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April 15, 2015

The Honorable Orrin Hatch
Chairman, Senate Committee on Finance
The Honorable Ron Wyden
Ranking Member, Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of America's Health Insurance Plans (AHIP), I appreciate the opportunity to offer comments on ways to address the current inequities and complexities with respect to the federal tax code. We understand that the Senate Finance Committee (Committee) is carefully exploring the implications of potential changes to the federal tax code and look forward to working closely with you to develop solutions that would create a simpler and fairer tax system.

Federal and state taxes have a considerable impact on health plans and the business environment in which they operate. The health insurance sector faces an effective federal tax rate of approximately 40 percent, which imposes significant costs on companies that offer health insurance coverage in addition to the purchasers and consumers who rely on this coverage.[1] When new taxes imposed by the Affordable Care Act (ACA) are accounted for, many of our companies' effective tax rates exceed 50 percent. In addition, states imposed over $17 billion in premium taxes on insurance products in 2013, according to the most recent data available from the U.S. Census Bureau.[2] We hope the Committee will look carefully at the impact of these taxes, and we are eager to discuss ways to reduce their impact on the affordability of coverage provided to the individuals, families, and employers that we serve.

As you know, the federal tax code also provides various incentives (and disincentives) for individuals and employers to access health coverage through mechanisms such as the deductions for the purchase of health insurance by individuals and businesses, recognition of health spending accounts (health savings accounts (HSAs), health reimbursement arrangements (HRAs), and health flexible spending arrangements (FSAs)), and insurance subsidies. Moving forward, as a principle, we believe it is important to maintain incentives that promote access by employers and individuals to a choice of affordable health coverage options.

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[1] CSI Market, "Accident and Health Insurance Industry Tax Rates," accessed at: http://csimarket.com/Industry/industry_Profitability_Ratiosc.php?ind=702

[2] U.S. Census Bureau, "State Government Tax Collections 2013," accessed at: http://www.census.gov/govs/statetax/ Data is for all lines of insurance, including health, disability, supplemental, and long-term care.

Based on considerable discussion within the industry, we would highlight three provisions in the ACA that we strongly encourage Committee to address as it proceeds with its work: the health insurer tax, the excise tax on so-called "high cost" employer-sponsored health coverage, and the limits on the deductibility of health insurer compensation.

ACA Health Insurer Tax

Beginning in 2014, the ACA imposed a new health insurance tax that will exceed $158 billion over ten years.[3] The tax is set at $8 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in 2017, and $14.3 billion in 2018. In subsequent years, the tax will increase annually based on premium growth.

The health insurance tax is particularly burdensome not only because of its significant cost to the industry, but also because it is not deductible for income tax purposes. This means that **health plans have a higher corporate tax liability** because they will not be able to reduce their taxable income by the amount of the health insurance tax liability.

The health insurance tax is imposed broadly on health insurance plans providing fully insured coverage, based on their market share. While the ACA health insurance tax is assessed on health plans, experts agree that it impacts consumers, employers, and other entities that purchase coverage directly from health insurance plans in the individual and group market as well as beneficiaries in public programs. The Congressional Budget Office (CBO) has stated that this tax will be "largely passed through to consumers in the form of higher premiums."[4]

Consequently, the health insurance tax directly affects tens of millions of American companies, organizations, and individuals, including:

- Businesses and their employees covered under fully-insured plans—particularly small businesses that often have more limited resources to purchase coverage;
- Public employers (e.g., school districts) that purchase health insurance on a fully insured basis;
- Individuals and families that purchase coverage in the individual market both inside and outside of Exchanges;
- Senior citizens and other Medicare beneficiaries who enroll in Medicare Advantage health plans and Medicare Part D prescription drug plans; and
- States with state Medicaid programs that contract with managed care organizations.

[3] Congressional Budget Office (CBO), "The Budget and Economic Outlook: 2015 – 2025," January 2015.
[4] CBO letter to Sen. Even Bayh. "An Analysis of Health Insurance Premiums under the Patient Protection and Affordable Care Act." November 30, 2009.

The magnitude of the expected premium increase is addressed by a pair of actuarial studies that have been conducted by the Oliver Wyman firm and commissioned by AHIP. The first study[5] examined the national impact the premium tax will have on individual market consumers, employers, Medicare Advantage enrollees, and state Medicaid programs. A second study[6] provides state-by-state data on the impact of the tax in all 50 states.

The Oliver Wyman analysis projected that the health insurance tax alone increased the cost of family coverage in the individual market by $270 in 2014 and will increase costs by an average of $5,080 over the ten-year period of 2014-2023. The study also estimated that the health insurance tax increased the cost of family coverage in the small group market by $360 in 2014 and will increase costs by an average of $6,830 over the same ten-year period. These findings are reinforced by Congress' Joint Committee on Taxation (JCT)[7], which has estimated that repealing the health insurance tax could decrease the average family premium in 2016 by $350 to $400.

Focusing specifically on the Medicare Advantage (MA) program, the Oliver Wyman study found that the health insurance tax increased costs for MA enrollees by $192 to $240 per year in 2014 and that this cost increase will reach $384 to $504 per year by 2023. The average expected increase in the cost of MA coverage over ten years is $3,590. This number represents a direct reduction in the resources that will be available to support the health care benefits of over 16 million seniors and persons with disabilities who value the improved quality of care, additional benefits, and innovative services their MA plans provide. Additional costs will also be imposed on almost 24 million beneficiaries in Medicare Part D plans, which are subject to the health insurance tax.

We also are deeply concerned that the health insurance tax, as estimated per the Oliver Wyman study, will put greater pressure on state Medicaid budgets by increasing the average cost of Medicaid coverage by an estimated $1,530 per enrollee between 2014-2023. Taking such a significant level of resources away from Medicaid at a time when most states are implementing major expansions in Medicaid eligibility seems unwise from a policy perspective and may compromise access to health care services for millions of vulnerable people.

As you are aware, legislation was introduced in Congress last session and again this year to repeal the ACA health insurer tax. We strongly support this legislation. Repealing the ACA health insurer tax will make health coverage more affordable by lessening the financial burdens imposed on consumers and businesses that have seen their costs increase as a result of the tax.

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[5] Carlson, Chris. "Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans." Oliver Wyman. October 30, 2011.
[6] Carlson, Chris. "Annual Tax on Insurers Allocated by State." Oliver Wyman. August 1, 2012.
[7] JCT Letter to Senator Jon Kyl, May 12, 2011.

Excise Tax on High Cost, Employer-Sponsored Health Coverage

The ACA imposes a non-deductible excise tax on certain "high-cost" employer-sponsored health coverage. The excise tax is equal to 40 percent of the cost of "excess" benefits determined by comparing the cost of coverage under the employer-sponsored group health plan to an arbitrary legislatively-determined amount for individual and family coverage. The provision is effective for taxable years after December 31, 2017, and according to an estimate from the CBO, the excise tax is expected to raise $87 billion in revenue between 2016 and 2025.[8]

Recently, the Internal Revenue Service (IRS) issued a request for public input on how the tax should be implemented. We are in the process of developing comments and are pleased to share several key observations.

First, the excise tax is extremely complex to administer and will raise significant operational burdens for health insurers, third-party administrators, and employers. As noted, the tax is based on the "cost" of coverage which involves calculating a range of costs beyond merely the premiums attributable to coverage. For example, employer and employee pre-tax contributions to HSAs, HRAs, Archer MSAs, health FSAs, and the costs associated with other employer health options–such as certain wellness programs and on-site medical clinics may also be included. Additionally, each employer's workforce will need to be analyzed to determine its overall composition, including the age and gender characteristics and the number of retirees and individuals who may be engaged in certain high-risk or other specified occupations (e.g., construction, mining, agriculture, forestry, and fishing industries). Simply compiling the information needed to determine the cost of coverage and workforce composition, in addition to calculating the tax liability, will be a significant undertaking.

Over time, the excise tax will impact the ability of employers to provide health coverage to their employees. While the impact of the excise tax is difficult to estimate with absolute certainty at this time, a recent analysis by the American Health Policy Institute concludes that coverage sponsored by 17 percent of American businesses (38 percent of large employers) will be subject to the excise tax in 2018.[9] Similarly, the National Association of Counties (NACo) estimated that if the tax were implemented in 2014, it would apply to at least 6 percent of their members' employer-sponsored health plans.[10] By 2018, absent significant changes in benefits, we expect the impact on NACo members would be substantially higher.

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[8] Congressional Budget Office, "Updated Budget Projections: 205 to 2025," March 2015. The estimate includes direct federal government revenue from the excise tax and additional tax revenue resulting from higher employee wages from employers in lieu of higher contributions to employee health coverage.
[9] American Health Policy Institute, "The Impact of the Health Care Excise Tax on U.S. Employees and Employers," accessed at: http://www.americanhealthpolicy.org/Content/documents/resources/Excise_Tax_11102014.pdf
[10] National Association of Counties, "County Health Benefits 2014," accessed at: http://www.naco.org/research/Documents/County%20Health%20Benefits%20FINAL_06.30.2014.pdf

The excise tax was originally proposed, in part, as a way to moderate the overall growth in health care costs and the associated burdens on employers. We strongly support efforts to reduce health cost trends and our members are at the forefront of a variety of innovative and successful strategies to control health care costs through such initiatives as pay-for-performance and quality improvement initiatives, wellness and care coordination programs, incentives for the adoption of technology and electronic health records to improve patient care, and value-based insurance designs. We are very concerned, however, that the excise tax is the wrong approach to efficiently lower health care costs and may in fact encourage employers to drop health coverage. In the end, we believe that any tax code reforms should keep and strengthen incentives for employers and individuals to access affordable health insurance.

Limits on the Deductibility of Health Insurer Compensation

The federal tax code generally allows businesses to deduct reasonable compensation paid to employees as an ordinary and necessary business expense. It also contains a long-standing deduction limit applicable to compensation paid by publicly-held corporations. Under this rule, such corporations may only deduct up to $1 million in remuneration paid annually to the Chief Executive Officer and the four other most highly-compensated officers for the taxable year.

The ACA imposed an unprecedented deduction limitation on health insurers. Beginning in 2013, health insurers are prohibited from deducting employee compensation above $500,000 and not the $1 million deduction permitted all other businesses. This deduction limit applies to all employees and certain service providers—not just the top five most highly-compensated officers, as is the case with all other businesses. Moreover, the limit applies to current compensation as well as compensation earned today but paid in future years rather than only to compensation paid in the year in which the individual is subject to the deduction limit. Unlike the more general deduction limitation for publicly-held companies, the deduction limitation for health insurers applies to commissions and performance-based compensation. Finally, the limit generally applies not only to the health insurer but also to any company that is part of a controlled group that includes the insurer. As a result, non-insurance subsidiaries or other related businesses are generally subject to the deduction limit.

In short, these ACA rules far exceed what is required for all other U.S. companies and result in significant tax inequities for health insurers. By comparison, participants in the Troubled Asset Relief Program were subject to less onerous deduction limitations than these highly-restrictive ACA rules that single out and apply only to health insurers.

Conclusion

Again, AHIP appreciates the opportunity to offer comments to the Committee as it works to reform the federal tax code. We look forward to working closely with you to develop solutions that would create a simpler and fairer tax system and that promote access to a choice of affordable health coverage options by employers, individuals, and other entities and organizations.

Sincerely,

Matthew Eyles
Executive Vice President
Policy and Regulatory Affairs