusted annually by the Consumer Price Index – Urban (CPI-U). Unfortunately, medical inflation has long exceeded the CPI. As such, over time, a greater number of employers and employees will subject to the Tax. In the end, even those employers offering relatively restrictive benefit plan options may

ultimately be subject to taxation. Accordingly, we recommend a more robust annual adjustment that better reflects the actual underlying costs of medical care and benefits.

Please know that, despite our concerns, we remain fully committed to working with the IRS and other departments to operationalize the Tax as required and to continue to provide employers and their employees with affordable and comprehensive coverage options. It is with this commitment in mind that we offer the following comments to specific elements of Notice 2015-52 and Notice 2015-16.

Notice 2015-52

Section III(B): Persons Liable for the Section 49801 Excise Tax: “*Person That Administers the Plan Benefits*”

Section 49801(c)(1) of the IRC provides that the coverage provider is liable for any applicable Excise Tax. The statute defines the “coverage provider” as (A) the health insurance issuer, in the case of applicable coverage under a group health plan that provides health insurance coverage; (B) the employer, in the case of applicable coverage under an arrangement in which the employer makes contributions to health savings accounts (HSAs) and Archer medical savings accounts (Archer MSAs); and, (C) “the person that administers the plan benefits,” in the case of any other applicable coverage. The Notice acknowledges that the statute does not define the term “*person that administers the plan benefits*,” nor is it used or defined elsewhere in the Code, ACA, Employee Retirement Income Security Act (ERISA), or the Public Health Service Act (PHSA). The Notice indicates that because there is no existing definition, the IRS is soliciting feedback on two alternative approaches to define the “*person that administers the benefits*” – the employer under one approach and third party administrators (TPAs) and pharmacy benefit managers (PBMs) under the second approach.

Our comments here are two-fold: first, rather than creating a new definition for a previously undefined statutory term – “*person that administers the plan benefits*” – we respectfully suggest that the IRS define the term in regulations to be the entity listed as the “plan administrator,” as defined by ERISA and used on Form 5500. ERISA’s well-established and existing definition of “plan administrator” refers to “(i) the person specifically so designated by the terms of the instrument under which the plan is operated; (ii) if an administrator is not so designated, the plan sponsor; or (iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the secretary may by regulation prescribe.” This approach would reduce the confusion that would likely result from infusing yet another definition into this regulatory scheme. Secondly, placing responsibility for the tax on the “plan administrator” would avoid the operational and practical challenges that placing this obligation on TPAs and PBMs would create. It is the employer, not the TPA or PBM, that maintains the

administrative authority to make plan benefit and cost of coverage decisions. Additionally, because many employers use multiple TPAs, placing responsibility on the plan administrator will also eliminate the challenges that coordinating payment calculations or assigning payment obligations across multiple TPAs would create.

Section V(C): Cost of Applicable Coverage: Exclusion from Cost of Applicable Coverage of Amounts Attributable to the Excise Tax

Notice 2015-52 states that *“it is expected that, if a person other than the employer is the coverage provider liable for the excise tax, that person may pass through all or part of the amount of the excise tax to the employer in some instances.”* The IRS notes that any Excise Tax pass through or reimbursement will be additional taxable income to the issuer, such that the amount the coverage provider passes through to the employer may include not only the excise tax reimbursement itself, but also an amount to account for the additional income tax the coverage provider will incur – the “income tax reimbursement.” We support the proposed allowance for pass-through, and exclusion from the cost of applicable coverage, of both the Excise Tax and any associated income tax reimbursement. We believe that this proposal strikes an appropriate balance by limiting measured costs to the actual cost of providing coverage, while still ensuring that issuers and employers have adequate flexibility to reach an agreeable arrangement regarding the allocation of any associated tax burden. We thank the IRS for recognizing the importance of excluding these amounts from the measured cost of applicable coverage, and for allowing the manner in which these costs are shared or passed through to be a contracting matter between the parties, rather than a regulatory prescription.

Section V(E): Allocation of Contributions to HSAs, Archer MSAs, FSAs, HRAs

In order to capture account-based plan contributions in the measured cost of applicable coverage, the IRS proposes to allocate such contributions on a pro-rata basis over the full period to which the contributions relate (generally the plan year). As more fully stated herein (see Notice 2015-16 Section III(B)(1), below), we support exclusion from the cost of applicable coverage for employee contributions to account-based plans. However, to the extent any account contributions are ultimately included in the measured cost of applicable coverage, we believe it is important to avoid any means of allocation that further discourages employers from offering account-based plans. We thank the IRS for recognizing the anomalous results that would occur if account-based plan contributions were allocated only to the month in which account funds first became available to employees, and support the proposed pro-rata allocation of contributions over a full plan year.

Section VI: Age and Gender Adjustment to the Dollar Limit

Section 49801(b)(3) of the IRC provides two baseline per-employee dollar limits for 2018 (\$10,200 for self-only coverage and \$27,500 for other than self-only coverage) but also provides that various adjustments will apply to increase these amounts. One of these adjustments set forth at Section 49801(b)(3)(C)(iii) of the Code provides for an increase in dollar limits based on the age and gender of all employees of an employer. We appreciate the IRS for recognizing that employers provide group health plan coverage to a diverse employee population with overall costs varying widely based upon age and gender. We also appreciate the IRS' acknowledgement that in determining the effect that the age and gender have on premium rates, it is not sufficient to simply compare the average age and gender of an employer's workforce to the average age and gender of the national workforce. Rather, it is critical to allow employers to compare costs based on the distribution of men and women in different age groups. Allowing for cost-adjustments in this manner will more accurately account for the varying costs of group health plan coverage.

We are, however, concerned that the Excise Tax does not recognize a crucial cost factor impacting all employers; specifically geographic location. In its 2013 report on the Geographic Variation in Health Care Spending, the Institute of Medicine (IOM) stated that *"geographic variation in spending and utilization is real...The committee's empirical analyses of Medicare and commercial data confirm the robust presence of variation, which persists across geographic units and health care services and over time."* Costs vary dramatically from state to state and between rural and urban geographic settings within a state. As such, we are concerned that without an adjustment factor based on geographic location, employers and employees operating in high-cost, urban settings will be disproportionately affected by the Excise Tax. Therefore, we respectfully recommend that the IRS consider allowing employers to adjust values for geographic location in the same manner as for age and gender differences.

Section VII(A): Notice of Calculation of Applicable Share of Excess Benefit

Section 49801(c)(4)(A) of the IRC provides that each employer must calculate for each taxable period, the amount of the excess benefit subject to the Excise Tax and the applicable share of such excess benefit for each coverage provider. The statute further provides that each employer must notify each coverage provider of the amount so determined for that provider. Health insurance issuers will depend upon timely notifications from employers as to the excess benefit amount owed. Additionally, health issuers will require additional time to verify, identify and resolve any issues or discrepancies with the employer about amounts owed. Accordingly, we respectfully suggest that employers be required to notify issuers of their share of the Excise Tax at least 120 days prior to the payment's due date to allow for the identification and resolution of any problems or disputes that may arise.

Notice 2015-16

Section III(B)(1): Definition of Applicable Coverage: Health FSAs & Section III(D): Definition of Applicable Coverage: HSAs/Archer MSAs

One of our primary concerns with the definition of “applicable coverage” is the inclusion of employee contributions to Health Savings Accounts (HSAs), Medical Savings Accounts (MSAs), Health Reimbursement Accounts (HRAs), and Flexible Spending Accounts (FSAs). Since Congress authorized HSA plans in 2004, employers have increasingly offered HSAs paired with consumer-directed health plans (CDHPs) as a means by which to control overall health care costs for both employers and employees. In fact, from 2011 to 2014, HSAs have grown on average 15 percent annually, with 17 million individuals being enrolled in such plans in 2014.¹ Health account contributions have increasingly been used as incentives to encourage employees to complete health risk assessments and biometric screenings, and to routinely receive preventive care; all behaviors designed to improve health and limit costs. Therefore, we are deeply concerned that the inclusion of account-based plan contributions, and in particular employee pre-tax salary contributions, within the measured cost of applicable coverage, will discourage employers from offering these important plan designs at all, lest they inadvertently trigger the Excise Tax. This result would benefit no one.

In addition, including employee pre-tax salary contributions within Excise Tax calculations will present significant administrative difficulties as contributions may vary substantially from employee to employee. For both of the foregoing reasons, we urge the IRS to exercise regulatory authority to exclude employee pre-tax salary contributions to HSAs, FSAs, MSAs, and HRAs from the definition of applicable employer-sponsored coverage.

Section III(E): Definition of Applicable Coverage: On-site Medical Clinics

Section 49801(d)(1)(B)(i) excludes from the definition of applicable coverage each of the excepted benefits listed in Section 9832(c)(1), other than on-site medical clinics. However, Notice 2015-16 acknowledges that *“Treasury and IRS, however, anticipate that the forthcoming proposed regulations will provide that applicable coverage does not include on-site medical clinics that offer only de minimis medical care to employees.”* The Notice also explains that the Joint Committee on Taxation (JCT) indicated in its technical review of the ACA, Congress did not intend to include on-site clinics that provide only “de minimis” medical care within the definition of applicable coverage.

¹ America’s Health Insurance Plans. “January 2014 Census Shows 17.4 Million Enrollees in Health Savings Accounts – Eligible High Deductible Health Plans (HSA/HDHPs). July 2014.

Employers are increasingly offering on-site medical clinics to their employees for certain primary and preventive care services and ultimately to facilitate referrals to more comprehensive care, if needed. By way of example, UPMC WorkPartners assists employers in establishing and/or offering such clinics to their employees. These clinics provide medical triage, new-hire screenings, occupational safety programs, general first-aid for workplace injuries, health and wellness education, and health coaching. These services are consistent with the description in the Consolidated Omnibus Budget Reconciliation Act (COBRA) regulations (Treas. Reg. Section 54.4980B-2) which provide that *“the 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 condition, illness, or injury that occurs during those working hours; (2) the health care available is available only to current employees; and (3) employees are not charged for the use of the facility.”*

It would be exceedingly difficult to accurately measure the value of these services, which often include both health and non-health related services, particularly given the variability and differing levels of service provided by each respective clinic. For the foregoing reasons, we appreciate the IRS’ acknowledgement and also support the JCT’s conclusion to exclude “de minimis” medical care offered through on-site clinics from the definition of applicable coverage. For purposes of defining “de minimis” medical care, we offer the following two safe harbor tests that would constitute “de minimis” medical care:

1. An on-site clinic is deemed to provide “de minimis” medical care if it provides services in the manner described in the COBRA regulations and limits additional services to the following: (a) immunizations; (b) injections of antigens provided to employees; (c) provision of a variety of aspirin and other nonprescription pain relievers; and, (d) treatment of injuries caused by accidents at work.
2. An on-site clinic is deemed to provide “de minimis” medical care if the marginal cost of providing on-site services does not exceed 15% of the applicable cost of group health plan coverage.

Section III(G): Definition of Applicable Coverage: Employee Assistance Programs (EAPs)

Notice 2015-16 proposes to exclude EAPs that qualify as excepted benefits from the definition of applicable coverage and requests comments as to any reasons why the IRS should not implement this approach. As discussed above, employers are taking steps to improve the general health and well-being of their employees, including by offering a wide range of services from wellness programs to health improvement programs to EAPs. Employers often look to customize the services available through EAPs to meet the specific identified needs of their employee population. UPMC WorkPartners' EAP, *LifeSolutions*, has been providing employer wellness

and productivity services for more than 35 years. *LifeSolutions* offerings include triaging for mental health and substance use disorders, short term assessments, resources and referrals for day care and elder care, mortgage referrals, and financial services, among other services. All of these services are valued by employers and employees alike. Accordingly, we support the IRS' proposal to exclude EAPs that qualify as excepted benefits from the cost of applicable coverage.

Thank you again for providing UPMC the opportunity to offer input regarding the IRS Notice 2015-52 and Notice 2015-16 on the Excise tax on high-cost employer-sponsored health coverage. We appreciate the IRS' consideration of these comments and look forward to working together in the future.

Sincerely,

A handwritten signature in black ink, appearing to read 'Sheryl Kashuba', with a stylized flourish extending to the right.

Sheryl Kashuba, Esq.
Chief Legal Officer
Vice President, Health Policy
UPMC Health Plan