May 14, 2015

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

Attention: IRS Notice 2015-16

Submitted electronically via notice.comments@irscounsel.treas.gov / Subject: Notice 2015-16

Ladies and Gentlemen:

The Midwest Business Group on Health (MBGH) appreciates the opportunity to provide comments in response to the Internal Revenue Service's recent regulatory guidance (Notice 2015-16) regarding the excise tax on high cost employer-sponsored health coverage under §4980I of the Internal Revenue Code.

The Chicago-based MBGH (www.mbgh.org) is one of the nation's leading non-profit business coalitions, comprised of over 120 primarily self-funded companies, providing health care coverage to over 4 million lives. Its members are dedicated to value-based purchasing of health care services, improving the health of their covered populations and addressing the quality, cost and safety issues of the health care system through the collective action of public and private purchasers.

Employer members have provided health insurance coverage as an employee benefit for many years, and are now faced with difficult decisions as to whether they should continue to provide this. Additionally, employers have long felt the burden of cost increases, and have begun taking steps to mitigate this, including the adoption of innovative strategies aimed at better cost and health management. The upcoming excise tax threatens the employer's ability to adopt tested strategies, and we hope you will consider the barriers laid out within this letter.

The excise tax provision, while one of the final pieces of reform to be implemented, will be one of the heaviest burdens to bear. A key question facing policymakers is how to effectively catalyze the delivery system changes required to lower costs and improve value in our nation's health care system. The Cadillac tax is a unique revenue generating mechanism that presumably targets excessively generous employer-sponsored health insurance packages, thereby increasing incentives for the prudent and efficient use of care.

The tax is not intended to work at cross purposes with the general concept of employer-sponsored insurance, undermine the overall movement toward consumer directed care or hinder an employer's ability to offer cost effective strategies for improving the health and wellbeing of their workforce.

The regulatory implementation of §4980I must serve these narrowly tailored objectives. To that end, the IRS should incorporate three overarching principles when considering the issues outlined in Notice 2015-16:

1. Promulgate a tight definition of "applicable coverage" so that only excessively generous, "gold plated" employer health insurance coverage is penalized;
2. Calculate costs in a way that does not discourage employee contributions to consumer-directed health care accounts, or impede an employer's use of health and wellness incentives; and,
3. Fairly apply costs in a manner consistent with the lawmakers' original intent by ensuring upward adjustments are only offered in the limited number of specific exceptions codified in current law.

Additionally, MBGH strongly urges that the timing of the regulatory process be sped up. With 2018 looming, employers, from benefits managers to CEOs, must begin a daunting strategic process to adjust benefits accordingly, and cannot complete this process until guidance is finalized.

<u>Defining applicable coverage:</u>

We urge the agency to tighten definition of "applicable coverage," ensuring this will only impact plans with excessively generous coverage. Casting too wide of a net on various types of coverage mechanisms will thwart the efforts of employers to contain cost, and result in a large scale cost shift to employees. The agency should therefore exercise the regulatory authority granted under §4980I to exclude the many cost effective and innovative activities employers are engaged in to improve employee health and wellness.

In the past decade, employers have made great strides to improve the health of their workforce, reducing overall cost of care, and controlling for quality, by adopting new models for on-site medical clinics. The evidence suggests that employers with more than 1,000 employees or arrangements where multiple employers share clinics, can experience a complete return on investment and decrease overall health plan costs by more than 20% after 3 years.

The IRS has indicated that it will exclude onsite medical clinics providing de minimis coverage—while excluding all onsite medical coverage would require a statutory change, the agency should implement as broad a definition of de minimis as possible, given that onsite medical clinics providing first aid, immunizations, and other forms of routine, non-intensive

care are lowering, rather than driving, unnecessary utilization. MBGH would recommend all onsite or near site clinics be excluded. If this is not possible, a broad definition of de minimis is key.

A broad definition of de minimis onsite medical coverage would include both the many forms of high value preventive care offered at clinics and the many innovative ways employers are using onsite care at large and small worksites. While many employers have built cost-effective clinics on their campuses, some smaller employers contract a single nurse to give onsite immunizations or provide routine care in a medical van on a periodic basis. The IRS should define de minimis coverage in a way that does not distinguish between the efforts of large and small employers pursuing strategies that increase the receipt of high-value primary care. A new trend in near site employer clinics, or shared clinics, should also be excluded, as it is on track to provide high value, lower cost care.

Additionally, Treasury and IRS are commended for initial exclusion of employee assistance programs from applicable coverage, and we ask on behalf of our employer network that this remains excluded. This type of support is not only essential for control of various forms of mental health, but when not offered, can trigger lack of compliance with other medical care, chronic condition management, and ultimately the ability to maintain employment.

<u>Calculating costs:</u>

MBGH and our employer network have strong concern with the cost calculation set forth in Notice 2015-16, specifically with limiting the tax preference for employee contributions to flexible spending accounts (FSAs), Archer medical savings accounts (MSAs), and health savings accounts (HSAs). This notice set forth as part of applicable coverage to include employee pre-tax contributions to FSAs, MSAs, and HSAs, presumably based on the assumption that employer contributions to those accounts are excluded from income under §106 and §4980I(d)(1)(C) does not differentiate between employer and employee contributions

Policymakers clearly did not intend to end the tax benefit associated with employee FSA, MSA, and HSA contributions, and included very explicit language for calculating the cost of coverage toward the threshold in §4980I(d)(2)(B)(i). This section plainly states that determining the cost of coverage in an FSA shall include only the "employer contributions under any salary reduction election." Similarly, calculating the cost of coverage for Archer MSAs and HSAs should only include "the amount of employer contributions," viz., not employee contributions. The IRS is urged to issue clarification that employee contributions to these accounts will continue to receive their traditional tax preference and will not be aggregated towards the Cadillac tax calculation

The agency should also support the stated goals of lawmakers and the position of this and prior administrations when it comes to the treatment of Health Reimbursement Accounts (HRAs).

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Excluding employer contributions to HRAs would preempt the possibility of double-taxation if employees used HRA funds toward the cost of applicable coverage. Excluding employer contributions is also consistent with a longstanding policy favoring wellness initiatives, activities recognized as reducing—rather than driving—health care spending. Many employers use HRAs to provide employees with wellness incentives, and including wellness payments in the cost calculation would have the unintended effect of discouraging the proliferation of those programs.

When costs and application of tax are considered, the current model of the tax applying without regard to plan design, individual plan provisions, geographic locations, and population demographics, must be revisited. It is imperative that the final Regulations allow for variations and reflect differences due to factors largely out of the control of employers, while focusing on "excessively generous" benefit designs.

Applying costs:

The IRS addressed the issue of "applying cost" in Notice 2015-16. As with other sections, the agency should apply cost in a manner consistent with the original intent of the statute, which includes an additional allowance only in a limited number of specific instances. MBGH and its members believe that costs should be applied equally to all groups except those explicitly provided for in §4980I(b)(3)(C)(iv)—qualified retirees, those engaged in high-risk professions, and groups with significant deviations from the age and gender balance of the national workforce.

MBGH appreciates your consideration of these comments. If you have any questions about these comments or wish to discuss further, please contact me at (312-372-9090 x 101) or lboress@mbgh.org.

Sincerely,

Larry Boress
President and CEO
Midwest Business Group on Health