



Submitted via email to Notice.comments@irscounsel.treas.gov

May 15, 2015

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

Re: **IRS Notice 2015-16: High Cost Health Coverage Excise Tax**

Dear Sir/Madam:

The Association of Governmental Risk Pools (“AGRiP”) respectfully submits these comments in response to Notice 2015-16 and in support of the development of regulatory guidance regarding the Excise Tax on High Cost Employer-Sponsored Health Coverage (the “excise tax”).

BACKGROUND

AGRiP’s mission is to promote pooling as a practical extension of local government’s obligation to be a good steward of public funds. Founded in 1998 and currently headquartered in Latham, New York, AGRiP is a national association of over 200 public entity risk pool members from more than forty (40) states, plus Canada and Australia. Eighty-percent of the more than 90,000 public entities in the United States participate in one or more risk pool, including some thirty (30) public entity health benefits pools or trusts.

For over twenty-five (25) years, public entity health pools have performed the essential government function of providing health benefits to public employees and their dependents at the lowest possible cost to local governments and their taxpayers. The pools are comprised of thousands of school districts, counties, municipalities, authorities and other governmental entities, and are all tax exempt, non-profit and funded by local tax revenues.

Overseen by directors or trustees elected from and by their public entity participants, these pools are established under state intergovernmental cooperation laws which allow their participating municipalities, counties, schools, and special districts to self-fund their health benefits on a pooled basis. Their public employer pool participants are all public entities and the

health benefits pools themselves are all governmental instrumentalities funded solely by taxpayers. It is on behalf of these pools, and the public employers they serve, that we are submitting these comments.

OUR CONCERNS

Our principal concern is that the excise tax will impose an undue fiscal burden on public employers and the health benefits pools in which they participate. Although the excise tax is not effective until 2018, it is having an immediate impact on the collective bargaining and budget planning of state and local governments, with the greatest impact on municipal union contracts for fire, police and school district personnel, many of which will expire between now and the end of 2017. Our members are further burdened in some states by statutorily mandated benefits for public sector retirees and their dependents. It is therefore no surprise that the excise tax will have significantly greater impact on public employers than their private counterparts.

We wish to share our comments with a view toward minimizing the impact of the excise tax on our membership and thereby allow them to continue to find creative and cost-effective ways of providing affordable health benefits to all public employees and retirees, and their dependents.

COMMENTS RELATING TO NOTICE 2015-16

1. Definition of Applicable Coverage [Section III]

A. On-site Medical Clinics [Section III.E]

Code Section 4980I(d)(1) requires on-site medical clinics that are part of a “group health plan” to be included in the cost of “applicable employer-sponsored coverage” in determining the “excess benefit” subject to the excise tax. Our comments on this issue reflect our concern that the imposition of that tax on employer-sponsored on-site medical clinics may unduly impede the ability of employers to effectively manage their health care costs and assure the well-being and productivity of their employees.

The significant investments that employers have made in their on-site medical clinics have enabled them to improve their employees’ general health and well-being, while keeping employee healthcare costs down. Employer-sponsored on-site medical clinics also enhance employee productivity by improving job performance and reducing absenteeism. Today, many employers use medical clinics to provide preventive care (*e.g.*, blood pressure readings, cholesterol screenings, biometric screenings, immunizations and checkups that include conversations about diet, smoking cessation and physical activity), encourage health and wellness, and raise awareness of medical conditions before they become chronic. This care often is provided during working hours and below prevailing market rates.

We want to stress that care at most employer-sponsored on-site medical clinics is *de minimis* medical care because such facilities do not have the staff, equipment or expertise necessary to treat employees that have significant health issues. On-site medical clinics don’t employ specialty physicians, such as cardiologists, oncologists or urologists, nor do they offer complex imaging (*e.g.*, CT scans or MRIs) and they don’t offer surgery or

hospitalization. When faced with an individual who is in need of significant medical treatment, an employer-sponsored on-site medical clinic will serve as a referral conduit to link that individual with a specialist who can provide optimal care. As such, these clinics focus less on treatment, and more on prevention and wellness. As observed by the Department in Notice 2015-16, most employees are not likely to consider their employer-sponsored on-site medical clinic as part of their health coverage. We agree with that point and believe that such a clinic is an *employer* benefit that is often offered as an *employee* benefit; from an employee standpoint, employer-sponsored on-site medical clinics are therefore at best a *de minimis* fringe benefit.

As stated in Code section 4980I(d)(2), the cost of employer-sponsored coverage subject to the high-value plan excise tax should be determined under rules which are *similar* (not identical) to those used to calculate COBRA premiums. The ACA therefore gives the Department the right to depart from its COBRA guidance with respect to on-site medical clinics.¹ We therefore urge the Department to adopt regulatory criteria that would minimize the impact of the excise tax on these clinics given the valuable role they play in managing healthcare costs and promoting healthy and productive employees - goals that go to the very heart of the ACA.

To best preserve the critical role played by employer-sponsored on-site medical clinics, we strongly recommend that the Department exempt “*de minimis* medical care” provided at on-site medical clinics, which should be defined to consist of:

- Preventive care (*e.g.*, blood pressure readings, cholesterol screenings, biometric screenings, immunizations and check-ups that include conversations about diet, smoking cessation and physical activity);
- Health and wellness programs that promote a healthy lifestyle; and
- The occasional treatment of minor medical ailments.

Like the Department, we have concerns about how to value care obtained at an employer-sponsored medical clinic. It is difficult and administratively burdensome for an employer to place a value on encounters that occur primarily because of convenience (rather than out of necessity) and that refers employees to external healthcare providers for treatment that is covered under the employer’s health plan. To address these concerns, we recommend that the Department exclude from the cost of coverage all care obtained at an employer-sponsored medical clinic that is primarily devoted to *de minimis* medical care (*i.e.*, more than 50% of clinic visits or more than 50% of the total clinic operating expenses relate to *de minimis* medical care). Alternatively, we recommend that the Department view as *de minimis*, and exclude from the cost of coverage, up to \$500 in annual care provided by an employer-sponsored medical clinic, which could be calculated by dividing the total cost to staff, supply and manage the clinic by the number of individuals who are eligible to use the clinic as of the first day of the applicable calendar year. This \$500 exclusion would be consistent with the *de minimis* expense rules set forth in the final capitalization regulations (T.D. 9636), which were issued by the Department in September 2013.

¹ Treas. Reg. § 54.4980B-2 (Q&A #1) contains this guidance.

We also recommend that the Department issue guidance that interprets the definition of “group health plan” for Code Section 4980I purposes differently than such term is interpreted for COBRA purposes. We suggest the Department interpret the term “group health plan” to include only those employer-sponsored on-site medical clinics that satisfy the following criteria:

- Access to the clinic is limited to current and former employees (and dependents, if eligible) who are enrolled in the employer’s health plans;
- Clinic services are included in the governing documentation for the plan (*e.g.*, plan document or summary plan description); and
- The majority of the healthcare services offered by the clinic are other than “*de minimis* medical care” (as such term is defined above).

We believe the foregoing recommendations balance the desire to tax the excess benefit in high-value health plans with the significant non-health plan-related benefits employers realize from owning and operating their own on-site medical clinics.

B. Limited Scope Dental and Vision Benefits [Section III.F]

We agree with the proposal to exclude from the cost of applicable coverage under Code Section 4980I self-insured limited scope dental and vision coverage that qualifies as an “excepted benefit”. Excluding self-insured limited scope dental and vision coverage for 4980I purposes would be consistent with the treatment of such coverage under other provisions of the Affordable Care Act (*e.g.*, market reform provisions, transitional reinsurance fee, PCORI fee).

C. Employee Assistance Programs (EAPs) [Section III.G]

We also agree with the proposal to exclude from the cost of applicable coverage under Code Section 4980I EAPs that qualify as an “excepted benefit”. Excluding EAPs for 4980I purposes would be consistent with the treatment of such programs under other provisions of the Affordable Care Act (*e.g.*, market reform provisions, transitional reinsurance fee, PCORI fee).

2. Determination of Cost of Applicable Coverage [Section IV]

A. In General

i. Specific Rules under Code Section 4980I - Health FSAs [Section IV.A.2(4)]

We encourage the Department to exclude from the cost of applicable coverage contributions to and/or reimbursements from limited-purpose Health FSAs. Limited-purpose Health FSAs only allow for reimbursement of eligible dental and vision expenses that are not covered under a dental or vision plan. Dental and vision plans often come in the form of excepted benefits, which means they are not subject to many other provisions of the Affordable Care Act. Excluding limited-purpose Health FSAs from the cost of applicable coverage would provide

for the harmonization of a similar exclusion for limited-purpose HRAs and the exclusion of limited scope dental and vision plans from the reach of the Affordable Care Act. This would promote consistency and good policy.

B. Potential Approaches for Determining Cost of Applicable Coverage [Section IV.C]

i. Similarly Situated Individuals [Section IV.C.1]

a. Aggregation by Benefit Package

We support the approach proposed by the Department to divide similarly situated employees based on the type of benefit package in which they are enrolled without regard to the employee's HRA, HSA, or FSA, then subdividing that group based on the mandatory disaggregation rules, and allowing further subdivision based on the permissible disaggregation rules. This seems like a viable starting point for active employees (but not retirees) and provides some administrative flexibility for employers. The enrollment and/or participation in a FSA, HSA or HRA would not impact the similarity of the benefit packages for purposes of mandatory aggregation.

b. Permissive Aggregation within “Other Than Self-Only” Coverage

We support the approach proposed by the Department to not require an employer to determine the cost of applicable coverage for employees receiving “other than self-only” coverage based on the number of individuals covered in addition to the employee (even if the actual cost of such coverage varied on this basis). This approach is consistent with the statute and provides administrative flexibility for employers.

c. Permissive Disaggregation

We support the approach proposed by the Department to permit further disaggregation of similarly situated individuals. To encourage administrative flexibility for employers, we encourage the Department to permit disaggregation based on a broad standard. The standard that comes to mind is the reasonability standard addressed in Treas. Reg. § 1.410(b)-4(b), which permits a facts and circumstances approach to determining reasonability and states that reasonable classifications generally include specified job categories, nature of compensation, geographic location, and similar *bona fide* business criteria. Permissive use of a broad disaggregation standard provides administrative flexibility for employers. If the specific standard disaggregation approach is preferable, wellness program completion should be one of the included criteria.

d. Retirees

The Department has asked whether additional guidance would be beneficial under Code Section 4980I(d)(2)(A), which provides that “the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries.” This correctly suggests that a plan should be allowed to average the cost of employer-sponsored coverage for pre-Medicare retirees with the cost of similar coverage for retirees who are entitled to benefits under Medicare (where such employer-sponsored coverage may be limited to a Medicare supplement plan).

Allowing employers to offset the typical high costs of pre-Medicare retiree coverage with lower cost Medicare supplement plans increases the likelihood that employers will preserve pre-Medicare retiree coverage (which was the main goal of the ACA’s Early Retiree Reinsurance Program) and provides relief to public employers who are legally required to offer retiree health coverage under constitutional and statutory mandates or as required by collective bargaining agreements. Interpreting this language in a contrary manner is likely to wreak further havoc on the financially vulnerable budgets of state and local governments.

ii. Self-Insured Methods [Section IV.C.2]

a. Past Cost Method (Costs Taken into Account) [Section IV.C.2.c.ii]

We encourage the Department to specify that the only factors that must be included under the past cost method are claims and premiums associated with stop-loss coverage and/or reinsurance (which directly relate to claims), because these are the principal cost drivers of a group health plan. We believe this approach would more closely align to the statutory phrase “*coverage under any group health plan*” set forth under Code Section 4980I. Section 5000(b)(1) of the Code defines a “group health plan” as a plan that provides “health care.” To our knowledge, the Internal Revenue Code does not define “health care,” but the Department has acknowledged that for COBRA purposes, this term has the same meaning as the term “medical care” under Code Section 213(d) (*i.e.*, “amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, for the purpose of affecting any structure or function of the body”).² Based on the meaning of this term under COBRA and the plain meaning of the phrase “coverage under,” we believe the past cost method calculation should be limited to claims and stop-loss/reinsurance premiums to guard against catastrophic claims.

² See Treas. Reg. § 54.4980B-2 (Q&A #1).

Furthermore, we strongly support the exclusion of administrative expenses (which, for COBRA purposes, have always been charged at the option of the employer) and not allocating overhead expenses (*e.g.*, compensation, rent, supplies, utilities) in favor of administrative simplicity. Including administrative expenses and allocating overhead expenses for individuals involved in health plan administration would be complicated, time consuming and burdensome for employers. Exclusion of these amounts is likely to have little bearing on the actual cost of any health plan.

Lastly, we strongly support the Department's proposal to exclude from the cost of applicable coverage (i) reserves for potential future costs; and (ii) claims that are subject to reimbursement under a stop-loss or reinsurance policy.

b. Actuarial Basis Method [Section IV.C.2.b]

We support a self-insured plan's ability to make an actuarial estimate of the cost of providing coverage for a determination period using reasonable actuarial principles and practices. For administrative simplicity, we encourage the Department to specify that the only factors that must be included in an actuarial estimate are claims and premiums associated with stop-loss coverage and/or reinsurance. The rationale for our position is set forth in Section 2.B.ii.a, above.

With respect to requiring an accreditation process to make actuarial estimates, most, if not all, self-insured plans already have competent actuaries making actuarial estimates or have underwriters using standards developed by actuaries, so requiring formal accreditation seems to be unnecessary. The need for accreditation would be lessened if actuarial estimates only had to factor in claims and premiums associated with stop-loss coverage and/or reinsurance.

iii. HRAs [Section IV.C.3]

We suggest that the Department issue guidance to permit employers to determine the cost of coverage by choosing to (1) take into account only the HRA amounts made newly available to a participant each year, or (2) add all claims (excluding administrative and overhead expenses) attributable to HRAs for a particular period (separately for each level of coverage if the employer allocation differs by employee election) and dividing that sum by the number of employees covered for that period (at that level of coverage).

An HRA, like a traditional health plan, should not be valued on the maximum amount of exposure it may have for a given year. In other words, using employer contributions to value an HRA, while easy, often overstates the value of the

arrangement. The value of an HRA, like a traditional health plan, should be based on an informed analysis of historical claims (or, in the case of an HRA, reimbursements). It seems counterintuitive to value HRAs based on maximum exposure and traditional health plans based on an analysis of historical claims. Our suggested approach would accurately value the HRA and is consistent with our suggestions in Sections 2.B.ii.a and 2.B.ii.b, above.

For consistency purposes, we also encourage the Department to exclude from the cost of applicable coverage contributions to and/or reimbursements from limited-purpose HRAs. Identification of expenses associated with limited-purpose HRAs can be accomplished with relative ease by requiring employees to list on a reimbursement form the type of expense which they are submitting for reimbursement. For example, dental expenses could be represented by a “D” and vision expenses could be represented by a “V”. An employer can verify the accuracy of requested reimbursements by reviewing supporting documentation that was submitted with the request. An employer that utilizes an HRA debit card can instruct its HRA administrator, which should be able to structure its claims adjudication system to delineate between different types of expenses, to determine the proper expense type. If the HRA administrator is unable to determine whether the debit card transaction relates to a dental or vision expense, either it or the employer can choose to follow-up with the HRA debit card holder. If the HRA administrator or employer is unable to obtain support to substantiate the type of expense (or chooses not to), the expense should be deemed medical and included in the cost of applicable coverage.

3. Applicable Dollar Limit [Section V]

A. Dollar Limit Adjustments [Section V.C]

i. Adjustments for Qualified Retirees [Section V.C.1]

We request that the Department issue guidance stating that a “qualified retiree” includes any individual who (1) is receiving health coverage by reason of being a retiree, (2) has attained age 55, or (3) is eligible to enroll in the Medicare program under title XVIII of the Social Security Act, but is not receiving Medicare benefits. As noted, many public employers are legally bound to offer legacy retiree benefits which provide primary coverage. Retirees of such employers are not required and have no incentive to enroll in Medicare (even if they are eligible). Our requested clarification of Code Section 4980I(f)(2)(C) would expressly allow these employers to utilize the higher applicable dollar limit, which is critical because legacy retiree benefits that are primary to Medicare are very costly for public employers and cannot be modified in most situations.

ii. Adjustments for High-Risk Professions [Section V.C.2]

We support the issuance of further guidance on what constitutes an “employee engaged in a high-risk profession.” We suggest that the Department specify in

that guidance that public works employees and municipal utility workers qualify as individuals in the “construction” trade because they utilize heavy machinery, work in dangerous environments (*e.g.*, roadways, elevated heights, and confined spaces that contain toxic gases and other hazardous materials), work during inclement weather (*e.g.*, snow storms and hurricanes), and are sometimes required to work with electrical current.

In determining whether the majority of employees covered by a plan are engaged in a high-risk profession, we suggest that the Department allow employers to have multiple “plans” as long as each plan can be justified using *bona fide* business criteria. For example, an employer should be allowed to have different plans for specified job categories, hourly and salaried employees, geographic locations, union personnel, and similar *bona fide* business criteria.

Thank you for considering our comments. If you have any questions or would like to discuss these comments further, please do not hesitate to contact me at (518) 220-0336 or agergen@agrip.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'Ann Gergen', with a long horizontal flourish extending to the right.

Ann Gergen
Executive Director
Association of Governmental Risk Pools