HEALTH SERVICE SYSTEM
CITY & COUNTY OF SAN FRANCISCO

September 30, 2015

Karen Levin
Office of the Associate Chief Counsel
CC:PA:LPD:PR (Notice 2015-52), Room 5203
Internal Revenue Service
P.O. Box 7604, Ben Franklin Station
Washington, DC 20044

Dear Ms. Levin:

The Health Service System of the City and County of San Francisco welcomes the opportunity to comment upon Section §4980I of the Internal Revenue Code, or the Excise Tax on High Cost Employer-Sponsored Health Coverage, for a second time. The Health Service System administers the health benefits for over 113,000 active employees, retirees, and their dependents – most of whom live in the San Francisco Bay Area, where medical costs are higher than the rest of California because of hospital and health system consolidation. In addition, the San Francisco Bay Area is a predominantly managed care area and benefits are governed by the California Department of Managed Care. Our dedication to continuing to provide comprehensive health coverage to our members, and our concern over the rising cost of health care in the United States leads us to a keen interest in the excise tax.

We recognize that curbing health care spending is part of the rationale for the excise tax, and we agree that efforts to do this are very important. To reduce our costs, we have taken the following steps: We take cost containment seriously have taken concrete steps towards doing this. For instance, we have restructured the delivery of services to create competition between two ACOs; our providers have added urgent care, advice lines and extended hours; and we are monitoring our providers' dashboards of ALOS,

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admits/1000, ED visits/1000, readmissions/1000 and generic prescribing rates.

Despite our understanding of the importance of reducing health care spending, we are concerned that the excise tax as it currently exists will lead to changes that are not congruent with the broader, deeper intentions of the Patient Protection and Affordable Care Act – such as the intention of increasing access to quality, affordable care. Below we articulate some of the reasons for our concern.

Our comments pertain to both the broader objectives of the excise tax, the specific requests made in the proposed regulation, and the implications of its implementation.

Who will pay?

The tax should be paid by the same person or entity that pays the HIT Tax and Transitional Reinsurance Fees and PCORI fees.

How will the tax be calculated?

We suggest plan year calculations, because not all employers' plans follow a calendar year schedule. We also believe that the tax should not be levied on state taxes on health care. In California, for example, there is a managed care organization tax which is passed on in premiums to the employer and employees. The federal excise tax should not be applied to state taxes, nor should it be applied to the federal HIT tax, PCORI fees, and transitional reinsurance fees because the excise tax is intended to discourage expensive plans and these taxes are unrelated to health costs. Applying the excise tax to these state and federal taxes amounts to taxing taxes.

Will shifting costs to employees reduce health care spending?

Some proponents of the excise tax argue that its implementation will discourage excessive health care spending.[1] The impetus on employers to restructure employee health plans in order to avoid the 40% tax on plans above the designated threshold (currently $10,200 for individual coverage and $27,500 for family coverage) is the presumed mechanism through which this will occur. To avoid the tax, employers are likely to alter the structure of their benefit plans in ways that either limit access to services or providers, require employees to contribute a higher post-tax copays, eliminate pretax flexible spending accounts which cover costs for vision and dental, or some combination thereof. Indeed, many employers have already begun making these sorts of changes to their health plans in preparation for 2018, when the tax takes effect.[2]

[1] The Editorial Board, "Keep the Tax on High-End Health Plans." *The New York Times*, August 12, 2015.
[2] Stich, Julie. "Six Things You Need to Know Now About the ACA Cadillac Tax." International Federation of Employee Benefit Plans Word on Benefits, August 11, 2015.

Proponents of the excise tax argue that benefit-rich plans insulate workers from the high cost of health care and thus encourage its overuse, through the utilization of unnecessary tests or unneeded hospital visits. Forcing employees to bear a greater proportion of the cost of their care, this theory holds, will discourage such use of unnecessary services and thus reduce the overall cost of health care.[3]

This perspective neglects consideration of the fact that in managed care environments, such as ours, overuse is tightly controlled. The uncontrollable factor is the hospitals and outpatient surgical centers and their high costs. Employers cannot discharge patients from hospitals, and hospitals have an incentive to keep patients in beds. Outpatient surgical centers are priced just under hospital surgical costs, and employers and insurers have no ability to prevent this kind of shadow pricing. The excise tax does not target these issues.

Defining "Cadillac" health insurance

What sort of plan counts as "benefit-rich," or structured in such a way that patients are truly insulated from the cost of health care and likely to over-utilize it? Health insurance plans that cost $40,000 per year for an individual, do not require the employee to make copayments or contributions to the premiums, and contain few limits on utilization or requirements for preauthorization certainly sound like "Cadillac" plans in the truest sense of the term. However, we know little about the prevalence of plans of this type. Although these sorts of plans are referenced in the media[4] as examples of bloated, overly-generous plans that encourage the overconsumption of health care, there has been little discussion of just how common these plans are within recent discussions about the excise tax.

Instead, much of the focus has been on plans that are right at the threshold for the excise tax – those that cost $10,200 for individual coverage, and $27,500 for family coverage or very close to these amounts. Within discussions of the excise tax, plans close to these prices are frequently referred to as "high cost" plans, and sometimes explicitly included in the category of "Cadillac" plans.

But plans at the threshold of the prices that would trigger the excise tax are not necessarily particularly generous. As we noted in our response to Notice 2015-16 (and as some news coverage/policy analysis has emphasized), there is great variation in the cost of health care premiums across geographic regions, and the demographics of a given employee pool. There is also variation in the premium rates that employers are able to negotiate: larger employers who have greater purchasing power are able to leverage lower premiums, but smaller employers are at a disadvantage. Although

[3] Piotrowski, Julie. "Health Policy Brief: Excise Tax on 'Cadillac' Plans." *Health Affairs* September 12, 2013.
[4] See for instance Christopher Beam's article, "Do I have a "Cadillac Plan"?" *Slate* October 14, 2009.

"Cadillac" insurance plans are typically defined by the total cost of the premium, rather than by other criteria, such as what the plan covers or how much the patient has to pay (in terms of their share of the health care premium and their copays and deductibles),[5] the absolute cost of a premium does not denote a particular level of coverage or benefit plan structure.[6]

As we recommended in our response to Notice 2015-16, at the very least, *measures of geographic variation* in medical costs need to be put in place (with provisions for regular updating), in order to ensure that people who are subject to higher medical premiums are not unfairly disadvantaged. If a tax is to be levied upon "Cadillac" employer-sponsored plans, we need to ensure that the plans which are taxed truly fit the bill. And, as previously alluded to, state laws regarding minimum coverage must be taken into consideration. Consideration must be given to the differences between markets. Northern California is one of the most expensive markets in the country for housing, transportation, food and medical care. Measuring all markets with the same ruler is unfair to those employees and employers who live in more costly markets. The Federal Government acknowledges these differences in reimbursement, and it should acknowledge them in setting the threshold for the excise tax as well.

Taxing the very highest-cost, most generous employer-sponsored health plans may be a worthwhile component of a broader strategy designed to reduce health care spending. But decisions about which plans to tax should to be based on robust considerations of where to draw the line between adequate and excessive health insurance coverage. In addition to these considerations, the nature of unnecessary medical services and the extent to which their use contributes to medical spending merits careful examination.

<u>The use of unnecessary medical services</u>

Americans' "preference" for high tech medicine, coupled with the belief that more care is necessarily better than less, are recognized as contributors to health care costs.[7] But it is essential to keep in mind that patients' preferences are not developed in isolation. High-technology medicine is venerated within and beyond the medical profession in the United States. The notion that technologically sophisticated care, and more of it, equates with receiving the best health care is prevalent in the United States. Patients' interactions with medical professionals are likely to reinforce, rather than challenge, these understandings.

[5] Gold, Jenny. "'Cadillac' Insurance Plans Explained." *Kaiser Health News* March 18, 2010.
[6] Gabel, Jon R., Jeremy Pickreign, Roland McDevitt, and Thomas Briggs. "Taxing Cadillac Health Plans May Produce Chevy Results." *Health Affairs* Web First, December 3, 2009.
[7] "What Is Driving U.S. Health Care Spending? America's Unsustainable Health Care Cost Growth," Bipartisan Policy Center, September 2012.

We also know that factors other than patients' preferences drive the utilization of medical services of questionable utility. The recent history of the use of colonoscopies in the United States illustrates the extent to which doctors' practices, rather than patients' preferences, contribute to the utilization of unnecessary care. Although cheaper (and less invasive) tests are recognized as effective screening tests for colon cancer, colonoscopies are prescribed and performed more frequently than medical guidelines recommend, leading to a dramatic increase in their use in the last 15 years.[8] In other words, the United States has defaulted to the most expensive option for colon cancer screening, despite evidence that it is not necessarily the most effective screening tool. Performing colonoscopies in surgery centers and billing them as quasi-operations make them lucrative procedures for multiple parties within the medical industry – and this profit motive, rather than patients' preferences for colonoscopies, is recognized as the driving force behind their increase. Employers and insurers have no control over where these procedures are performed – and again, the excise tax does not target this issue.

Even if doctors do not actively promote procedures that are unnecessary but costly, they may at times do little to discourage patients from obtaining care that has no demonstrable value. For instance, research suggests that annual physical exams are "basically worthless" for people who are generally in good health and do not have any particular symptoms or complaints. Yet even in the face of evidence that annual exams for healthy patients do not improve health outcomes but result in billions of dollars in costs to the health care system, physicians have not taken the lead in discouraging the practice.[9] This may be due to doctors' reluctance to let go of the continuity that annual exams lend to the doctor-patient relationship, or to a steadfast belief that annual exams are a pillar of effective preventive medicine just as they have long been seen, rather than sheer profit motive. But whatever their motivations, doctors' failure to discourage unnecessary annual exams health care costs impacts health care costs.

Another doctor-driven practice that contributes the prescription and utilization of unnecessary health care is "defensive medicine," which physicians employ in response to the threat of medical malpractice lawsuits. Rather than leave themselves vulnerable to accusations that they did not order enough care or the correct care, doctors will order tests, specialist visits, or hospitalizations that they know are not truly necessary to treating a patient's condition, but believe will protect them from lawsuits.[10] (It is of course important to point out that doctors' concerns about litigation are not unfounded,

[8] Rosenthal, Elisabeth. "The $2.7 Trillion Medical Bill: Colonoscopies Explain Why U.S. Leads the World in Health Expenditures." *The New York Times* June 1, 2013.
[9] Emanuel, Ezekiel J. "Skip Your Annual Physical." *The New York Times*, January 8, 2015.
[10] Hettrich, Carolyn M., Richard C. Mather III, Manish K. Sethi, Ryan M. Nunley, Amir A. Jahangir, and the Washington Health Policy Fellows. "The costs of defensive medicine." *American Academy of Orthopaedic Surgeons Now* December 2010.

and that doctors, like patients, are influenced by multiple forces within the health care arena.)

Thus, while steering patients away from superfluous medical services is indeed a worthy goal, its achievement requires policy change above and beyond shifting a greater portion of the cost of care to patients. For instance, the incentives to providers for ordering high-cost tests need to be addressed, and providers need to be equipped to have meaningful conversations with patients about the efficacy of various treatment options.[11]

Policy also drives the use of unnecessary services. Both the Affordable Care Act and Medicare encourage annual exams, despite evidence that suggests they may contribute to excess spending. Health care policy that both prescribes and reinforces distinctions between necessary and unnecessary care needs to be driven by evidence-based medicine and regular, rigorous reviews of best practices in order to both reduce health care costs and improve population health.

It is also important to keep in mind that while some distinctions between "necessary" and "unnecessary" care are fairly straightforward (one might imagine that elective cosmetic surgery would reasonably fall into the latter category), some are much less so. When developing policy interventions designed to address the overuse of medical care or the utilization of unnecessary care we must remain aware of the long history of unequal access to healthcare in the United States. While we know that some Americans have received care that could reasonably be considered excessive, many Americans have *not* received care that could reasonably be considered essential.[12]

<u>The rising cost of pharmacy benefits</u>

Another set of rising costs that employers and health plans do not have control over are pharmacy costs.

The Bureau of Labor Statistics' Consumer Price Index (CPI) report for June 2014 reported a 2.6 % growth rate for the medical services CPI, and a 2.8% growth rate for medical commodities CPI between June 2013 and June 2014.[13] Prescription drugs, a component of the medical commodities index, increased by 4.1% within this same period.[14] That growth is expected to continue. The 2013 Drug Trend Report from Express Scripts (April 2014, p. 5) predicts that the cost of traditional (non-specialty)

[11] "What Is Driving U.S. Health Care Spending? America's Unsustainable Health Care Cost Growth," Bipartisan Policy Center, September 2012.
[12] Hoffman, Beatrix. 2010. *Health Care for Some: Rights and Rationing in the United States Since 1930*. Chicago: The University of Chicago Press.
[13] Bureau of Labor Statistics, United States Department of Labor, Consumer Price Index, June 2014, p.9.
[14] Robert Wood Johnson Foundation Issue Brief on Specialty Tier Pharmacy Benefit Designs in Commercial Insurance Policies, August 2014.

drugs will increase at a rate of 2% per year through 2017, and the cost of specialty drugs will increase at eight times that rate - meaning **16% per year**. The Centers for Medicare & Medicaid Services projects sustained increases in drug spending of 6% or more annually from 2015 to 2022. Specialty drugs make up a disproportionate share of overall drug spending. The cost for treatment of metastatic prostate cancer is $105,800 per month, hepatitis C costs $29,900 per month, Gleevec for chronic myeloid leukemia costs $11,900 per month, and Revlimid for multiple myeloma costs $9,300 per month - to name only a few. A new class of specialty drugs are "biologics," which can be 22 times more expensive than traditional medications. A decade ago there was only one biologic in the top ten list of specialty drugs; eight of the top ten will be biologics in 2016. It is estimated that specialty drugs will make up more than 50% of all drug spending by 2018.

Given these extremely high costs along with the lack of employers' power to control them, the proposal to use the CPI rather than the medical CPI to adjust the excise tax threshold simply does not make sense.

Age and gender adjustments

The proposed regulations specifically asked for comments on adjusting for age and gender of the workforce. This is a very blunt measure and it would be much more appropriate to adjust for the risk of the population which takes medical diagnoses into account along with age and gender. This issue is closely related to the high and rising cost of pharmaceuticals.

Suburban populations tend to have lower risk scores and more families. Urban centers have older employees and much higher risk scores. For example, the San Francisco Bay Area has a high population of people living with HIV. HIV antiretroviral drugs make up 25% of the pharmacy spend for the SF Health Service System, when spread across 12,000 covered lives. Specialty drug prices put the sustainability of medical and prescription drug benefits into jeopardy.

Compelling consumers to make informed choices about health care consumption

Closely related to the idea that compelling employees to bear a larger portion of the cost of their health care will motivate them to reduce their use of unnecessary services is the belief that taking on more costs will also prompt employees to become generally more informed, efficient consumers of health care.[15] Employees who are responsible for a larger portion of their health care costs, the theory holds, will be more inclined to seek out services and providers that are reasonably priced.

[15] Piotrowski, Julie. "Health Policy Brief: Excise Tax on 'Cadillac' Plans." *Health Affairs* September 12, 2013.

This perspective is problematic for several reasons. Perhaps most critically, the need for healthcare is not entirely predictable, even if it is universal. When accidents occur or illnesses arise suddenly, it is not possible for patients to research their treatment options and shop around for the best deal. They are not able to make efficient economic decisions about their health care in these situations. If we choose to regard health care as a commodity (as many do in the United States[16]), we must also recognize, at the very least, that health care is fundamentally different from other commodities or services, and the roles of health care *patient* and health care *consumer* are not simultaneously compatible.

Even when patients/consumers are able to schedule health care procedures in advance and research the treatment and pricing options that are available to them, they do not necessarily have access to all of the information that they need to make the most economically efficient choices. It is widely recognized that consumer choice is restricted by a lack of transparency in health care costs and quality, and by limited data about the costs of procedures and services.[17] As a result, comparison shopping is virtually impossible.[18] Even patients who have the time and resources to scrupulously research their medical procedures in advance may later receive bills for surprise charges, incurred as a result of additional, out-of-network medical personnel participating in their care and then billing for their services.[19] These cost drivers require their own targeted policy interventions.

Unaffordable plans and an underinsured workforce

By prompting a restructuring of employer-based health insurance, the excise tax threatens to push the United States towards a trend of unaffordable health insurance plans and an underinsured workforce.[20] Most non-elderly Americans (a total of approximately 160 million people) receive health insurance through their job, or through their parent's or spouse/domestic partner's job.[21] This will continue to hold true, even after the Affordable Care Act is fully implemented.[22] The excise tax, in its current form, will undermine two important stated goals of health care reform – building upon employer-based coverage, and lowering costs.

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[16] Hoffman, Beatrix. 2010. *Health Care for Some: Rights and Rationing in the United States Since 1930*. Chicago: The University of Chicago Press.

[17] "What Is Driving U.S. Health Care Spending? America's Unsustainable Health Care Cost Growth," Bipartisan Policy Center, September 2012.

[18] Gorenstein, Dan. "A push for transparency in healthcare pricing." *Marketplace* March 27, 2015.

[19] Rosenthal, Elisabeth. "After Surgery, Surprise $117,000 Medical Bill From Doctor He Didn't Know." *The New York Times*, September 20, 2014.

[20] Frist, William H. "Obamacare's 'Cadillac Tax' Could Help Reduce The Cost Of Health Care." *Forbes* February 26, 2014.

[21] Blumenthal, David. "Higher employee cost-sharing could undermine job-based coverage system." *Modern Healthcare* June 6, 2015.

[22] Ibid.

If employer-based health care increasingly features plans with higher copays and deductibles, the essential feature of health insurance – protecting policy holders from the major costs associated with health care – will effectively be eroded. Broad reductions in employer-based health insurance pose a serious threat to the health and economic wellbeing of American workers and their families.

For the millions of Americans living with chronic disease, the paring down of insurance coverage and Flexible Spending Accounts (FSAs) will very likely have a serious, detrimental impact on their quality of life. Higher deductibles and copays may put many patients in the position of having to decide between their health and their financial stability, and this will likely result in postponing or skipping treatment and medication. Counting FSAs toward the total premium discriminates against people with chronic illness who pay more for copays. In the short term, the results of this strategy may be relatively bearable, but the long-term health and economic consequences will be significant for individuals and for society. Conditions that are undetected or untreated may worsen. The long-term outcomes include poorer personal and population health, and higher costs of medical care later on – which ultimately increases, rather than reduces, medical spending.[23]

Some proponents of the excise tax argue that for those who really need "gold plated" health care, there will be little alternative to paying more for it.[24] But there is little evidence that this is the case for the majority of Americans. Medical bills are a leading driver of debt and bankruptcy in the U.S., and having health insurance is not necessarily a guarantee against either.[25] Health plans that have deductibles in the thousands of dollars provide little true insurance for middle class (and below) families, particularly those with significant health challenges. For a family of four living off of $52,000/year (approximately the median household income in the U.S.), a $5,000 deductible is likely to present a substantial financial barrier to the utilization of badly-needed care. Raising employees' share of health insurance and health care costs will force many families to make choices between forgoing or postponing badly needed health care services, or incurring insurmountable debt.[26]

Even for Americans who are in relatively good health, the growing expense of health insurance will redirect resources away from other things that consumers spend money on – such as housing, education, food, or savings. For the already-beleaguered

[23] Ibid.
[24] Piotrowski, Julie. "Health Policy Brief: Excise Tax on 'Cadillac' Plans." *Health Affairs* September 12, 2013.
[25] Himmelstein, David U. and Steffie Woolhandler. 2013. "Medical Debt: A Curable Affliction Health Reform Won't Fix." *Communities & Banking* September 2013.
[26] Piotrowski, Julie. "Health Policy Brief: Excise Tax on 'Cadillac' Plans." *Health Affairs* September 12, 2013.

working middle class, a rising share of health care costs poses a serious threat to income security, financial stability, and overall quality of life.[27]
Healthcare costs rise faster than inflation, meaning that two things will happen over time. First, more and more plans will be impacted by the Cadillac Tax over time.[28] Second, employees' out-of-pocket health care expenses will continue to rise. Meanwhile, real wage growth remains weak and has not exceeded 1% for several years. Stagnant wages exacerbate the burden of increased employee responsibility for health care costs.[29]

Concluding points

We agree with Lee Saunders, President of the American Federation of State, County and Municipal Employees who wrote "We should be creating incentives to provide better coverage, not punishing the ones who already do," to *The New York Times* (letter to the editor, August 19, 2015). In the absence of a single-payer system, bolstering, rather than whittling away at employer-based health insurance is essential to maintaining the health and economic stability of working Americans and their families. And supporting the health and economic stability of working American families is essential to ensuring the overall social and economic vitality of the nation.[30]

Moreover, adding a 40% excise tax with no evaluation of the risk score of the population will contribute to discontinuation of employer-sponsored retiree benefits. The provision of other post-employment benefits (OPEB), including retiree health insurance, represents a significant component of the compensation that state and local government employees receive. The imposition of the excise tax will compromise government employers' ability to provide OPEB to their workers.

The pursuit of cost containment in health care is undoubtedly important, but strategies to address it need to target not only consumers' usage, but the costs themselves. Health care industry practices and the laws and policies that govern them require careful scrutiny and meaningful interventions if costs are going to be effectively contained. Multiple entities within the United States health care industry have strong incentives to keep profits high.[31] Policies that target the pharmaceutical, for-profit insurance industries and for-profit hospital industries, promote transparency in health

[27] Altman, Drew K. "The Connection Between Health Coverage and Income Security." *Washington Wire* August 3, 2015.
[28] Frist, William H. "Obamacare's 'Cadillac Tax' Could Help Reduce The Cost Of Health Care." *Forbes* February 26, 2014.
[29] Blumenthal, David. "Higher employee cost-sharing could undermine job-based coverage system." *Modern Healthcare* June 6, 2015.
[30] Stiglitz, Joseph E. 2012. *The Price of Inequality: How Today's Divided Society Endangers Our Future* New York: W.W. Norton & Company.
[31] Rosenthal, Elisabeth. "The $2.7 Trillion Medical Bill: Colonoscopies Explain Why U.S. Leads the World in Health Expenditures." *The New York Times* June 1, 2013.

care costs and quality, and reduce the administrative costs of health care delivery must be implemented in order to reduce costs - and to create an environment in which patients can reasonably be expected to become savvier consumers of health care and thus do their part to reduce health care spending.

We thank you for your time and consideration of our comments.

Sincerely yours,

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