

May 11, 2015

Ms. Karen Levin
Office of Associate Chief Counsel (Tax Exempt and Government Entities)
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: A Response to the Call for Public Comment on Section 49801 - Excise Tax on High Cost Employer-Sponsored Health Coverage

Dear Ms. Levin,

Thank you for the opportunity to offer comments in response to the notice of proposed IRS rulemaking regarding the excise tax on high cost employer-sponsored health coverage under § 49801 of the Internal Revenue Code (Code).

Introduction: Guiding Principles for Rule Evaluation

This rule-related commentary has been guided by three overarching principles. It seeks to support IRS efforts to:

- (1) promote basic national standards that reinforce the concept of health insurance as a shared-risk and shared-benefit endeavor,
- (2) maintain ideals of political neutrality and "non-interference," and
- (3) minimize the bureaucratic burden and financial cost of monitoring rule compliance with respect to Section 49801 for all responsible administrative parties, including state-level and plan-level officials.

On Determining the Costs of Applicable Coverage (Notice, Section IV, p.15)

"... allowing some employers to make distinctions that they have not previously made when offering coverage to participants and beneficiaries could result in a standard that is susceptible to abuse." (Notice 2015-16, Section IV, page 15, emphasis added)

"Mandatory Disaggregation (Self-Only Coverage and Other-Than-Self-Only Coverage)" is the ONLY approach for determining cost of applicable coverage outlined in Notice 2015-16 that harmonizes fully with all three value principles above. All other cost approaches outlined—namely, "aggregation by benefit package," "permissive aggregation within other-than-self-only coverage" and "permissive disaggregation"—are not only "susceptible to abuse" but also liable to frustrate IRS efforts to maintain ideals of "neutrality" and "non-interference" with respect to state decision making.

The potential "benefits" of the IRS adopting a single, two-tiered (self-only and other-than-self only) "mandatory disaggregation" model are many. First, this option reinforces IRS "neutrality" (principle 3) by respecting the diversity of health care laws and policies currently in force across the 50 states. "Self-only" and "other-than-self-only" are "neutral" categories not subject to possible "politicization" in ways that, say, "self-plus-spouse", "self-plus-dependent(s)", or "family" are. The sheer simplicity of a single, two-tiered "mandatory disaggregation" model also means that the IRS need not devote any extra resources to rule interpretation, education, litigation, re-evaluation, etc. (principle 2). Plan administrators and state-level cost monitors will also be spared, since it is much easier to aggregate than divide up extant categories or tiers. The aggregate simplicity of "other-than-self only" concept also reinforces the basic premise of collective health insurance (principle 1).

Although there are potentially many sub-divisions that could be introduced by diverse insurance companies, it is important to recognize that the rules the IRS is developing with respect to "permissive" or "mandatory" aggregations and disaggregation beyond the original two dollar figures linked to the "self-only" and "other-than-self only" categories will have ramifications far beyond the actuarial intricacies of US tax law. State and local governments and other large-scale employers that currently operate two-tier premium, health insurance programs will come under pressure to remodel their coverage categories and offerings to conform to whatever approach for "determining cost of applicable coverage" is ultimately adopted by the IRS with respect to ACA's excise tax. If coverage for stand-alone dental and vision coverage is pronounced "excludable" by the IRS, insurers are less likely to maintain such coverage, wherever it currently exists, in their group health insurance policies. If the IRS decides to accept "permissive aggregation within Other-Than-Self-Only Coverage" and/or "Permissive Disaggregation," many insurers will be tempted to seize upon them as novel actuarial opportunities for fracturing risk groups, trimming policy benefits and raising premiums for "qualified retirees" and, potentially, any other category of "similarly situated individuals" acceptable to the IRS. Adopting anything beyond a simplified and self-evident "self/self-plus" distinction runs the risk of the IRS inadvertently tipping the political balance of forces engaged in healthcare policy debates within and across diverse states.

Consider the State of Wisconsin, whose Employee Trust Fund (ETF) manages the only 100% funded public pension program in the entire nation, encompassing approximately 570,000 state and local government employees and annuitants, their dependents and surviving spouses. Wisconsin's ETF also maintains a financially solid, two-tiered premium, "uniform benefit design," group health insurance program presently serving some 240,000 people and overseeing nearly \$1.4 billion in annual insurance premiums. 18 competing, fully insured, HMOs serve the health needs of 98% of these participants, with the remaining 2% being enrolled in alternative, PPO, state-administered health plans. Despite the proven, long-term success of Wisconsin's insurance system, Governor Scott Walker's administration seeks to dismantle and replace it with a state "self-insured" program. The explicit rationale offered for proposing this insurance overhaul is to "reduce" the state's future "exposure" to ACA's 40% excise tax liabilities,

which the report asserts could be as high as \$193 million by 2027 (see especially pages 6, 11, 61-93 and 114-118 of the attached "Segal" report, commissioned by the state's Government Insurance Board).

The report does not mention that, under Wisconsin's present HMO-dominant model, the primary party responsible for any paying future ACA "excise tax" would not be the state but, rather, the insurers of various HMOs. The state would be responsible for tallying and reporting to these HMO insurers the cost of annual pre-tax "employer" contributions (or more accurately, "individual employee salary deductions") deposited in individual flexible health savings accounts and associated pharmaceutical benefits. (Retirees cannot make deposits from their annuities into flexible health savings accounts.) However, competing HMO's insurers would be ACA's taxes. They would also be deciding on whether or not passing on some or all of those fees through higher monthly premiums will threaten the size of their participant pools vis-a-vis other HMOs during the state's annual "Its Your Choice" period for covered employees and annuitants to switch health plans. Were Wisconsin's system to shift entirely to a state "self-insured" system, the state would then be responsible for paying ACA's excise tax, if and when applicable.

The Segal Report "anticipates" that the IRS will decide to allow "qualified retirees," aged 50 years and above (not just 55 and above per ACA) to be disaggregated from active employees and regrouped together with "medicare retirees," whose annual net costs to ETF is acknowledged as \$0 dollars (p. 11). It thus recommends dismantling Wisconsin's "uniform benefit design" program into two separate insurance systems, one for "retirees" and their surviving spouses and the other restricted to "active employees" and their dependents. No cost/benefit analysis of the impact such a change would have the premiums of retirees and employees or on the quality of care coverage. The entire rationale for proposing this radical change is to decrease the allegedly enormous, future, liabilities of Wisconsin tax payers in the years ahead for the ACA excise taxes!

What merits emphasis here is the sheer political volatility of debates about healthcare reform and related social policy issues now taking place across every state. The most challenging question for the IRS, perhaps, is how to uphold the ideals of political neutrality and non-interference on such contested terrains? The simplest and easiest way for the IRS to avoid inadvertently "weighing in" to state-level deliberations would be to define "similarly situated individuals" as "individuals residing in the same state"—a more literal interpretation of "situated" than appears in Notice 2015-16.

This interpretation merits serious consideration for many other reasons as well. Not only does it "respect" the autonomy of state rights, so to speak. It also implicitly acknowledges and "accepts" the full spectrum of political outlooks and opinion shaping healthcare policy decisions and related social policy issues in the United States today. The bureaucratic burdens of IRS rule interpretation, compliance and enforcement would lighten for everyone. No avalanche of letters from insurers seeking IRS confirmation of ever more finely defined groups of "similarly situated individuals." State government and insurers responsible for calculating and reporting the annual cost of "applicable

coverage" will be working with Federal W-2 forms, which are already "sensitive" to variations in state-level income tax policies. For larger health insurance companies operating in diverse states, it would seem to require only the effort to cluster policyholders into state-based pools, just as they must group their employees for W-2 purposes. Certainly it will be much easier for insurers, private and public, to aggregate the costs of three, four or more tiered systems into "self-only" and "other-than-self-only" pools of participants than it will be for "two-tiered" systems to further sub-divide such costs.

In sum, it would seem to be in the long-term interests of the IRS and, indeed, everyone trying to support affordable access to quality healthcare to resist pressures to sub-divide the ACA's basic division between "self-only coverage" and "other-than-self-only coverage" since this approach supports and harmonizes with all three guiding principles for rule evaluation mentioned above.

Re: "Limited Scope Dental and Vision Benefits"

"Section 4980I(d)(1)(B)(ii) excludes from applicable coverage 'any coverage under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye.'" (Notice 2015-16, Section III, page 9)

Excluding stand-alone, limited scope dental and vision benefit contracts of insurance from "applicable coverage" is not advisable because it runs counter to all three overarching principles outlined above.

Many group health insurance policies issued by employers and state governments currently include at least some dental and vision coverage. If the IRS opens up the possibility that stand-alone dental and vision benefit policies are "excludable," it will create simultaneously novel financial incentives for plan administrators to pre-emptively strip such coverage from current group policy holders, wherever it exists. It also opens up possibilities for further benefit fragmentation. Why should the health of "the mouth" and "the eyes" be divorced from basic health policies and not that of "the ears"? Opening up this actuarial possibility would seem to run counter to all three guiding principles above.

I appreciate the opportunity to present these comments. Please do not hesitate to contact me with any further questions.

Sincerely,
Dr. S. E. Hutchinson

Submitted electronically by Dr. S. E. Hutchinson of Madison, WI on May 11, 2015, together with a PDF copy of the March 2015 "Segal Report," commissioned by the Group Insurance Board of the Employee Trust Fund, State of Wisconsin.