May 15, 2015

Commissioner John Koskinen
Internal Revenue Service
U.S. Department of Treasury
CC:PA:LPD:PR (Notice 2015-16)
Room 5203
P.O. Box 7604
Ben Franklin Station
Washington, D.C. 20044

RE: Notice 2015 – 16

Sent via email to notice.comments@irscounsel.treas.gov

Dear Commissioner Koskinen,

The Council for Affordable Health Coverage (CAHC, www.cahc.net) is writing to share our views and concerns regarding Notice 2015-16 regarding regulatory guidance with respect to the excise tax on high cost employer-sponsored health coverage. We appreciate the opportunity to comment on the potential approaches the Internal Revenue Service (IRS) could take in future regulations of Section 49081 of the Internal Revenue Code (Code).

CAHC is a broad-based alliance with a singular focus: bringing down the cost of health care for all Americans. Our membership reflects a broad range of interests—organizations representing small and large employers, manufacturers, retailers, insurers, brokers and agents, physician and consumer organizations.

Under current law, in taxable years beginning after December 31, 2017, any amount of applicable employer-sponsored health coverage exceeding a set and annually revised dollar limit – currently, $10,200 for individuals and $27,200 for non-individuals (self and spouse or family) - will be subject to a 40 percent tax.

Generally, CAHC believes the tax may raise health costs rather than lower them. Structurally, the tax is badly flawed and should be modified or repealed. According to estimates by actuaries and others, this tax could affect nearly every employee benefits package over the next decade. In fact, as many as one-third of plans could be subject to Cadillac Tax in 2018 — could penalize workers with high claims because of sick workers or high cost areas. By 2021, average cost health plans would be subject to Cadillac Tax. By 2021, one-third of company small group accounts likely to be affected by Cadillac Tax. As a result, the tax is misnamed. It is not a tax on high cost plans, but rather a tax on average plans.

As a result, we urge the Administration to take great care in crafting the implementing regulations so that unintended consequences may result, including discouraging employers from offering affordable health coverage.

Our comments on the specific sections of the notice are below. These comments reflect the positions of the Coalition and may not reflect the individual views of our members.

Comments:

In drafting future rules related to applicable coverage, we urge the IRS and Treasury to exempt plans that comply with the statutory definition of minimum value as defined by the law and implementing regulations. These benefits are mandated by the Affordable Care Act and determined Congress to include essential benefits. As a result, we encourage these plans to be excluded from the tax via a regulatory safe harbor.

Section III B. Types of Coverage Included in Applicable Coverage

Contributions made to Health Savings Accounts (HSAs) – both pre-tax and after-tax -- should be excluded from the definition of applicable coverage. HSAs, pared with high deductible health insurance, are useful tools for millions of Americans that empower consumers while, at the same time, providing lower cost coverage option for individuals. Employers and health plans have no control over employee contributions to HSAs. Outside of a new and complicated reporting structure, CAHC believes it would be very difficult to determine whether an individual' coverage would be subject to the tax.

An approach we encourage Treasury and IRS to consider would be to allow differentiation in the mandatory aggregation rules for HSAs. These could be segregated into levels of contributions (both employer and employee) and further differentiated by distinguishing between the insurance component and the savings component due to the potential variation in contributions. Taxing employees who choose to save more in a given year in anticipation of future medical costs will disincent this behavior, leasing to higher individual out-of-pocket costs. We encourage Treasury and the IRS to craft regulations that mitigate against this incentive.

Section III E. On-site Medical Clinics

CAHC believes on-site medical clinics provide low cost options for employees to access health services. We encourage Treasury and IRS to take an expansive view of the definition of health care that goes beyond the COBRA definition. Specifically, we urge Treasury and the IRS to treat most medical care provided in on-site clinics as *de minimus* if it replaces care at an external office or facility that is more expensive than the clinic. We suggest revising the COBRA criteria related to care in addition to first aid and related to a health condition, illness or injury that occurred during working hours or for treatment of a chronic health condition that requires ongoing care. Employers are increasingly integrating wellness programs into on-site clinics and often care for chronic conditions such as diabetes, obesity and heart disease can be managed via a clinic. We encourage Treasury and the IRS to not dissuade employers and their employees from accessing care via this venue.

Section III F. Limited Scope Dental and Vision Benefits

CAHC supports excluding from applicable employer-sponsored coverage self-insured limited scope vision and dental plans as an excepted benefit.

Section III G. Employee Assistance Programs

CAHC supports exclusion of Employee Assistance Programs (EAPs) from the definition of applicable coverage under Section 49801. EAPs are supplemental programs that offer a wide array of assistance to employees and their families/dependents to improve morale and performance. We encourage Treasury and the IRS to keep the excepted benefits consistent and exclude those that qualify under Section 9831 as excluded under Section 49801 as well.

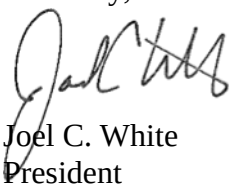
Section IV C 3. HRAs

CAHC urges Treasury and the IRS to not count the value of HRAs in determining the cost of applicable coverage as we believe doing so will double count the cost of the plan. Employees and their spouses may use HRAs in coordination with their insurance coverage to fill in cost sharing related to the plan. In this case, counting the HRA contribution and the cost sharing related to the plan (for example, the deductible) would double count the value of the dollars applied to cost sharing and inappropriately penalize employers. Under soon-to-be applied IRS rules (2013-54), stand-alone HRAs are an unlikely offering as the ACA excise tax would apply unless the HRA were integrated, offered as a stand-alone retiree-only HRA, an after-tax or premium only arrangement, or an excepted benefit health FSA. As a result, we see little need for Treasury or IRS to currently distinguish between multiple methods for determining the cost of applicable coverage with respect to HRAs. We encourage Treasury and IRS to exclude HRA expenditures from the determination of cost.

Conclusion

CAHC appreciates the opportunity to comment on Notice 2015-16. Please do not hesitate to contact me with any question regarding our comments. We look forward to working with you in the future to ensure affordable and meaningful access to health care for all Americans.

Sincerely,



Joel C. White
President