National Business Group on Health

20 F Street, NW, Suite 200
Washington, D.C. 20001
202.558.3000 • Fax 202.628.9244
www.businessgrouphealth.org

Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

May 15, 2015

Submitted electronically via: Notice.comments@irscounsel.treas.gov

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

Re: Notice 2015-16: Section 4980I – Excise Tax on High Cost Employer-Sponsored Health Coverage

Dear Sir or Madam:

The National Business Group on Health appreciates the opportunity to comment on the Internal Revenue Service's potential approaches to the excise tax on high cost employer-sponsored health coverage under § 4980I of the Internal Revenue Code. Because the excise tax will have a profound impact on long-term health care strategy for most large employers, we particularly urge the Department of the Treasury and the Service to allow for flexibility in implementing rules for this tax.

The National Business Group on Health represents 418 primarily large employers, including 68 of the Fortune 100, who voluntarily provide group health plan coverage and other health programs to over 55 million American employees, retirees, and their families. Our members employ and provide health coverage for employees under a wide variety of work arrangements, including full-time, part-time, seasonal, and temporary. They also often operate multiple lines of business in multiple states and tailor employee work and benefit arrangements to the specific needs of each line of business.

As our members prepare for implementation of Code § 4980I and other new Code requirements under the Affordable Care Act (ACA), primary concerns will be:

(1) Having flexibility to continue innovative plan designs and health care delivery models that lower the overall cost of health coverage and

(2) Minimizing the administrative and cost burdens associated with those requirements.

Our members believe that taking into account the need for plan design flexibility in final §4980I regulations will reduce compliance burdens and allow plan sponsors to continue devoting resources to maintaining high-quality, cost-effective health coverage for employees and their dependents. To that end, we encourage the Service, in developing § 4980I guidance and regulations, to take into account the features typical of large, self-insured employer-sponsored plans. Specifically, we urge the Service to consider the following:

- **Encouraging high-quality, cost-effective health coverage.** § 4980I should be an incentive for plan sponsors to implement and maintain plan designs that reduce overall health care costs and maintain high-quality care. In particular:

    - **Consumer-directed health plans (CDHPs)**, especially high-deductible health plans (HDHPs) paired with health savings accounts (HSAs), will become more widespread and play an increasingly critical role in containing health care costs for employers and employees in the coming years. Therefore, final regulations under § 4980I should not discourage employer or employee contributions to CDHPs.

    - **On-site clinics.** For many large employers, on-site clinics have become key tools in encouraging employees to obtain preventive care, improving employee health and access to health services, improving employee morale and productivity, and reducing overall health coverage costs. § 4980I implementation should not discourage adoption of or innovation in on-site clinics.

    - **Delivery system innovations.** Similarly, § 4980I should be an incentive for plan sponsors to engage with providers to improve the health care delivery system, reduce overall health care costs, and maintain high-quality care. To that end, § 4980I should encourage innovations such as adoption of accountable care organizations (ACOs), patient-centered medical homes, and other bundled payment arrangements.

- **Adjustments to reflect employee populations.** Our members provide group health plan coverage to large, diverse employee populations. Often, the cost of coverage will vary widely within these populations, depending on employees' age, gender, retiree status, collective bargaining status, and other factors. Therefore, we support the Service's proposals to (1) in determining the cost of applicable coverage, allow permissive disaggregation based on specific employee categories and (2) provide for dollar limit adjustments based on factors such as age, gender, and retiree status.

- **Flexibility in determining cost of applicable coverage.** Determining the cost of applicable coverage under § 4980I will require extensive staffing resources and coordination between our members' payroll, human resources, and recordkeeping

systems—a process that will likely involve substantial administrative and cost burdens. Therefore, in developing guidance and regulations, we encourage the Service to allow plan sponsors flexibility to (1) minimize costs and (2) adapt cost of coverage determinations to current plan designs and payroll and recordkeeping systems.

We provide further discussion of these recommendations and responses to the Service's specific requests for comment below.

I. Expected Impact of the Excise Tax on High-Cost Employer-Sponsored Health Coverage

Of the Affordable Care Act provisions applicable to group health plans, § 4980I is perhaps the most significant in terms of potential impact on plan costs, plan design, and future health care strategy for Business Group members. Our members are deeply concerned that implementation of § 4980I will (1) substantially increase the cost of providing group health plan coverage and (2) impede their ability to implement and maintain innovative plan features that, in the long run, would improve health care quality or lower the overall cost of health coverage—two of the ACA's primary policy aims. In developing § 4980I guidance and regulations, we strongly encourage the Service to consider the following:

- Based on preliminary estimates, Business Group members expect their cost of applicable employer-sponsored coverage to reach or exceed the applicable dollar limits for self-only or other-than-self-only coverage between 2018 and 2025.

- Higher-cost plan options such as plans with low participant cost-sharing and higher-cost family coverage will exceed the applicable dollar limits first. Based on preliminary estimates, our members expect that for the first year that the cost of applicable employer-sponsored coverage for these plan options exceeds the applicable dollar limits, resulting § 4980I tax liability will be approximately $1-2 million.

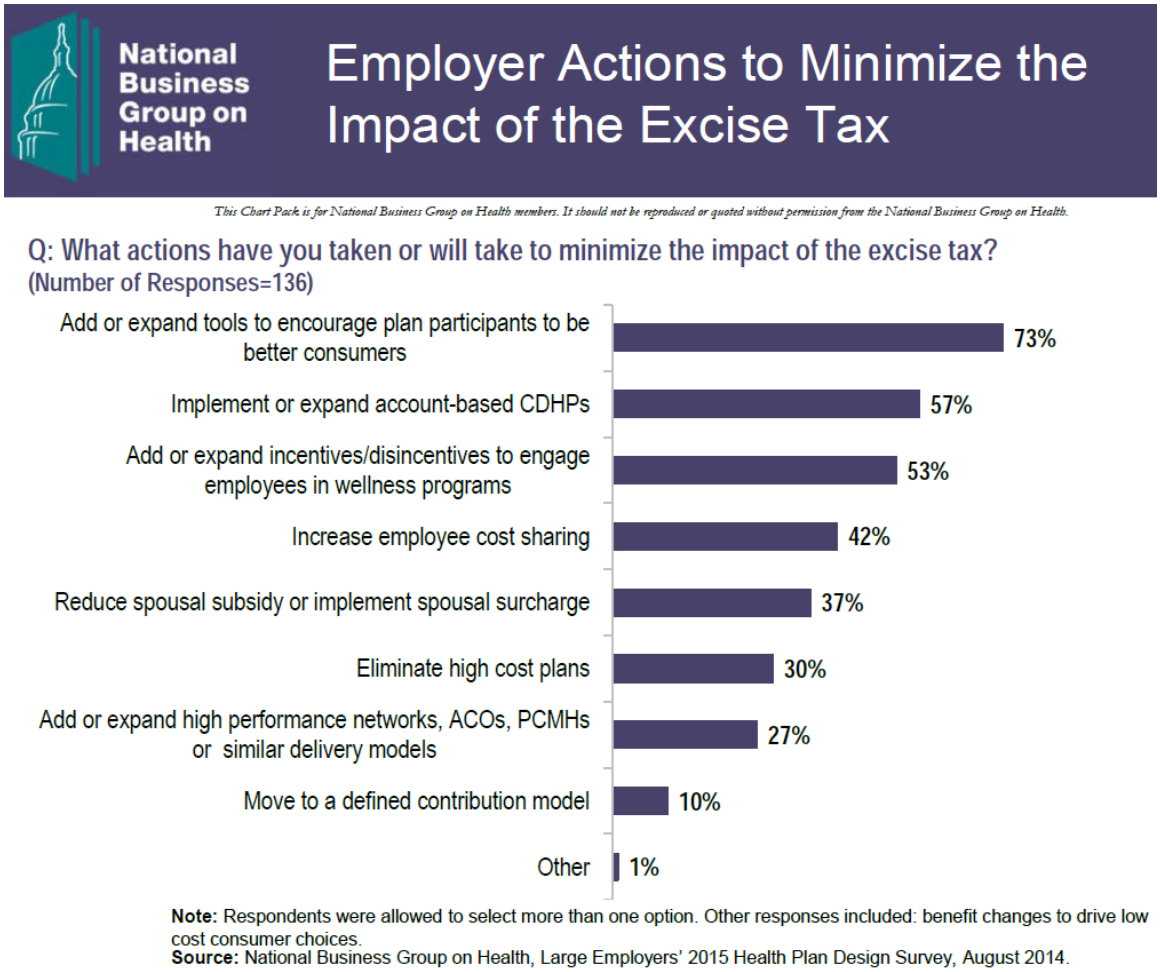
- The above estimate will vary depending on overall health care cost inflation and plan sponsors' ability to contain their own group health plan costs through plan design changes. If plan sponsors are not able to contain group health plan costs, § 4980I tax liability could easily exceed the estimated $1-2 million in the first year. In addition, the cost of applicable employer-sponsored coverage for more plan options will exceed applicable dollar limits earlier, resulting in higher § 4980I tax liability.

- Our members are also concerned that as health care cost inflation continues to outpace increases in the consumer price index, it will be increasingly difficult to offer plan options that (1) satisfy annual cost-sharing limitations under § 1302(c) of the ACA, (2) meet the minimum value standard under Code § 36B, thereby minimizing liability under § 4980H, and (3) do not exceed applicable dollar limits

under § 4980I. This will be particularly true if only a cost-of-living adjustment—as opposed to an adjustment for health care cost inflation—applies to determine § 4980I applicable dollar limits for taxable years after 2018.

- Business Group members, because of their large plan participant populations, are in a unique position to achieve health care savings and improved quality of care through innovative plan features such as on-site clinics, high-performance networks, and ACOs. However, incurring § 4980H or § 4980I liabilities will have a chilling effect on these innovations.

- To the extent feasible and necessary, our members will implement plan design and delivery system changes (such as those outlined in the table below) to shield their group health plans and employees from the costs of § 4980I liability, including reducing or eliminating higher-cost plan options. However, we emphasize that any such plan changes will not be accompanied by increases in compensation.



II. Definition of Applicable Coverage

A. Consumer-Directed Health Plans

One of our members' primary concerns with the definition of applicable coverage is the inclusion of contributions to health flexible savings arrangements (health FSAs), health reimbursement arrangements (HRAs), and especially health savings accounts (HSAs) paired with high-deductible health plans. These account-based arrangements play a critical role in employer-sponsored health coverage for the following reasons:

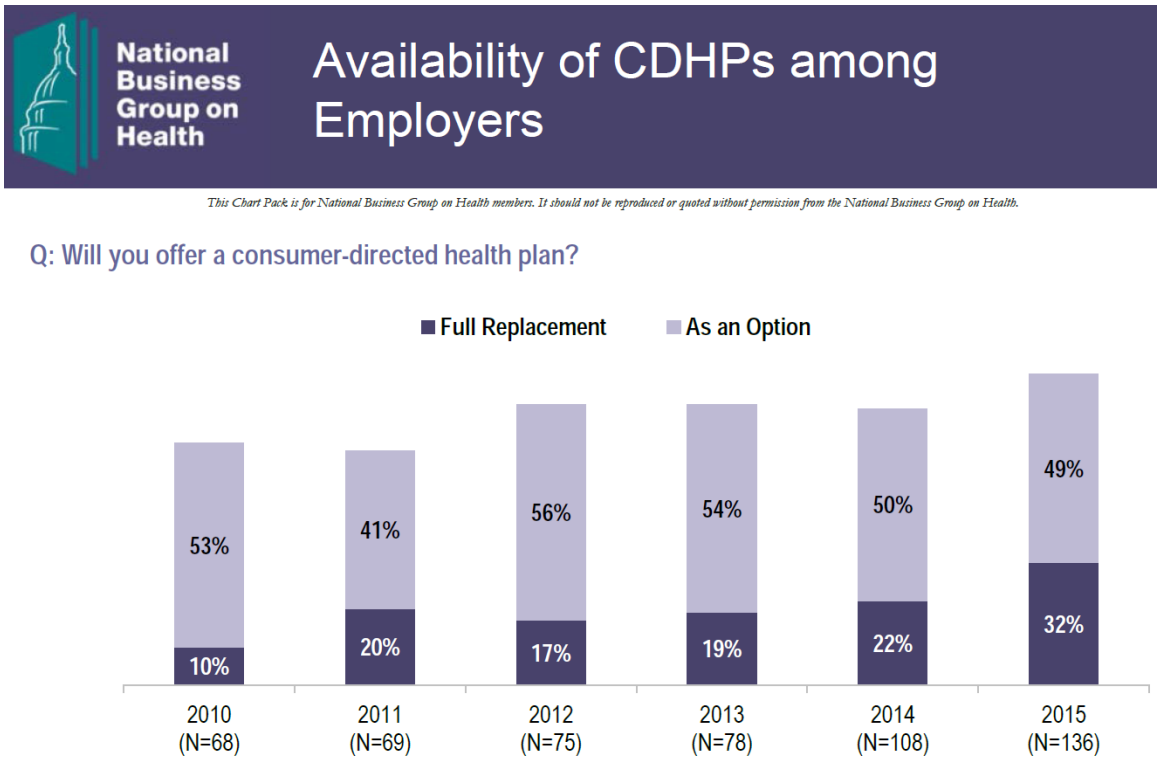
- Health accounts paired with CDHPs are one of the most effective plan designs for containing overall health care costs for plan sponsors and participants.

- Health accounts paired with price transparency tools for health care purchasing encourage participants to seek higher-quality and lower-cost health care services and providers.

- As employees transition between employers and positions within companies, their health coverage options often change. Health accounts ease these transitions by giving employees and former employees a tax-advantaged, more portable source of funds to pay for out-of-pocket health care expenses.

- Health account contributions often serve as incentives for employees and their dependents to participate in employer-sponsored wellness programs, which include health risk assessments, biometric screenings, exercise, and preventive care. These activities serve more long-term goals such as improved participant health, better engagement in health activities, higher employee morale and productivity, and overall health care cost savings.

Steadily increasing enrollment in CDHP arrangements reflects large employers' increasing reliance on these plan designs as a method for improving quality of care, increasing participant engagement, and controlling overall health care costs—goals that are consistent with § 4980I policy aims.



Source: National Business Group on Health, Large Employers' 2015 Health Plan Design Survey, August 2014.

Because both employer and employee health FSA, HRA, and HSA contributions play an important role in maintaining the quality and affordability of employer-sponsored health coverage, ***we urge the Service, in developing § 4980I guidance and regulations, to exercise regulatory authority to exclude from the definition of applicable coverage contributions to health FSAs, HRAs, and HSAs to the maximum extent possible***. We also recommend that the Service consider the following specific issues related to account-based plans:

- HSA contributions—particularly employee pre-tax salary reduction contributions—vary substantially from employee to employee and therefore will present significant administrative difficulties if they are to be included in the definition of applicable coverage. Tracking these contributions each year for § 4980I purposes would involve substantial administrative and cost burdens. We therefore recommend that these contributions be excluded from the definition of applicable coverage.

- Including salary reduction contributions to HSAs in applicable coverage but excluding employee after-tax contributions creates an arbitrary distinction within HSA account balances. Separating these types of contributions for § 4980I

purposes will only add to plan sponsors' administrative and cost burdens and will discourage the use of HSA/HDHP arrangements.

- Limited-purpose health FSAs that reimburse only dental and vision expenses should be excluded from the definition of applicable coverage in a manner similar to insured dental and vision benefits.

- HRA and HSA contributions that are contingent on completing wellness activities are particularly difficult to segregate and value because they often vary depending on participants' plan options, compensation, or participation levels. Therefore, these contributions should be excluded from the definition of applicable coverage.

- Employers should have flexibility to determine the cost of applicable coverage under an HRA based on (1) amounts made newly available to participants each year *or* (2) an actuarial basis method.

- HRA amounts that reimburse health coverage premiums should be excluded from the definition of applicable coverage, given that employer and employee premium contributions will already be included in the cost of applicable coverage for § 4980I purposes.

B. On-Site Clinics

Many Business Group members offer on-site medical clinics to their employees—often regardless of whether they are group health plan participants or not. Increasingly, these clinics play a significant role in:

- Serving as an access point for primary and preventive care;

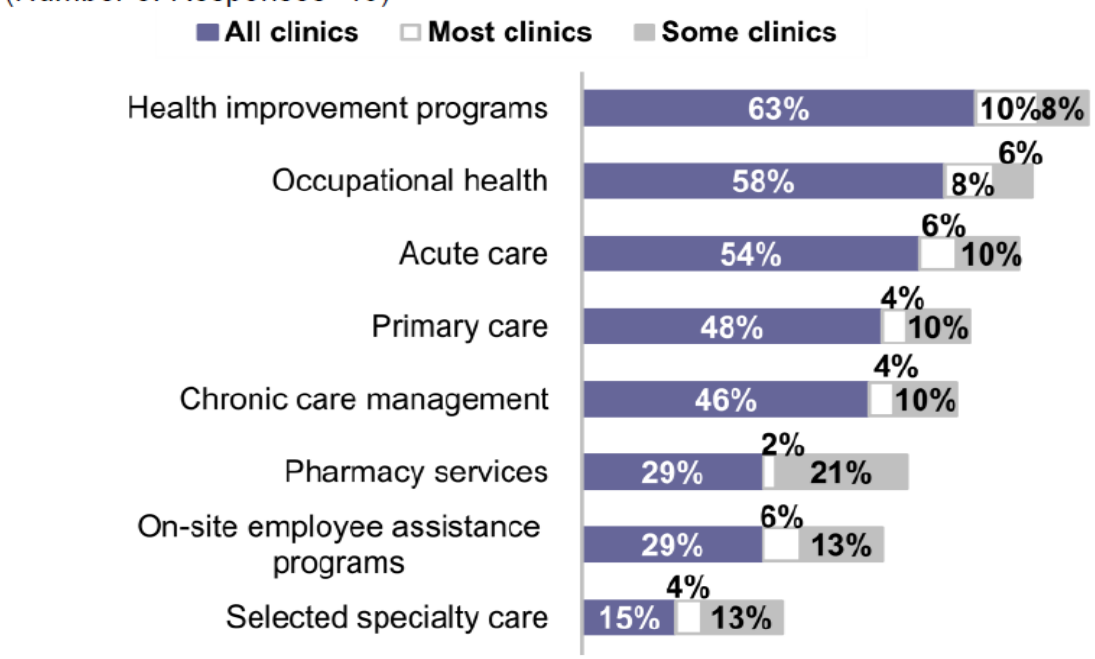
- Initiating or increasing employee engagement in wellness, EAP, disease management, and occupational health programs;

- Improving adherence to treatment and medications related to chronic conditions; and

- Providing health services that are lower-cost and higher quality than those available outside the clinics.

In addition to their role in improving health and lowering health care costs—consistent with § 4980I policy aims—for many of our members, on-site clinics have proven to be extremely popular benefits that substantially improve employee morale and productivity because of the convenience of having health care services available at or near the worksite.

Figure 25: Services Provided at On-Site Health Clinics
(Number of Responses=48)



Note: Respondents were allowed to select more than one option.

Based on current estimates provided by some of our members, the average cost of providing on-site clinic services ranges from approximately $200-650 per person per year for employers. However, including on-site clinics in the definition of applicable coverage would present substantial administrative challenges for plan sponsors because clinics often provide both health and non-health services. Clinic costs also may include group health plan services but also include other costs such as equipment, space, staffing, and administrative costs unrelated to group health plan benefits. Furthermore, employers may not offer the same range of clinic services at every location, which results in clinic costs varying by location and employee population.

Furthermore, we emphasize that many on-site clinic services are those that, if not provided through employer-sponsored clinics, would be provided by local health care providers, often at higher cost. Therefore, including on-site clinic services in applicable coverage would, by reducing employers' incentive to offer these services at clinics and contrary to the policy aims of § 4980I, drive plan participants to higher-cost, less efficient care settings.

Therefore, ***we recommend that the Service, in developing § 4980I guidance and regulations, exercise regulatory authority to exclude from the definition of applicable coverage the cost of on-site clinics to the maximum extent possible***. We also recommend the following:

- Onsite clinic services, to the extent they are included in the definition of applicable coverage, should not include services excluded in COBRA regulations

such as first aid, immunizations, injections of antigens, nonprescription pain relievers, or treatment of injuries caused by accidents at work.

- Onsite clinic services, to the extent they are included in the definition of applicable coverage, also should not include services that generally are not covered by group health plans, such as wellness and occupational health services.

- We support exclusion from the definition of applicable coverage de minimis medical care offered through onsite clinics. Generally, a dollar amount or percentage exclusion—such as $650 per employee per year, adjusted annually for medical inflation, or 10% of the cost of applicable coverage—would be the simplest for plan sponsors to administer.

C. Health Improvement Programs

For similar reasons, we recommend that costs associated with health improvement programs, as opposed to direct medical costs, be excluded from the definition of applicable coverage. These costs include, but are not limited to, those associated with exercise, fitness, weight management, and nutritional counseling. Excluding these costs from the definition of applicable coverage would be consistent with their treatment under Code § 213(d) and with the fact that these generally are not ERISA-covered benefits.

D. Self-Insured Dental and Vision Coverage

Many of our members offer self-insured, limited-scope dental and vision benefits at no cost or very low cost to participants. In some cases, our members provide this coverage automatically to accommodate existing administrative processes, information systems, or collective bargaining agreement requirements. In some cases, large plan sponsors offer both insured and self-insured dental and vision coverage options. Nevertheless, self-insured dental and vision benefits are essentially identical to insured dental and vision benefits because (1) plan sponsors contract for this coverage through separate third-party service providers or through separate agreements and (2) both plan sponsors and participants view this coverage as supplemental to major medical coverage. As the Service notes, Treasury and the IRS, the Department of Labor, and the Department of Health and Human Services have amended the excepted benefit regulations to achieve consistency between insured and self-insured dental and vision coverage.

Treating self-insured and insured dental and vision coverage differently for § 4980I purposes would create an arbitrary distinction between insured and self-insured coverage. Such treatment would also create unnecessary administrative and cost burdens for plan sponsors, as they would either (1) have to segregate insured from self-insured dental and vision costs for § 498I purposes or (2) convert self-insured benefits to insured benefits to achieve the same treatment for all dental and vision coverage. Therefore, we recommend that the Service exercise its regulatory authority to exclude from the definition of applicable coverage self-insured limited scope dental and vision coverage that qualifies as an excepted benefit under Code § 9831.

E. Employee Assistance Programs (EAPs)

Likewise, we recommend that the Service exercise its authority to exclude from the definition of applicable coverage EAPs that qualify as excepted benefits under Code § 9831.

Most of our members offer EAP benefits at no cost, often to all employees and their family or household members, regardless of whether they are group health plan participants. These benefits often are not health-related and are designed to supplement other employer-sponsored plans or programs. For example, EAP benefits can include screening and triaging for mental health and substance use disorders, wellness coaching, coping skills, care management, resources and referrals for day care and elder care, mortgage referrals, and financial services. EAPs may also provide support to managers on how to handle challenging situations such as incidents of workplace violence or the aftermath of a robbery.

Because EAPs (1) include such a wide variety of benefits, (2) often provide benefits outside the group health plan context, and (3) are usually very low-cost, it will be difficult for plan sponsors to segregate and value EAP benefits for § 4980I purposes. We therefore recommend that EAP benefits qualifying as excepted benefits under Code § 9831 not be included in the definition of applicable coverage.

F. Required Health Benefits and Services

We also note that the ACA and other laws require employers and their group health plans to provide coverage for certain health benefits such as recommended preventive services under § 2713 of the Public Health Service Act and physical examinations required for certain job categories by the Department of Transportation. Given that these benefits are mandatory, they should not be treated as "excess benefits" for § 4980I purposes. Therefore, we recommend that these benefits and services be excluded from the definition of applicable coverage.

III. Determination of Cost of Applicable Coverage

A. Similarly Situated Individuals

Business Group members generally support the potential approaches to determining the cost of applicable coverage described in Notice 2015-16. However, our members have specific concerns related to their large and diverse participant populations:

- Our members often operate multiple lines of business and tailor plan designs to the specific needs of each line of business. Their health plans often make numerous benefit packages with different premium, coinsurance, deductible, and

copayment levels available to employees. Cost-sharing levels, premiums, and coverage options may vary with employees' compensation.

- As noted above, our members employ full-time, part-time, seasonal, and temporary employees. Employees' eligibility for and enrollment in employer-sponsored health coverage often changes from year to year as employees change positions, locations, and compensation levels. Therefore, determining the cost of applicable coverage each year will likely require substantial changes to administrative procedures and reprogramming of payroll and recordkeeping systems.

- Although our members generally are familiar with § 4980B rules, they may not maintain the information required to adjust their § 4980B premium calculations for § 4980I purposes. Often, our members engage different third-party administrators for § 4980B compliance, group health plan administration, and payroll functions. Thus, for many of our members, determining the cost of applicable coverage will involve extensive coordination between third-party administrators and our members' payroll and recordkeeping systems.

Therefore, in developing § 4980I guidance and regulations, we encourage the Service to allow plan sponsors flexibility to (1) minimize costs and (2) adapt cost of coverage determinations to current plan designs and payroll and recordkeeping systems. We also urge the Service to consider the following:

- We support the proposal to use a standard similar to that under § 4980B for determining cost of coverage for groups of similarly situated individuals, i.e., aggregating by benefit package and then disaggregating based on enrollment in self-only or other-than-self-only coverage.

- Because our members' plan offerings vary so widely, we recommend that final regulations permit plan sponsors flexibility in designating benefit packages. Plan sponsors also should have the option of aggregating all self-only coverage and all other-than-self-only coverage for purposes of determining cost of applicable coverage.

- With respect to permissive disaggregation, we recommend that plan sponsors be permitted to disaggregate based on collective bargaining status, current vs. former employee status, bona fide geographic distinctions, or the number of individuals covered in addition to the employee. We also recommend that employers be permitted to consider all retirees (those under and over 65) similarly situated.

B. COBRA Premiums for Self-Insured Plans

Consistent with the need for flexibility discussed above, we recommend the following with regard to cost of applicable coverage determinations for self-insured plans:

- Our members support allowing plan sponsors a choice between the actuarial basis method or past cost method, similar to the options under § 4980B.

- However, plan sponsors should be required to use a chosen valuation method—either actuarial value or past cost—for no more than 2 years.

- Regarding the actuarial basis method, we support permitting a broad standard under which the cost of applicable coverage for a group of similarly situated individuals would be equal to a reasonable estimate of the cost of providing coverage under the plan for individuals in that group for the determination period, using reasonable actuarial principles and practices.

- In addition, because our members generally are familiar with using reasonable actuarial principles and practices—and often have long-standing relationships with third parties who provide actuarial services for their group health plans—we recommend that the Service use a reasonableness standard and not be overly prescriptive in rules for actuarial determinations.

- Regarding the past cost method, our members generally support using as the 12-month measurement period for a current determination period any 12-month period ending not more than 13 months before the beginning of the current determination period.

- With respect to the cost of claims, we support allowing plan sponsors to include either claims incurred during the measurement period or claims submitted during the measurement period.

- Regarding reasonable overhead expenses, for self-insured plans with a third party administrator, we support the presumption that reasonable overhead expenses are reflected in a third-party administrator fee.

IV. Applicable Dollar Limit

For reasons described in Sections I and III(A) above, Business Group members strongly support permitting adjustments to applicable dollar limits to reflect retiree status, age, and gender. These adjustments would mitigate the impact of § 4980I for employers with participant populations that vary from the national average such as mature workforces. We also recommend that § 4980I regulations provide flexibility for plan sponsors in making such adjustments. Specifically:

- Plan sponsors should be permitted to make adjustments to the annual dollar limits for retirees, as defined by their group health plans. While some of our members are able to identify Medicare-eligible employees through the Medicare Secondary Payer system, many do not track this status.

- Plan sponsors should be permitted to make adjustments based on retiree status, age, and gender based on reasonable actuarial principles and practices.

- In addition, plan sponsors should have the option of adjusting for retiree status, age, and gender based on a safe harbor that compares a given employee population to the average of the national workforce, for example, as reported by the Bureau of Labor Statistics. This option would allow for a simple, transparent, and equitable calculation for all employers and would not require extensive and costly actuarial analysis.

V. Other Methods for Determining Cost of Applicable Coverage

Finally, we support the Service's proposal to consider alternative approaches to determining the cost of applicable coverage, such as by reference to the cost of similar coverage based on actuarial values, metal levels (bronze, silver, etc.), or other metrics.

Specifically, we encourage the Service to include in § 4980I regulations a safe harbor such that plan sponsors providing coverage with an actuarial value of up to 80% will not be subject to § 4980I liability. Such a safe harbor would provide substantial administrative and cost savings for plan sponsors because (1) plan sponsors would be able to determine § 4980I liability based on clear, easily ascertainable factors and (2) an actuarial value standard would "smooth" the effects of geographic differences in the cost of health care, unusually high cost claims, and age and gender variations in participant populations. Providing a safe harbor at 80% actuarial value also would encourage plan sponsors to offer coverage consistent with the individual insurance market, which provides premium tax credits based on the cost of silver level Marketplace plans.

We also recommend that the Service consider alternative approaches to § 4980I that take into account plan sponsors' continuing efforts to contain health care costs. As 2018 approaches, many of our members have undertaken a variety of innovative plan design features and health care delivery system innovations that show great promise in keeping plan costs within the § 4980I applicable dollar limits or reducing plan costs if they have already exceeded these limits. These plan features include: coverage of evidence-based benefits; prescription drug management, especially for specialty pharmacy products; pay-for-performance arrangements with providers; use of high-performance networks; providing consumer decision support tools; and comprehensive workplace wellness programs. Promising delivery system innovations include ACOs, patient-centered medical homes, centers of excellence, and other bundled payment initiatives.

Because many plan sponsors are still in the early stages of implementing these features, we believe that § 4980I should not discourage plan sponsors from such innovation. Therefore, we recommend that § 4980I regulations exclude the costs of these plan features and delivery system innovations from the cost of applicable coverage. In addition, we recommend that § 4980I regulations permit either (1) a credit against § 4980I liability proportional to group health plans' cost reductions over the previous year

or (2) relief from § 4980I liability if group health plans succeed in achieving cost reductions from the previous year.

Again, thank you for considering our comments and recommendations on the implementation of Code § 4980I. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012 if you would like to discuss our comments in more detail.

Sincerely,

Brian Marcotte
President