REPORT OF THE HEALTH TAX POLICY TASKFORCE

TO THE

UNITED STATES SENATE FINANCE COMMITTEE

September 2019

Table of Contents

Introduction

Since the end of 2017, 29 temporary tax provisions have expired, with more than a dozen other temporary provisions set to expire at the end of this year. The Finance Committee formed bipartisan taskforces to examine this group of over 40 expired or about-to-expire tax provisions and identify options for long-term resolution of these temporary tax policies.

The Health Tax Taskforce was charged with examining the temporary tax policies in the health area that expire between December 31, 2017 and December 31, 2019. The list of these provisions is set out below, and additional background on each was provided in the pamphlet prepared by the Joint Committee on Taxation.[1]

The Taskforce received feedback from stakeholders, interested Senate offices, and other interested parties to examine the original basis of each provision, determine whether there continues to be a need for the provision as currently drafted, and identify long-term resolutions when possible. With respect to the temporary health tax policies, the Taskforce focused on whether the policy should be extended and for what duration, and not the underlying health care policy of the provision. The Health Tax Taskforce received and considered comments and proposals from stakeholders and other interested parties with respect to its set of temporary tax policies, which are summarized below.

The Health Tax Taskforce was led by Senators Pat Toomey (R-PA) and Bob Casey (D-PA), with Senators Mike Enzi (R-WY) and Mark Warner (D-VA) also serving as members.

The Taskforce was instructed to review six expired tax provisions:
1. Health coverage tax credit
2. Paid family and medical leave tax credit
3. Medical expense deduction - 7.5% AGI floor
4. Black lung disability trust fund excise tax rate
5. Medical device excise tax
6. Health insurance tax

The Taskforce solicited comments from stakeholders on the provisions and received 128 written comments. The Taskforce held five meetings on June 20th and June 21st where stakeholders convened to discuss their views and answer questions from the Taskforce. Additionally, the Taskforce hosted a briefing from the Joint Committee on Taxation regarding the provisions on June 19th.

This report contains background on each provision, a summary of the input received from stakeholders, a list of stakeholders for each provision, relevant legislation, and finally an appendix categorizing the stakeholder comments that were received. The Taskforce did not come to a consensus on the expiring provisions within its scope.

[1] JCX-22R-19, https://www.jct.gov/publications.html?func=startdown&id=5188

Provisions Studied by the Taskforce

Health coverage tax credit

Summary of Provision

The health coverage tax credit is a refundable tax credit for 72.5 percent of health premiums, available for certain recipients of benefits from Trade Adjustment Assistance (TAA) and the Pension Benefit Guaranty Corporation (PBGC). About 30,000 workers receive HCTC payments.[2] The credit will expire for coverage months beginning after December 31, 2019 without legislative action.[3]

Stakeholder Input

The Taskforce received thirty-six comments regarding the health coverage tax credit. Stakeholders in support of the credit included current beneficiaries and a union advocacy organization. Beneficiaries of the credit advocated for extension of the HCTC, stating that it makes health insurance more affordable to them. Credit beneficiaries who receive Trade Adjustment Assistance stated that the credit provides them with the health insurance coverage they lost as a result of trade-associated job loss. Those who receive the credit due to their pension being turned over to the PBGC – some of whom are retired pilots of airlines that went through bankruptcy – argued that the credit helps to offset the portion of their pension that was lost.

No stakeholders submitted comments opposing the continuation of the HCTC. However, one member noted that arguments against the credit include that it should be allowed to expire because it is a narrowly targeted benefit that helps a small subset of individuals, and that it is duplicative in light of the premium tax credits provided in the *Affordable Care Act of 2010.*

Stakeholders

The Taskforce received written and/or in-person feedback from individuals from North Carolina, Kentucky, Arizona, Florida, Nevada, Indiana, California, Michigan, Minnesota, Ohio and Pennsylvania, and the AFL-CIO.

Relevant legislation

S. 2414, introduced by Senators Rob Portman (R-OH) and Sherrod Brown (D-OH), would extend the health coverage tax credit for five years.
2 cosponsors (2 D).

H.R. 1939, 7 cosponsors (4 D, 3 R).

[2] https://www.irs.gov/statistics/soi-tax-stats-affordable-care-act-aca-statistics
[3] For a more in-depth summary of the health coverage tax credit and the other provisions, please see Joint Committee on Taxation Publication JCX-22R-19.

Paid family and medical leave tax credit

Summary of Provision

The paid family and medical leave tax credit is a business tax credit that offsets between 12.5 and 25 percent of an employee's wages associated with paid family and medical leave, depending on the wage replacement rate provided by the employer. The credit is available to all employers, including those who already provided paid family and medical leave prior to the availability of the credit. The credit applies to wages paid to employees making $72,000 or less per year. The credit will expire for taxable years beginning after December 31, 2019 without legislative action.

Stakeholder Input

The Taskforce received twelve comments regarding the paid family and medical leave tax credit. Senators Deb Fischer (R-NE) and Angus King (I-ME) advocated for the credit's extension, asserting that enacting the nation's first paid family leave policy was a major victory and that it would be a loss to allow the credit to expire only two years after enactment. Other stakeholders in support of the credit's extension cited the importance of paid family leave in the workplace and their preference for a voluntary employer-sponsored policy. Supporters also claimed the extension is needed because a two-year period does not provide enough certainty for businesses to provide a new benefit to employees. Providers of private disability income insurance, whose products may make a company eligible for the credit, advocated for permanence. Providers of private disability income insurance also discussed with staff the cost of private short term disability insurance, which averages $271 a year per employee.[4] Advocacy groups for seniors weighed in to support the credit on the grounds that it eases the financial burden on unpaid family caregivers. A think-tank underscored the lack of data on employer participation and effectiveness of the credit and the need for data collection if the credit is extended.

Some advocacy groups who opposed extension of the credit preferred the creation of a universal paid family and medical leave program. One such proposal would be funded through a two-tenths of 1 percent (two cents per $10 in wages) increase in employer and employee payroll taxes, at an average cost of $2 a week or $104 a year each.[5] These advocacy groups also contended that the tax credit puts too many upfront costs on small businesses. Other advocacy groups in opposition to the credit claimed the policy was unlikely to induce new employers to offer paid leave programs and was more likely to be a windfall to employers already providing paid leave. They further asserted that the narrowly-tailored credit rules would encourage a one-size-fits-all approach to paid family and medical leave and discourage innovative and flexible policies currently being pursued by some employers. Furthermore, they warned of the risk that the tax credit may grow into an expensive federal program over time.

[4] U.S. Workplace Disability Insurance Sales and In Force Survey, Fourth Quarter 2018, LIMRA.
[5] Cost is based on an individual earning $52,000 a year in income.

Stakeholders

The Taskforce received written and/or in-person feedback from the American Benefits Council, ACLI, Unum, Lincoln Financial Group, National Partnership for Women and Families, AEI, Americans for Tax Reform, Heritage Foundation, and Main Street Alliance.

Relevant legislation

S. 1628, The *Paid Leave Pilot Extension Act*, introduced by Senators Deb Fischer (R-NE) and Angus King (I-ME), would extend the credit for three years and make other modifications. 3 cosponsors (1 I, 1 R, 1 D).

Medical expense deduction - 7.5% AGI floor

Summary of Provision

The medical expense deduction is an itemized deduction available to individual taxpayers to the extent that unreimbursed medical expenses exceed 7.5% of a taxpayer's adjusted gross income. The deduction is designed to offset the cost of medical care for those with a high level of medical expenses relative to their income. After the passage of the 2017 tax reform legislation, which also altered the standard deduction and personal exemption amounts, the Joint Committee on Taxation projects the number of taxpayers claiming the medical expense deduction will decline from 11.8 million in 2017 to 5 million in 2018.[6] The *Patient Protection and Affordable Care Act of 2010* raised the adjusted gross income threshold for the deduction from 7.5% to 10% for all taxpayers except for those ages 65 or older. The 2017 tax legislation reduced the threshold back to 7.5% for all taxpayers for 2017 and 2018. The adjusted gross income threshold will increase to 10% for taxable years ending after December 31, 2018, resulting in a less generous deduction, without legislative action.

Stakeholder Input

The Taskforce received three comments regarding the medical expense deduction adjusted gross income threshold. Stakeholders in support of the lower threshold included seniors' advocacy groups and a taxpayer advocacy group. The taxpayer advocacy group supported the lower threshold on the grounds that the lower threshold will expand access to the deduction to more taxpayers. Seniors' advocacy groups asserted that the deduction provides financial protection for taxpayers with high medical costs, which may be the result of a serious medical condition, an unexpected hospital visit, or simply routinely high out of pocket expenses. A study conducted by AARP and the Institute on Taxation and Economic Policy found that taxpayers claiming the medical expense deduction are largely middle class, with 70 percent of taxpayers claiming the deduction reporting income between $23,100 and $113,000.[7] The study also found that the lower

[6] JCT estimates are based on tax year 2015 data extrapolated to 2017 and 2018 levels. Values may change when data for tax years 2017 and 2018 are available.
[7] https://www.aarp.org/ppi/info-2019/defraying-high-out-of-pocket-health-care-costs.html

threshold for the deduction compared to the higher threshold allows 792,100 more individuals to take advantage of the deduction, and increases the average deduction by $380.[8]

No stakeholders submitted comments supporting the continuation of the higher adjusted gross income threshold.

Stakeholders

The Taskforce received written and/or in-person feedback from AARP, Americans for Tax Reform, and the Alzheimer's Association.

Relevant legislation

S. 110, The *Medical Expense Savings Act*, introduced by Senator Collins (R-ME) and Senator Cantwell (D-WA), would make permanent the 7.5% adjusted gross income threshold for medical expenses.
3 cosponsors (2 D, 1 R).

Black Lung Disability Trust Fund excise tax rate

Summary of Provision

The Black Lung Disability Trust Fund, created by the Black Lung Benefits Revenue Act of 1977, imposes an excise tax on sales of coal produced and sold domestically to fund health and disability benefits paid to coal miners affected by coal workers' pneumoconiosis (CWP, commonly referred to as black lung disease) and other lung diseases linked to coal production. As black lung is a preventable disease, the black lung disability trust fund holds operators accountable for funding benefits provided to workers who develop black lung. The excise tax rates established at the tax's inception in 1977 were $0.50 per ton of underground-mined coal or $0.25 per ton of surface-mined coal, not to exceed two percent of the sales price. The rates were not adjusted for inflation. Higher rates of $1.10 per ton of underground-mined coal or $0.55 per ton of surface-mined coal, not to exceed 4.4 percent of the sales price, were established in 1986 and remained in effect until December 2018 as a result of two temporary extensions. For sales after December 31, 2018, the rates reverted back to the lower rates originally established. Since 1968, black lung disease has been the underlying or contributing cause of death of more than 78,000 miners.[9]

Stakeholder Input

The Taskforce received three comments regarding the Black Lung Disability Trust Fund excise tax rate. Stakeholders in support of extending the higher tax rates included a mine worker union and coal miner advocacy organizations. These groups stated that the growing incidence of black lung disease necessitates preserving higher rates to protect the solvency of the fund, and

[8] Ibid.
[9] https://wwwn.cdc.gov/eworld/Grouping/Coal_Workers_Pneumoconiosis/93

recommended at least a 10-year extension of the higher rates. Since 2000, rates of black lung disease have increased significantly for both underground and surface coal miners, as has the prevalence of the most severe form of the disease known as progressive massive fibrosis.[10] According to the Congressional Research Service, allowing the contribution rate to drop would cause the Black Lung Benefits Program debt to increase significantly.[11] The coal miner advocates claimed that money from the trust fund provides small but critical benefits for coal miners and widows to cover basic necessities.

Stakeholders in support of the lower Black Lung Disability Trust Fund tax rates included mining companies and their trade coalitions. These groups believe reinstating pre-2019 tax rates would adversely affect the coal industry as it continues to recover from a number of competitive, economic, and regulatory factors. Advocates of the lower tax rates also argue that while the fund has operated with revenues in excess of benefits paid, it has been hampered by debt to cover legacy black lung claims and increasing administrative and overhead costs. They cited changes made in 2010 as increasing eligibility and placing further financial liability on the trust fund. Furthermore, they recommend that the authorizing committees review the operation and needs of the trust fund and potentially adopt necessary reforms.

Stakeholders

The Taskforce received written and/or in-person feedback from the National Mining Association, United Mine Workers of America, and a coalition of 32 faith and heath-based advocacy organizations representing coal miners in Kentucky, Virginia, West Virginia, Colorado, Pennsylvania, and Ohio.

Relevant legislation

S. 27, The *American Miners Act of 2019*, introduced by Senator Manchin (D-WV), would extend the excise tax rate in effect before December 31, 2018 for ten years, among other provisions. 13 cosponsors (12 D, 1 I).

H.R. 3876, 11 cosponsors (11 D).

Medical device excise tax

Summary of Provision

The *Patient Protection and Affordable Care Act of 2010* enacted a 2.3 percent excise tax on the sale of certain medical devices. The tax was in effect from January 1, 2013 to December 31, 2015. Congress has passed several moratoriums on collection of the tax, most recently suspending the tax through December 31, 2019. Barring legislative action, the tax will apply to sales of medical devices after December 31, 2019.

[10] https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2018.304517?journalCode=ajph; https://www.cdc.gov/niosh/updates/upd-07-20-18.html

[11] Based on CRS analysis of GAO study, according to the moderate simulation. https://crsreports.congress.gov/product/pdf/R/R45261; https://www.gao.gov/assets/700/692103.pdf

Stakeholder Input

The Taskforce received fifty-six comments regarding the medical device excise tax. Stakeholders in opposition to the medical device excise tax included medical device manufacturers, patient advocates, advocates for medical research, and certain health care provider groups. Medical device manufacturers pointed to the experience of 2013-2015 in highlighting negative effects of the tax, including manufacturers' diminished ability to invest in employment, research, and development. Specifically, U.S. Department of Commerce data shows 29,000 jobs were lost in the industry while the tax was in effect.[12] It is also estimated that there was a $34 million decrease in research and development in the medical device industry over this time frame.[13] Certain health care provider groups in opposition to the medical device excise tax note that, to the extent the tax is passed on to providers in the form of higher prices, it compromises the ability of providers, particularly those with low margins, to purchase the supplies necessary to administer high-quality health care. Patient groups weighed in to express their concerns about the tax having a negative impact on medical innovation and therefore patient outcomes and quality of life. Stakeholders in opposition to the medical device excise tax further argued that the tax penalizes companies that have yet to break even on their investments because it applies to a business's revenue, not profits. According to a survey of medical technology companies, 91% of pre-revenue companies report that the reinstatement of the medical device tax will make it more difficult for them to raise capital.[14] Stakeholders highlighted the importance of addressing the tax as soon as possible this year, citing survey results where 81% of respondents stated they would begin taking adverse steps to prepare for the tax if a moratorium was not passed by September 30, 2019.[15] Lastly, stakeholders advocated for full repeal of the tax over short-term suspensions, in order to allow for the certainty necessary to plan for long-term investments in research and development.

No stakeholders submitted comments supporting the continuation of the medical device excise tax.

Stakeholders

The Taskforce received written and/or in-person feedback from AdvaMed, Cognizance Biomarkers, LLC, RTM Vital Signs, LLC, Siemens Healthineers, The AIDS Institute, Georgia Bio, Florida Medical Manufacturers Constortium, Smith and Nephew, Life Sciences PA, Medical Imaging and Technology Alliance, America's Blood Centers, Council for Citizens Against Government Waste, Hitachi Healthcare America, Indiana Health Industry Forum, BioForward Wisconsin, Massachusetts Medical Device Industry Council, ALung Technologies, OraSure Technologies, Inc., GE Healthcare, Edwards Lifesciences, Zimmer Biomet, Medical Device Manufacturers Association, BioUtah, Cook Group, Colontown, California Life Sciences Association, FUJIFILM SonoSite, Inc., Life Science Washington, Abbott, American Association

[12] https://www.advamed.org/newsroom/press-releases/medtech-industry-lost-nearly-29k-jobs-while-device-tax-effect
[13] https://www.sciencedaily.com/releases/2018/06/180605120745.htm
[14] https://www.medicaldevices.org/page/ImpactReinstatement
[15] Ibid.

of Neurological Surgeons and Congress of Neurological Surgeons, FUJIFILM Medical Systems, GenOmind, Inc., 3M, Vensana Capital, Americans for Tax Reform, Bio Ohio, Organized Dentistry Coalition, United Spinal Association, Boston Scientific, Lungpacer Medical, Inc., Research!America, U.S. Chamber of Commerce, BD, Biocom, Colorado BioScience Association, HealthCare Institute of New Jersey, Teleflex, Medical Alley Association, Michigan Biosciences Industry Association, National Association of Manufacturers, North Carolina Biosciences Organization, Intact Vascular, Inc., Virginia Bio, Tyber Medical LLC, and the Medical Device Competitiveness Coalition.

Relevant legislation

S. 692, the *Protect Medical Innovation Act of 2019*, introduced by Taskforce co-lead Pat Toomey and Senator Amy Klobuchar (D-MN), would permanently repeal the medical device excise tax.
34 cosponsors (24 R, 10 D), including Taskforce co-lead Bob Casey.

H.R. 2207, 245 cosponsors (186 R, 58 D, 1 I).

Health insurance tax

Summary of Provision

Created by the *Patient Protection and Affordable Care Act of 2010,* the health insurance tax (HIT) is a fee on certain health insurers assessed based on market share. CBO estimated that insurers may pass this tax onto their enrollees which can result in higher premiums.[16] Congress has passed moratoriums to suspend collection of the tax for calendar years 2017 and 2019. The tax will apply for calendar year 2020 without legislative action. The tax is scheduled to go into effect at a higher level - $15.5 billion in 2020 - due to yearly increases and indexation to the rate of premium growth built into the statute.[17]

Stakeholder Input

The Taskforce received fourteen comments regarding the health insurance tax. Senators Cory Gardner (R-CO) and Jeanne Shaheen (D-NH) advocated for congressional action to suspend the tax as soon as possible in order to prevent the cost from being passed on to consumers in the form of higher premiums. Other stakeholders supporting the repeal or suspension of the HIT included health insurers, large and small employers, employer coalitions, and a taxpayer advocacy group. Stakeholders asserted that the health insurance tax is passed on to consumers and therefore passing a suspension is a way to lower health care costs. Stakeholders cited a study estimating the impact of the health insurance tax on 2020 annual premium costs.[18] Opponents of the tax claimed that the 6 percent reduction in Medicare Advantage premiums in 2019 was partly due to the moratorium on the tax. Opponents also argued that the tax has a cost to the

[16] http://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums.pdf
[17] https://www.irs.gov/pub/irs-drop/n-19-50.pdf
[18] https://health.oliverwyman.com/content/dam/oliver-wyman/blog/hls/featured-images/August18/Insurer-Fees-Report-2018.pdf

government through increased Medicaid managed care premiums – a 2014 study estimated the cost at $38.4 billion over 10 years ($13.6 billion to state governments and $24.8 to the federal government).[19] A business advocacy group discussed the disparate impact on businesses that insure through the group market versus those that are able to self-insure, and are therefore exempt from the HIT. Stakeholders stated that the non-deductibility of the tax makes it more punitive because for every dollar assessed and paid in taxes, more than a dollar in additional premiums must be collected. Lastly, some commenters noted that a suspension of the tax for 2020 may lead to a windfall for insurers, because rates for 2020 that take into account the cost of the tax will likely have been finalized before any moratorium or repeal is enacted.

No stakeholders submitted comments supporting the continuation of the health insurance tax.

Stakeholders

The Taskforce received written and/or in-person feedback from Medicaid Health Plans America, Better Medicare Alliance, Anthem, Blue Cross Blue Shield Association, AHIP, STOP the HIT Coalition, Humana, CVS Health, Americans for Tax Reform, United Health Group, American Farm Bureau Federation, Triple-S, the U.S. Chamber of Commerce, the National Association of Manufacturers, and NFIB.

Relevant legislation

S. 172, The *Health Insurance Tax Relief Act*, introduced by Senators Gardner and Shaheen, would suspend the collection of the health insurance tax through the end of 2021.
28 cosponsors (23 R, 5 D).

H.R. 1398, 127 cosponsors (107 R, 20 D)

S. 80, The *Jobs and Premium Protection Act*, introduced by Senator Barrasso (R-WY) and Kyrsten Sinema (D-AZ), would permanently repeal the health insurance tax.
6 cosponsors (5 R, 1 D)

H.R. 2447, 6 cosponsors (3 R, 3 D)

[19] https://www.medicaidplans.org/_docs/MillimanReport_January_2014_Update.pdf

Appendix of Submissions

Provision	Stakeholder	Location
Health Coverage Tax Credit	ALF-CIO	National
Health Coverage Tax Credit	Individuals	Multiple
Paid Family and Medical Leave Tax Credit	American Benefits Council	National
Paid Family and Medical Leave Tax Credit	Coalition of Franchisee Associations	National
Paid Family and Medical Leave Tax Credit	ACLI	National
Paid Family and Medical Leave Tax Credit	National Partnership for Women and Families	National
Paid Family and Medical Leave Tax Credit	AARP	National
Paid Family and Medical Leave Tax Credit	Alzheimer's Impact Movement	National
Paid Family and Medical Leave Tax Credit	AEI	National
Paid Family and Medical Leave Tax Credit	Americans for Tax Reform	National
Paid Family and Medical Leave Tax Credit	Heritage Foundation	Washington, D.C.
Paid Family and Medical Leave Tax Credit	Dunkin Donuts Independent Franchise Owners (DDIFO)	National
Paid Family and Medical Leave Tax Credit	Main Street Alliance	National
Paid Family and Medical Leave Tax Credit	Senator Fischer and Senator King	Nebraska and Maine
Medical Expense Deduction	AARP and coalition	National
Medical Expense Deduction	Americans for Tax Reform	National
Black Lung Disability Trust Fund Excise Tax	National Mining Association	National
Black Lung Disability Trust Fund Excise Tax	United Mine Workers of America	National
Black Lung Disability Trust Fund Excise Tax	Appalachian Citizens' Law Center and Coalition	National
Medical Device Excise Tax	AdvaMed	National
Medical Device Excise Tax	Cognizance Biomarkers, LLC	Lower Gwynedd, PA
Medical Device Excise Tax	RTM Vital Signs, LLC	Fort Washington, PA
Medical Device Excise Tax	Siemens Healthineers	Malvern, PA
Medical Device Excise Tax	The AIDS Institute	National
Medical Device Excise Tax	Georgia Bio	Georgia
Medical Device Excise Tax	Florida Medical Manufacturers Consortium	Florida

Medical Device Excise Tax	Smith & Nephew	Pittsburgh, PA
Medical Device Excise Tax	Alliance for Aging Research	National
Medical Device Excise Tax	Life Sciences PA	Pennsylvania
Medical Device Excise Tax	Medical Imaging and Technology Alliance	National
Medical Device Excise Tax	America's Blood Centers	National
Medical Device Excise Tax	Council for Citizens Against Government Waste	National
Medical Device Excise Tax	Hitachi Healthcare America (HHA)	Twinsburg, OH
Medical Device Excise Tax	Indiana Health Industry Forum	Indiana
Medical Device Excise Tax	BioFoward Wisconsin	Wisconsin
Medical Device Excise Tax	Massachusetts Medical Device Industry Council	Massachusetts
Medical Device Excise Tax	ALung Technologies	Pittsburgh, PA
Medical Device Excise Tax	OraSure Technologies, Inc.	Bethlehem, PA
Medical Device Excise Tax	GE Healthcare	Wauwatosa, WI
Medical Device Excise Tax	Edwards Lifesciences	Irvine, CA
Medical Device Excise Tax	Zimmer Biomet	Warsaw, IN
Medical Device Excise Tax	Medical Device Manufacturers Association	National
Medical Device Excise Tax	BioUtah	Utah
Medical Device Excise Tax	Cook Group	Bloomington, IN
Medical Device Excise Tax	Colontown	National
Medical Device Excise Tax	California Life Sciences Association	California
Medical Device Excise Tax	FUJIFILM SonoSite, Inc.	Bothell, WA
Medical Device Excise Tax	Life Science Washington	Washington
Medical Device Excise Tax	Abbott	Chicago, IL
Medical Device Excise Tax	American Association of Neurological Surgeons and Congress of Neurological Surgeons	National
Medical Device Excise Tax	FUJIFILM Medical Systems U.S.A., Inc.	Lexington, MA
Medical Device Excise Tax	GenOmind Inc.	King of Prussia, PA
Medical Device Excise Tax	3M	St. Paul, MN
Medical Device Excise Tax	Vensana Capital	Fairfax, VA
Medical Device Excise Tax	Americans for Tax Reform	National
Medical Device Excise Tax	Bio Ohio	Ohio
Medical Device Excise Tax	Organized Dentistry Coalition	National
Medical Device Excise Tax	United Spinal Association	National
Medical Device Excise Tax	Boston Scientific	Marlborough, MA

Medical Device Excise Tax	Lungpacer Medical, Inc	Exton, PA
Medical Device Excise Tax	Research!America	National
Medical Device Excise Tax	U.S. Chamber of Commerce	National
Medical Device Excise Tax	BD	Franklin Lakes, NJ
Medical Device Excise Tax	Biocom	San Diego, CA
Medical Device Excise Tax	Colorado BioScience Association	Colorado
Medical Device Excise Tax	HealthCare Institute of New Jersey	New Jersey
Medical Device Excise Tax	Teleflex	Wayne, PA
Medical Device Excise Tax	Medical Alley Association	Minnesota
Medical Device Excise Tax	Michigan Biosciences Industry Association	Michigan
Medical Device Excise Tax	National Association of Manufacturers	National
Medical Device Excise Tax	North Carolina Biosciences Organization	North Carolina
Medical Device Excise Tax	Intact Vascular, Inc.	Wayne, PA
Medical Device Excise Tax	Virginia Bio	Virginia
Medical Device Excise Tax	Tyber Medical LLC	Bethlehem, PA
Medical Device Excise Tax	Medical Device Competitiveness Coalition	National
Health Insurance Tax	Medicaid Health Plans America	National
Health Insurance Tax	Better Medicare Alliance	National
Health Insurance Tax	Better Medicare Alliance – PA Coalition	Pennsylvania
Health Insurance Tax	Anthem	Indiana, IN
Health Insurance Tax	Blue Cross Blue Shield Association	National
Health Insurance Tax	AHIP	National
Health Insurance Tax	STOP the HIT Coalition	National
Health Insurance Tax	Humana	Louisville, KY
Health Insurance Tax	CVS Health	Woonsocket, RI
Health Insurance Tax	Americans for Tax Reform	National
Health Insurance Tax	United Health Group	Minnetonka, MN
Health Insurance Tax	American Farm Bureau Federation	National
Health Insurance Tax	Senator Gardner and Senator Shaheen	Colorado and New Hampshire
Health Insurance Tax	Triple-S	San Juan, Puerto Rico
Health Insurance Tax	U.S. Chamber of Commerce	National
Health Insurance Tax	National Association of Manufacturers	National

ALLIANCE TO FIGHT THE 40

Stop the 40% tax on health benefits

Don't Tax My Health Care

Save Employer Sponsored Health Benefits

May 30, 2019

The Honorable Charles Grassley
Chairman
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

cc: Senators Patrick Toomey (R-PA) and Robert Casey, Jr. (D-PA), Co-Leaders, Health Taskforce, Health_Tax_Taskforce@finance.senate.gov

Dear Chairman Grassley and Ranking Member Wyden,

As you work to examine temporary tax provisions through the Finance Committee's bipartisan taskforces, we hope you will expressly endorse repeal of the Affordable Care Act's (ACA) 40 percent "Cadillac Tax" on employer-provided health care. Originally scheduled to take effect in 2018, Congress has temporarily on a bipartisan basis extended the effective date due to its negative implications for working Americans. Although the tax will not take effect until 2022, employers are making changes to avoid the tax today. Full repeal is critical to providing long-term sustainability of our nation's health care system and is the correct policy conclusion and outcome for this misguided tax.

The Alliance to Fight the 40 ("the Alliance") is a broad-based coalition comprised of businesses, patient advocates, private sector and public-sector employer organizations, consumer groups, and other stakeholders that support employer-provided health coverage. This coverage is the backbone of our health insurance system and protects over 181 million[1] Americans across the United States. The Alliance appreciates Congress' efforts to delay the 40 percent tax as part of legislation enacted in 2015 and 2018. It is vitally important, however, that Congress fully *repeal* the 40 percent tax on employee health benefits to ensure that employer-provided health coverage remains an affordable option for working Americans and their families.

The "Cadillac Tax" is a 40 percent tax on health coverage above set thresholds that will take effect in 2022.[2] These costs include not only the employer and employee share of premiums, but also many other costs borne by employers (e.g. on-site clinics, preventive services such as cancer screening and immunizations, etc.). Working families are already stretched too thin and cannot afford higher health care costs. An election night poll on key issues in the 2018 midterm election showed that 81 percent of voters oppose taxes on employer-provided health coverage. Despite this overwhelming sentiment, the 40 percent "Cadillac Tax" is set to tax these benefits for the first time.

[1] U.S. Census: https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf Table 1

[2] The effective date of the "Cadillac Tax" was delayed from 2020 to 2022 in the January 2018 HEALTHY KIDS Act (H.R. 195) to fund the government to February 8, 2018.

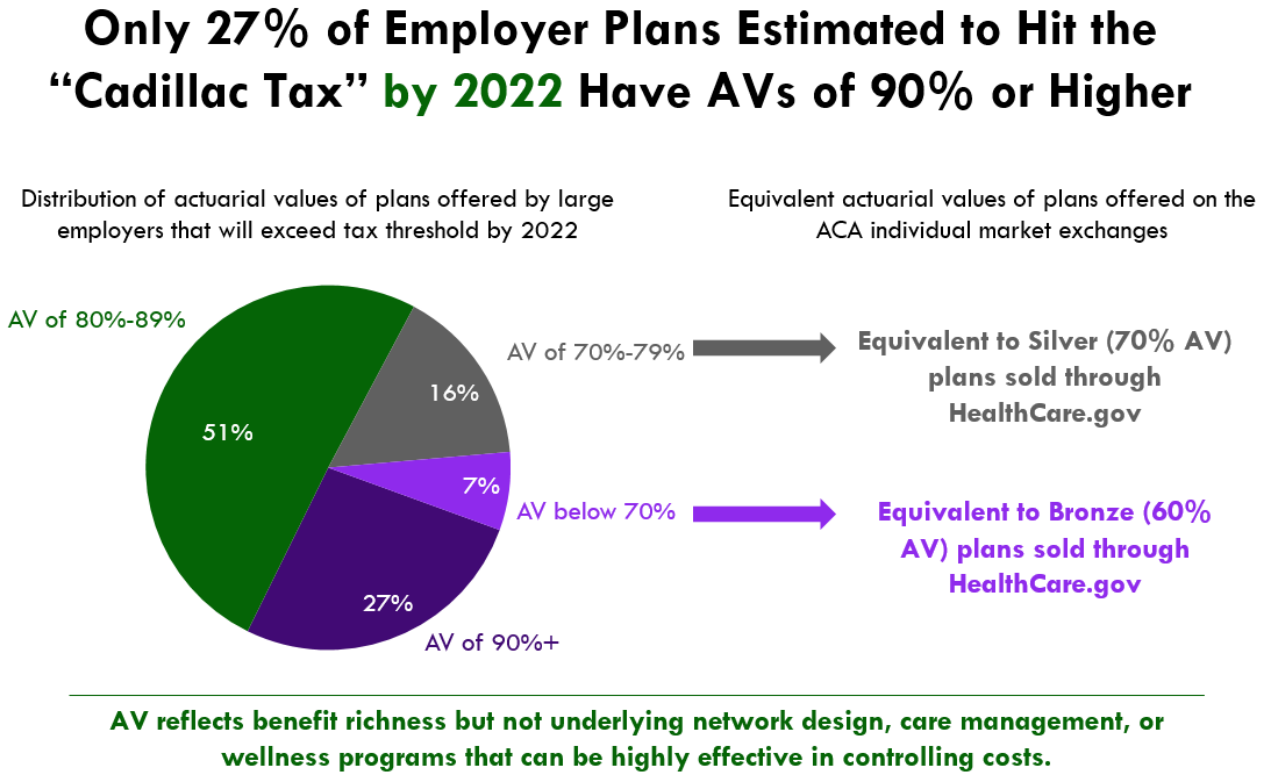
Repealing the 40 percent "Cadillac Tax" on health benefits is an important step in lowering health care costs and would benefit all patients and families that rely on employer-provided health benefits – the primary source of affordable quality coverage for working Americans.

DISCUSSION

Repeal the 40 percent "Cadillac Tax" on health benefits to protect access, choice, and affordability

Impact Far Beyond 'High-Priced' Plans. The ACA's 40 percent tax on employer-provided coverage is disrupting the health care marketplace by shifting ever increasing costs to workers. Contrary to the notion that only "gold-plated," high-value plans would be affected, the tax will eventually impact virtually *all* employer plans of both small and larger employers. The first plans to be hit will not be "Cadillac" plans that have the most extensive benefits – they will be plans that are expensive because they cover older Americans, retirees, women, families and individuals with chronic health conditions, those who have suffered catastrophic health events, and those living in higher-cost geographic areas. The tax will affect families and retirees from all walks of life and in many professions, including low-wage and part-time workers, public servants who protect our safety like firefighters and police officers, and workers in diverse professions and economic sectors including retail, education, health care, hospitality, and the clergy.

As illustrated by the below chart, it is the population covered by a plan – not the relative richness of the benefits – that determines whether a plan hits the tax. Twenty-three percent of the plans that trigger the tax in the first two years will have actuarial values in the lower (i.e. below 79 percent) allowable range. The minimum value plan prescribed under the ACA has a 60 percent actuarial value.



Note: The analysis was conducted before the tax's delay to 2022 and is based on 2014 medical plan premiums for the employer's highest-cost or only health plan, trended forward to 6%.
Source: Mercer's National Survey of Employer-Sponsored Health Plans.

Greater Cost-Sharing. The "Cadillac Tax" is already harming the most stable source of health coverage for Americans. Earlier studies by the American Health Policy Institute[3] and Aon Hewitt[4] indicate significant numbers of employers are already modifying their plan designs by increasing deductibles, co-pays and other cost-sharing features, to avoid paying the 40 percent tax. Although they are reluctant to do so, requiring employees to bear a larger share of the cost is the primary lever employers are compelled to use to decrease a plan's value. Higher cost-sharing curtails the ability of some lower and middle-class individuals to access their insurance. As deductibles rise, and approach $5,000 or more, many middle-income families who *have* insurance will not be able to access the medical system due to large out-of-pocket costs. According to a 2018 report, just 39 percent of Americans have enough money in savings to cover an unexpected $1,000 bill.[5] In the last decade, deductibles for individuals have increased by 212 percent.[6] The workers of those employers that contemplate paying the tax can expect their already large cost-sharing to rise even higher.

Stifling Private Sector Innovation. The punitive structure of the "Cadillac Tax" results in taxing health plan features that are designed to promote better health and reduce costs, such as employee assistance plans which help with drug addiction treatment, on-site health clinics, wellness initiatives, flexible spending accounts, health reimbursement arrangements, and employer and employee pre-tax contributions to health savings accounts – which are all counted toward the thresholds that trigger the tax. Even the cost of preventive benefits such as cancer screenings and immunizations is included, despite the fact that the ACA requires such benefits to be provided with no employee cost-sharing. Providing and administering health care coverage for employees is a significant expense for employers. Implementing the convoluted "Cadillac Tax" will only add complexity, cost and administrative burden for employers and employees— it will do nothing to address the actual cost of health care services.

Penalizing Employers for Factors Beyond Their Control. The 40 percent tax also taxes employers for factors they do not control. Employers with higher numbers of workers who have chronic diseases or larger families are disproportionately targeted by the tax, as are employers in specific industries, such as manufacturing or law enforcement. A study by the Economic Policy Institute found that because the tax is focused on high costs, not high levels of coverage, companies that tend to pay higher premiums – such as small businesses and employers with a high proportion of sick workers – could wind up paying the tax even though their benefits are not particularly generous.[7]

Geographic Disparities. Notably, employers with workers who live in higher-cost areas would pay more of the 40 percent tax for the same level of health coverage than people in lower cost areas. A 2014 report by the benefits consulting firm Milliman found that geography could potentially account for a 69.3 percent variation in premiums. For example, a plan that would cost $9,189 in one area would cost $15,556 elsewhere.[8] The report also demonstrated that the age and gender adjustments permitted under the law fail to compensate for the impact those factors have on premiums when combined with a high-cost geographic area and/or lower provider discounts.

Additionally, because the tax thresholds are pegged to the chained consumer price index, which is lower than health care inflation, every year an increasing number of health plans will be subject to the tax. In fact, 2017

[3] American Health Policy Institute, "ACA Excise Tax: Cutting Family Budgets, Not Health Care Budgets," October 2015, http://www.americanhealthpolicy.org/Content/documents/resources/AHPI_Excise_Tax_October_2015.pdf
[4] Aon Hewitt, "New Aon Hewitt Survey Shows Majority of Companies Taking Immediate Steps to Minimize Exposure to Excise Tax," October 16, 2014, http://aon.mediaroom.com/2014-10-16-New-Aon-Hewitt-SurveyShows-Majority-of-Companies-Taking-Immediate-Steps-to-Minimize-Exposure-to-Excise-Tax.
[5] Bankrate, "Most Americans don't have enough savings to cover a $1k emergency," January 18, 2018, https://www.bankrate.com/banking/savings/financial-security-0118/
[6] Kaiser Family Foundation, 2018 Employer Health Benefits Survey.
[7] Economic Policy Institute, "Increased Health Care Cost Sharing Works as Intended. It burdens patients who need care the most," May 8, 2013, http://www.epi.org/files/2013/increased-health-care-cost-sharing-works.pdf
[8] Milliman (study prepared for the National Education Association), "What does the ACA excise tax on high-cost plans actually tax?," December 9, 2014, http://www.nea.org/assets/docs/Milliman--What_Does_the_Excise_Tax_Actually_Tax.pdf

Mercer data found that 52% of employers would trigger the tax within the first five years of implementation, based solely on premium costs. This conservative estimate does not include other employer offerings that increase the likelihood of hitting the tax, such as employee assistance plans, on-site health clinics, and pre-tax contributions to health savings and flexible spending accounts.[9]

Measures to Reduce Health Care Costs

Instead of trying to raise revenue from working families through a blunt instrument like the 40 percent tax on employer coverage, Congress should focus on strategies that reduce the true cost of health care. Long before the ACA was enacted, employers were driving innovative delivery system reforms, experimenting with new payment structures, consumer education tools and innovative payment reforms like bundled payments, reference pricing, and value-based purchasing. Rather than imposing a new tax on top of already costly coverage, other efforts have more potential to drive down costs, such as: systematically measuring and reporting quality; reducing health care fraud and abuse; simplifying administrative burdens on providers and insurers; adopting interoperable health information technology; and programs that improve population health through a focus on at-risk populations and those with high needs and high costs. Additionally, reforms that improve meaningful price transparency and enhance consumer tools would be welcomed by patients and their families.

Proposals to tax employee health premiums suffer many of the same defects as the "Cadillac Tax"

The Alliance believes it is important to consider the lessons learned from the troubled "Cadillac Tax" so future policy recommendations will avoid similar pitfalls. Policy options that rely on limiting the current tax exclusion that employees receive for employer-provided health coverage may unintentionally cause similar market distortions and harm to working Americans and their families. To achieve the goals of affordable health care, any new policy proposals should not disrupt elements of the current employer system that work well.

We offer the following lessons learned from the impending "Cadillac Tax" that should inform future policy decisions:

- **Taxing health care hurts middle income families and retirees.** Joseph Antos, Ph.D., Wilson H. Taylor Scholar in Health Care and Retirement Policy for the American Enterprise Institute, in his testimony before the House Ways and Means Committee, pointed out that the "Cadillac tax has serious defects." Antos highlighted that "low-wage workers are disadvantaged by the Cadillac Tax" and that "the Cadillac Tax will eventually impact everyone with employer coverage." Proposals that directly tax employees could mistakenly recreate these problems.

- **Reducing incentives to participate in employer coverage could increase government spending.** Employers contribute on average about 70 percent of the cost of employer-provided health care coverage. This is a significant benefit to the 181 million individuals receiving employer-sponsored coverage and it reduces the need for costly government subsidies to help individuals afford health care services.[10] According to CMS expenditure and enrollment data, employers spend an average of $5,727 per beneficiary while Medicare and Medicaid spend $12,046 and $7,941 per beneficiary, respectively. In addition, the American Benefits Council found that for every dollar of tax expenditure attributed to the employer coverage tax exclusion, employers paid $4.45 to finance

[9] Employers with 500+ employees; Estimates based on: premium costs (medical plan only) from Mercer National Survey of Employer-Sponsored Health Plans 2017, trended at 4.7percent; excise tax threshold trended at CPI+1 in 2019 and CPI in future years; CPI estimated at 2.0percent, chained CPI at 1.75 percent. Threshold in 2018: $10,200 for employee-only coverage, $27,500 for other than self-only coverage.

[10] A 2014 study of health care expenditures by the American Health Policy Institute found that the federal government is spending nearly three times as much on health care for its beneficiaries as employers are spending to cover their employees.

health benefits.[11] Enabling the provision of health coverage through a tax incentive is far more efficient than providing the same benefits through government-funded public programs. Employers are a critical force in the market, negotiating with plans and providers to keep costs down and quality high. Employers also help employees navigate the complex health care system, improving their ability to act as informed consumers and providing them with tools to improve their health such as wellness plans and on-site medical clinics. Health and tax policy should encourage employer-sponsored coverage – not tax it.

- **Taxing health care coverage does not directly affect the unit cost of health care**. The "Cadillac Tax" does not address the true costs that comprise the health care delivery process. It also does nothing to improve the actual health of American workers. The majority of health care costs are primarily driven by a relatively small population with high cost health care needs. Taxing their health coverage does not reduce their utilization of health services – it just makes it more expensive. For example, in 2017, the Health Care Cost Institute found that price increases drove per-person spending growth among the employer-provided population. While average prices for services increased 17.1 percent from 2013-2017, average utilization declined 0.2 percent.[12]

- **Taxing health care coverage results in a loss of coverage options.** The Congressional Budget Office (CBO) estimated that one alternative, a cap on the exclusion of $7,800 for individual coverage and $18,500 for family coverage, would cause 3 million fewer people to have employment-based coverage than current law.[13]

- **Employer-sponsored insurance is efficient, effective, and affordable for working Americans and their families.** Employers have numerous incentives to manage costs and improve health outcomes by investing in innovative approaches such as on-site medical clinics, employee wellness programs and other initiatives. Ironically, such innovations would be penalized by the "Cadillac Tax," which treats such programs only as expenditures that help to trigger the tax. Elimination or capping the tax exclusion would have a similar impact if these innovations are subject to tax. Employers also provide valuable assistance to employees regarding their health coverage, including assistance selecting the best health plans, resolving claims questions, choosing higher quality providers and other assistance. Changes that undermine or weaken the employer-provided insurance market, like the "Cadillac Tax," could force more people to be uninsured, enroll in Medicaid or go to the individual market for insurance, a market that is not as efficient, not as innovative, and likely not as affordable as employer-provided coverage.

CONCLUSION

As the Committee considers long-term solutions for temporary tax policy and continues its focus on health care costs, we urge lawmakers to repeal the 40 percent tax on employer-provided health coverage. We hope policymakers will focus on reforms that preserve and protect employer-provided health care and achieve true savings and sustainability of the system—not artificial cost-shifting to workers and their families but promotion of high-quality, affordable care and elimination of fraud and waste in our health care system.

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[11] American Benefits Council, "American Benefits Legacy: The Unique Value of Employer Sponsorship," October 2018, https://www.americanbenefitscouncil.org/pub/1dd3e00e-c823-6e88-89f4-35e547e284fc

[12] Health Care Cost Institute, "2017 Health Care Cost and Utilization Report," February 2019, https://www.healthcostinstitute.org/research/annual-reports/entry/2017-health-care-cost-and-utilization-report

[13] CBO, "Options for Reducing the Deficit: 2019 to 2028," December 2018, page 235, https://www.cbo.gov/system/files?file=2018-12/54667-budgetoptions.pdf

Thank you for the opportunity to work with the Committee. We look forward to working with Congress to provide permanent relief from the "Cadillac Tax" and to support other health care reforms that strengthen our health care system.

Respectfully,

The Alliance to Fight the 40

For more information about the tax, the Alliance to Fight the 40, or this statement, please contact: info@fightthe40.com

June 6, 2019

Senator Susan Collins
U.S. Senate
413 Dirksen Senate Office Building
Washington, DC 20510

Senator Maria Cantwell
U.S. Senate
511 Hart Senate Office Building
Washington, DC 20510

Dear Senators Collins and Cantwell:

We, the undersigned organizations, write to thank you for introducing S.110, the Medical Expense Savings Act which would make permanent the 7.5 percent threshold for the medical expense deduction.

As you know, for the past 75 years, Americans with high health care costs have been able to deduct medical expenses from their taxes. For the approximately 4.4 million Americans[1] who annually take this deduction, it provides important tax relief which helps offset the costs of acute and chronic medical conditions for older Americans, children, pregnant women and other adults as well as the costs associated with long term care and assisted living. Medical expenses that qualify for this deduction can include amounts paid for prevention, diagnosis, treatment, equipment, qualified long-term care services costs and long term care insurance premiums. Families across the country with high health care costs face a constant stream of deductibles and high co-pays, and also pay out-of-pocket for various services and devices that enable the individual to live a productive life in the community. 70% of the taxpayers who claim this deduction have income between $23,100 and $113,000 per year[2].

Even with Medicare, beneficiaries spend a large portion of their income on out-of-pocket expenses. The average Medicare beneficiary spends about $5,680 out-of-pocket on medical care. Furthermore, older Americans often face high costs for long term services and support, which are generally not covered by Medicare, as well as hospitalizations and prescription drugs. Tax relief in this area can provide needed resources, especially important to middle income seniors with high medical costs.

We look forward to working with you to ensure that tax filers with high out-of-pocket health care costs can continue to claim the current medical expense deduction after this tax year. We thank you for your leadership on protecting this important tax deduction. If

[1] https://www.aarp.org/content/dam/aarp/ppi/2019/02/defraying-high-out-of-pocket-health-care-costs-the-medical-expense-tax-deduction.pdf
[2] Ibid.

you have any questions or need additional information you can reach out to Brendan Rose at 202-434-3922 or brose@aarp.org.

Sincerely,

AARP
ACCSES
Alliance for Aging Research
ALS Association
Alzheimer's Association
Alzheimer's Impact Movement
American Association on Health and Disability
American Cancer Society Cancer Action Network
American Health Care Association (AHCA)
American Heart Association
American Psychological Association
American Seniors Housing Association
Argentum
Autistic Self Advocacy Network
Bazelon Center for Mental Health Law
Children's Cause for Cancer Advocacy
Christopher & Dana Reeve Foundation
Colorectal Cancer Alliance
Disability Rights Education and Defense Fund (DREDF)
Disability Rights Legal Center
Family Voices
Fight Colorectal Cancer
FORCE: Facing Our Risk of Cancer Empowered
HealthyWomen
Justice in Aging
Lacuna Loft
Lakeshore Foundation
Leading Age
Lupus Foundation of America
Lutheran Services in America
Lymphoma Research Foundation
Medicare Rights Center
Muscular Dystrophy Association
National Academy of Elder Law Attorneys
National Adult Day Services Association
National Assocation of Councils on Developmental Disabilities
National Center for Assisted Living (NCAL)
National Coalition for Cancer Survivorship
National Council on Aging

National Organization for Rare Disorders (NORD)
National Patient Advocate Foundation
National Respite Coalition
Paralyzed Veterans of America
Pioneer Network
Susan G. Komen
The Cancer Support Community
The Huntington's Disease Society of America
The Jewish Federations of North America
The Leukemia & Lymphoma Society
The Michael J. Fox Foundation for Parkinson's Research
Triage Cancer
USAgainstAlzheimer's
Well Spouse Association
Zero Cancer

CC: US Senate Finance Committee Health Care Task Force

AdvaMed
Advanced Medical Technology Association

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Fax: 202 783 8750
www.AdvaMed.org

A. Scott Whitaker
President and CEO
Direct: 202 434 7200
swhitaker@advamed.org

June 10, 2019

Senator Pat Toomey
U.S. Senate
Washington, DC 20510

Senator Bob Casey, Jr.
U.S. Senate
Washington, DC 20510

Dear Senator Toomey and Senator Casey,

Thank you for the opportunity to submit comments and recommendations to the Task Force in response to the Finance Committee's efforts to develop long-term solutions to temporary tax policies. On behalf of the Advanced Medical Technology Association (AdvaMed), I appreciate your interest in hearing from stakeholders on such an important issue.

AdvaMed is the leading trade association representing medical technology manufacturers and suppliers that operate in the United States. AdvaMed's member companies produce the medical devices, diagnostic products, and digital health technologies that are transforming health care through earlier disease detection, less invasive procedures, and more effective treatments. Our members range from the largest to the smallest medical technology innovators and companies. Collectively, we are committed to ensuring patient access to life-saving and life-enhancing devices and other advanced medical technologies.

However, this commitment is threatened by a number of regulations and policies that have increased costs, lengthened timelines, and deterred companies from investing in the next generation of treatments and cures. Chief among these policies is the 2.3% excise tax on the sale of certain medical technology that was enacted as part of the Affordable Care Act (ACA). Since its enactment, the medical device tax has been a significant drag on medical innovation and resulted in the loss or deferred creation of jobs, reduced R&D, and slowed capital expansion. What is even more troubling is that this tax was imposed without any real policy justification. The medical device tax is not grounded in any health care policy. It is not connected to individual insurance coverage. It was designed purely as a means of raising revenue from the industry to offset the budgetary impact of the ACA.

Medical devices have revolutionized health care. To cite one example, medical technology has helped add more than five years to U.S. life expectancy since 1980. Advances in treatment mean patients experience less-invasive procedures, shorter hospitalizations, reduced recovery times, and lower overall costs. New technologies diagnose illnesses earlier, lowering the impact of care on a person's daily life. Breakthrough concepts reduce the overall cost of health care for patients and the system. All these gains are at risk if the medical device tax is reinstated.

The effects of the tax are felt across the industry, as every dollar of revenue (not income or profit) earned by a company is generally subject to the tax. For large, established companies, the device tax equals tens, if not hundreds, of millions of dollars that could be used to expand research and create jobs. For start-up firms, the effect of the tax is two-fold – it deters company growth, since the tax is imposed on the first dollar of revenue earned; and it restricts the ability of established medical technology companies to invest in or acquire start-up companies by limiting the amount of available funds.

Large bipartisan majorities in Congress agree that the medical device tax is bad policy. Thanks in no small part to your leadership and the efforts of the Committee on Finance, Congress has suspended the tax twice for a total of four years. Notably, by the end of this year, Congress will have suspended the tax for longer than it was in effect, with no measurable impact on coverage. Clearly, repeal of the device tax will not have a significant impact on the overall finances of the ACA, despite prior concerns.

Suspension of the tax has enabled medical device makers to reactivate important research and development projects that were canceled as well as make new hires that were delayed while the tax was in effect. Specific examples of investments companies made since the tax was first suspended include:

- Boston Scientific was able to double a long-running collaboration with the renowned Mayo Clinic, focusing on several projects including two new technologies that could help thousands of cardiovascular patients.
- Smith & Nephew accelerated investment in product development and manufacturing, including the creation of 100 positions for newly qualified graduate engineers across six U.S. facilities.
- Abiomed used savings to help double its U.S. manufacturing and to create a new state-of-the-art physician training and education center in Massachusetts. In addition to the multi-million-dollar manufacturing expansion, Abiomed used these resources to hire more than 150 new employees in the U.S. to support the growing field of heart recovery.

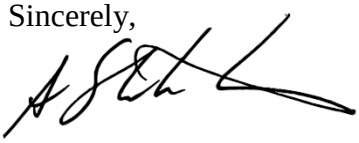
However, these advances are all short-term investments because of the uncertainty over whether they will soon have to pay the excise tax. Medical technology has improved efficiencies and produced savings to the system through minimally invasive procedures, more precise and accurate diagnostics, and devices that reduce hospitalizations or length of stay. These improvements mean better outcomes and higher-quality care for patients, which lowers cost. Taxing the development and manufacture of medical technology imposes an unnecessary penalty on these savings and erodes the value these technologies provide to the system in the long run.

The current suspension expires on December 31, 2019. Individual companies are already making important planning decisions for the next fiscal year, including how to allocate resources toward research and development as well as employment tied to research and development. As an excise tax, the device tax cannot be addressed retroactively in an effective manner. The longer Congress waits to act, the bigger the impact on the industry's ability to develop the next life-saving, life-enhancing technology.

We strongly encourage the Task Force to recommend full repeal of the medical device excise tax and urge the Committee to move promptly to consider legislation that includes repeal. We stand ready to work with you to advance any legislative vehicle that will address the medical device tax. Permanently repealing the device tax will provide medical technology innovators with the long-term certainty necessary to support future job growth and sustainable, cutting-edge R&D that will ultimately lead to the next generation of breakthroughs in patient care and treatment. With any other policy outcome, effective planning for a sustainable future becomes much more difficult.

Thank you again for this opportunity to share our thoughts on behalf of America's medical technology companies. We look forward to working with you and your staff on a solution that will allow our members to retain their position as world leaders in developing and manufacturing technology that will improve the lives of patients in the United States.

Sincerely,



Scott Whitaker

Dear Members of the Senate Finance Committee Health Tax Task Force:

I understand the Senate Committee on Finance is currently examining temporary tax policies in varying issue areas including health. As the CEO of Cognizance Biomarkers, LLC in Lower Gwynedd, PA, I urge you to ensure the permanent repeal of the Medical Device Tax is included in any of the proposals or recommendations that are produced by this comprehensive exercise. This is especially important as the current suspension of the Medical Device Tax will end December 31 of this year.

The damage this short-sighted policy caused when it was in place from 2013-2015 is well known, and if it goes into effect again it will undoubtedly stifle innovation and patient care. Though currently under a temporary suspension, if the tax is not repealed our company and many others like ours, will be diverting tens of millions of dollars to the IRS instead of investing in innovation and creating new high-tech manufacturing jobs.

We look forward to working with you to put a permanent end to a policy that only served to impede our common goals of growing our country's economy and improving patient care. Additionally, and if interested, we would be honored to host you at Cognizance Biomarkers, LLC to give you a first-hand look at the medical technology ecosystem this country enjoys, and the benefits our innovation, research and development provide to patients and their families.

Warm regards,
Todd

Todd Wallach
President & CEO
Cognizance Biomarkers, LLC
todd@cognizancebio.com
215-896-7001

Dear Members of the Senate Finance Committee Health Tax Task Force:

I understand the Senate Committee on Finance is currently examining temporary tax policies in varying issue areas including health. As the CEO of RTM Vital Signs, LLC in Fort Washington, Montgomery County, PA, I urge you to ensure the permanent repeal of the Medical Device Tax is included in any of the proposals or recommendations that are produced by this comprehensive exercise. This is especially important as the current suspension of the Medical Device Tax will end December 31 of this year.

The damage this short-sighted policy caused when it was in place from 2013-2015 is well known, and if it goes into effect again it will undoubtedly stifle innovation and patient care. Though currently under a temporary suspension, if the tax is not repealed our company and many others like ours, will be diverting tens of millions of dollars to the IRS instead of investing in innovation and creating new high-tech manufacturing jobs.

RTM is developing two medical devices - one for the timely detection of impending opioid overdose which can save countless lives and the other to continuously monitor blood pressure what can save lives of people with chronic hypertension. Both devices are particularly applicable to veterans. Over 1200 people a day die from these two health issues each day in the US and the costs are well over $1 BILLION a day!

We look forward to working with you to put a permanent end to a policy that only served to impede our common goals of growing our country's economy and improving patient care. We would be pleased to send you information on either or both of our devices. This issue is important to the health and welfare of our citizens as well as the control of spiraling health care costs. The US has always been at the forefront of innovation in health care - a tax on medical devices will stifle that innovation.
Sincerely,

Nance Katherine Dicciani
President and CEO
RTM Vital Signs, LLC

Mike Mahoney
Chairman and CEO

Boston Scientific

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Marlborough, MA 01752

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June 11, 2019

Senator Pat Toomey
U.S. Senate
Washington, DC 20510

Senator Bob Casey, Jr.
U.S. Senate
Washington, DC 20510

Senator Mike Enzi
U.S. Senate
Washington, DC 20510

Senator Mark Warner
U.S. Senate
Washington, DC 20510

Dear Senator Toomey, Senator Casey, Senator Enzi, and Senator Warner,

Millions of Americans struggle every year to manage complex and chronic diseases—and many rely on life-changing medical technologies, like the 13,000 devices and therapies made by Boston Scientific. From implantable devices that can prevent cardiac arrest or manage Parkinson's symptoms, to surgical instruments and diagnostics, medical technologies are critical to diagnosing and treating diseases and conditions that significantly impact patients' lives.

Every facet of the healthcare ecosystem already relies on some form of medical technology, helping people to live longer, healthier and more productive lives. At Boston Scientific, we continuously challenge ourselves to help doctors treat patients more effectively, and new life-changing technologies are on the horizon. Since the medical device tax's initial suspension in 2016, Boston Scientific has reinvested millions of dollars of tax relief into developing novel therapies that address unmet patient needs including collaborations with institutions like the Mayo Clinic, investments in innovative start-up companies, as well as our own R&D pipeline. I know that the impending reinstatement of the medical device tax, if allowed to happen, will curtail investment in the development of innovations, and lead to the creation of fewer next-generation treatments and cures for patients in need.

At this point, the debate on the substance of the device tax is settled. It is poor public policy. While in effect, the tax caused significant industry job loss, reductions in R&D investment, and hampered innovation for both small and large companies.

We have consistently called for a permanent repeal of the medical device tax and we ask that the Senate Finance Committee Task Force evaluating health care tax extenders support such a recommendation. Continued suspensions, though helpful given the alternative of the tax's reinstatement, do not provide the level of certainty required to make effective, long-term strategic investments in our technology pipeline. Only full repeal will allow us to continue to make investments like our Mayo Clinic collaboration, which will enable clinical advances for

Boston Scientific

years into the future. This is good for business and the healthcare system overall, and—most importantly—it's good for patients.

On behalf of Boston Scientific and the patients and physicians we serve, we strongly encourage the Task Force to provide permanent relief from the medical device tax in its tax extender policy recommendations. This will help ensure investments in new life-changing medical technologies, increase job creation and spur economic growth. We look forward to working with you to pass this important effort.

Sincerely,

Mike Mahoney
Chairman and Chief Executive Officer
Boston Scientific

CC Senator Chuck Grassley
Senator Ron Wyden

Dear Members of the Senate Finance Committee Health Tax Task Force:

I am the President & CEO of Lungpacer Medical Inc, in Exton, Pennsylvania and I am writing in regard to health related tax policies that are being examined by the Senate Committee, specifically the Medical Device Tax . As you know the suspension of the Medical Device Tax will end December 31, 2019, so it is imperative that we ensure this tax be permanently repealed in any of the proposals or recommendations that are produced by this examination.

Lungpacer Medical Inc. is a start-up company in the clinical phase, developing a novel therapeutic solution for preserving or restoring the integrity and strength of the diaphragm muscle in critically ill patients who require mechanical ventilation. Mechanically ventilated patients can struggle with regaining the ability to breathe independently following extended illness and our device can help these patients regain the ability to breathe independently faster. Our device is expected to **save many lives, improve surviving patient outcomes and greatly reduce hospital care costs**. It was given a breakthrough designation by the FDA because the Lungpacer device represents a technology that provides a clinically meaningful advantage over existing technology and the availability of the device may be in the best interest of patients because it addresses an unmet medical need.

This tax will have a significant impact on future innovation within Lungpacer. The damage this short-sighted policy caused when it was in place from 2013-2015 is well known, and if it goes into effect again it will undoubtedly stifle innovation and patient care across all of healthcare. If the tax is not repealed companies will be diverting tens of millions of dollars to the IRS instead of investing in innovation and creating new high-tech manufacturing jobs.

We would like to work with you to put a permanent end to a policy that only serves to impede our common goals of growing our country's economy, improving patient care and saving lives. Additionally, and if interested, we would be honored to host you at Lungpacer to give you a first-hand look at our device and talk to you about our successes, the benefits and our future plans for the technology.

Sincerely,

Doug Evans
President & CEO
Lungpacer Medical, Inc.
260 Sierra Drive, Suite 116
Exton, PA 19341
www.lungpacer.com

Dear Members of the Senate Finance Committee Health Tax Task Force:

I understand the Senate Committee on Finance is currently examining temporary tax policies in varying issue areas including health. As the CFO of Tyber Medical in Bethlehem, Pennsylvania, I urge you to ensure the permanent repeal of the Medical Device Tax is included in any of the proposals or recommendations that are produced by this comprehensive exercise. This is especially important as the current suspension of the Medical Device Tax will end December 31 of this year.

The damage this short-sighted policy caused when it was in place from 2013-2015 is well known, and if it goes into effect again it will undoubtedly stifle innovation and patient care. Though currently under a temporary suspension, if the tax is not repealed our company and many others like ours, will be diverting millions of dollars to the IRS instead of investing in innovation and creating new high-tech manufacturing jobs.

We look forward to working with you to put a permanent end to a policy that only served to impede our common goals of growing our country's economy and improving patient care. Additionally, and if interested, we would be honored to host you at Tyber Medical to give you a first-hand look at the medical technology ecosystem this country enjoys, and the benefits our innovation, research and development provide to patients and their families.

Sincerely,

Michael Emery
CFO

Tyber Medical LLC
83 S. Commerce Way, Suite 310
Bethlehem, PA 18017

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F: 866-889-9914

Web: www.tybermedical.com

Tyber Medical
Expand Your Brand

AMERICAN BENEFITS COUNCIL

June 12, 2019

The Honorable Charles Grassley
Chairman
U.S. Senate Committee on Finance
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
U.S. Senate Committee on Finance
Washington, DC 20510

Dear Chairman Grassley and Ranking Member Wyden,

As you work to examine temporary tax provisions through the Finance Committee's bipartisan taskforces, the American Benefits Council (the "Council') offers support for the Paid Family Leave Pilot Extension Act S. 1628. This legislation, introduced by Senator Deb Fischer and co-sponsored by Senators Angus King and Susan Collins, extends the Paid Family Leave (PFL) tax credit from December 31, 2019 until December 31, 2022. We hope you will consider extension of PFL tax credit as set forth in the legislation to help employers offer solutions for the health and family needs of their employees. The Council commends the efforts of Senators Fischer, King and Collins to address this important topic, and appreciates their consideration of changes to the legislation to better accommodate the needs of nationwide employers.

The Council is a Washington D.C.-based employee benefits public policy organization. The Council advocates for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial well-being of their workers, retirees and families. Council members include over 220 of the world's largest organizations serving employers of all sizes. Collectively, our members directly sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans.

Extension of the program with technical corrections designed to facilitate participation by nationwide businesses with employees in multiple jurisdictions is useful for employers and working families alike. Notably, S. 1628 would allow employers seeking the tax credit to take into account payments for family and medical leave that is paid by a state or local law or required by state or local law with respect to the 50% wage requirement for all covered employees, although not counted towards the tax credit itself.

1501 M Street NW Suite 600 Washington, DC 20005 202-289-6700 Facsimile 202-289-4582 www.americanbenefitscouncil.org

The Council's members are primarily very large companies with operations across the country – often in all 50 states and numerous localities. Large employers understand the value of sponsoring excellent paid leave programs that enable employees to address their own, and their family members' health needs, as well as to have personal, holiday or vacation time. These programs foster greater productivity and contribute to the success of the business.

As more states and political subdivisions enact paid leave laws, it has become increasingly difficult for large, multistate employers to consistently offer and administer paid leave. Many state and local mandates use completely different definitions of terms and have inconsistent recordkeeping requirements and thresholds that trigger coverage or accrual of benefits. As a result, employers have had to design their leave programs to meet administrative and other requirements, rather than meet employer and employee objectives.

The Council seeks legislative solutions to paid family and medical leave that recognize the challenge presented by the increasingly complex myriad of state paid leave laws. We support an approach to paid family and medical leave that provides a federal, uniform and voluntary paid leave option that will benefit employers and employees alike and allows flexibility for private plan solutions. Such an approach would enable companies to design uniform programs that benefit their employees and their families wherever they may live or work. Uniform, voluntary federal standards that foster private plan solutions would be both efficient and equitable. Multistate employers need the predictability and uniformity of a national paid leave solution, so they can maintain consistent policies for their entire workforce across different states and local jurisdictions. By having the option of a single, national standard for paid leave they can treat all their employees equally, rather than on a fragmented, jurisdiction-by-jurisdiction basis. Companies need programs that fit what have become increasingly mobile workforces. A voluntary national standard could make it easier to communicate available programs so that employees get full value and would limit complexity of administration for employers.

The Paid Family Leave Pilot Extension Act would extend tax credits that serve to incentivize employers, including multistate employers, to adopt paid family and medical leave programs that benefit working families. Clarity about extension of the program is important to its users and could spur even greater participation by employers. We urge Congress to prevent the expiration of these tax credits this year.

Thank you for the opportunity to inform your work examining temporary tax policies. We look forward to working with you on long-term solutions to address paid family and medical leave.

Sincerely,

Ilyse Schuman
Senior Vice President, Health Policy

cc: Senators Patrick Toomey (R-PA) and Robert Casey, Jr. (D-PA), co-leaders, Health Taskforce

Edwards

June 14, 2019

Senator Pat Toomey
U.S. Senate
Washington, DC 20510

Senator Bob Casey
U.S. Senate
Washington, DC 20510

Dear Senator Toomey and Senator Casey,

I am writing to the Senate Finance Committee Health Care Task Force regarding support for ending the Medical Device Excise Tax (MDET). Specifically, I want to express concern with the imminent reinstatement of the Device Tax at the end of this year.

As Chief Financial Officer of Edwards Lifesciences, we are proud to be the global leader in patient-focused medical innovations for structural heart disease, as well as critical care and surgical monitoring. We are driven by a passion to help patients and collaborate with the world's leading clinicians and researchers to address unmet healthcare needs while working to improve patient outcomes and enhance lives.

When the MDET was suspended in early 2018, Edwards was able to invest a significant portion of the tax savings to accelerate high priority growth initiatives, including research and development in clinical trials in important therapy and patient impact programs, such as our transcatheter aortic valve replacement (TAVR) program, disease awareness programs and infrastructure to support growth within the company. If the MDET is not fully repealed, Edwards will absorb a more than 40 million dollar impact, which will adversely impact jobs and hinder our ability to invest in innovations that save and improve lives.

For these reasons, I respectfully request that the Health Care Task Force formally support the Protect Medical Innovation Act of 2019 (S. 692). This bipartisan measure will provide a long-term solution by repealing this harmful tax.

Thank you for the opportunity to provide Edwards Lifesciences' perspective on the MDET and the impact on our employees, patients and our partners around the world.

Sincerely,

Scott Ullem
Corporate Vice President and Chief Financial Officer
Edwards Lifesciences

Edwards Lifesciences LLC
One Edwards Way · Irvine, CA USA · 92614
Phone: 949.250.2500 · Fax: 949.250.2525 · www.edwards.com

June 12, 2019

Senator Pat Toomey
U.S. Senate
Washington, DC 20510

Senator Bob Casey, Jr.
U.S. Senate
Washington, DC 20510

Dear Senator Toomey and Senator Casey,

Thank you for the opportunity to submit comments and recommendations to the Task Force in response to the Finance Committee's efforts to develop long-term solutions to temporary tax policies. On behalf of the medical device members of Florida Medical Manufacturers Consortium (FMMC), we appreciate your interest in hearing from stakeholders on such an important issue.

The Florida Medical Manufacturers Consortium (FMMC) is Florida's statewide association of medical technology manufacturers and allied firms. The FMMC exists to unite, promote and grow the Florida medical device industry, and to enhance the business success of its member companies. Florida is home to one of our nation's largest medical device economies – encompassing 683 device manufacturers employing nearly 21,000 Floridians, paying an average annual wage of more than $60,000. Florida ranks 2nd nationally in the number of FDA-registered medical device establishments. The vast majority of Florida medical device manufacturers (80%+) are small, entrepreneurial firms, employing fewer than 25 people. These are the companies driving Florida's job creation and innovation in patient care in the med-tech sector.

Medical device manufacturers in Florida are committed to bringing breakthrough innovations to patients, but that commitment is threatened by a number of regulations and policies that have increased costs, lengthened timelines, and deterred companies from investing in the next generation of treatments and cures.

Chief among these policies is the 2.3% excise tax on the sale of certain medical technology that was enacted as part of the Affordable Care Act (ACA). Since its enactment, the medical device tax has been a significant drag on medical innovation and resulted in the loss or deferred creation of jobs, reduced R&D, and slowed capital expansion.

The medical device tax is, quite simply, a jobs and innovation issue. In effect for three years (2012-2015), the medical device tax had a significant negative impact on medical innovation and resulted in the loss or deferred creation of jobs, reduced R&D, and slowed capital expansion. According to U.S. Department of Commerce data, the U.S. medical technology industry saw its jobs ranks fall by nearly 29,000 while the medical device excise tax was in effect. The medical device tax is indeed a job killer that has eroded our international dominance and competitiveness in the medical technology sector.

We are of course very grateful for Congress' decisions to suspend the tax beginning in 2016, but this suspension is set to expire on December 31, 2019. Placing this tax on "pause" has freed up resources that have been re-invested in R&D, innovation and growth, new hiring, and capital formation and expansion, providing more opportunities to help address the needs of patients. We cannot allow this bad tax to be reinstated in 2020.

Incredibly, the medical device tax is based on sales, not profit, and has done the most harm to small-to-midsize medical device companies – the lifeblood of Florida's medical device industry. As devised, the tax extracts 2.3% on every sale of a medical device, and cares not if the company is large or small – or is making any profit at all. Removing precious resources

from the top line of these innovative manufacturers devastates their ability to develop new life-saving and life-improving devices and create quality jobs for Floridians.

The medical device tax is not grounded in any health care policy. It is not connected to individual insurance coverage. It was purely a revenue raiser that is no longer needed. The tax has been suspended for more years than it has been in effect and insurance coverage, access to insurance, or affordability of health care has not been impacted.

The repeal of the medical device tax is an overwhelming bi-partisan issue. Last Congress, legislation (H.R. 184)to repeal the medical device tax boasted 279 co-sponsors, including 46 Democrats. More impressively, last summer, this legislation passed the full House by a vote of 283-132, with 57 Democrats joining the prevailing side.

The medical device tax must be addressed immediately. Individual companies are already making important planning decisions for next year and beyond. Repealing the device tax will provide medical technology innovators with the long-term certainty necessary to support future job growth and sustainable, cutting-edge R&D that will ultimately lead to the next generation of breakthroughs in patient care and treatment. But none of this is possible if innovation is stifled by the re-instatement of the medical device tax.

We strongly encourage the Task Force to recommend full repeal of the medical device excise tax and urge the Committee to move promptly to consider legislation that includes repeal. We stand ready to work with you to advance any legislative vehicle that will address the medical device tax. Permanently repealing the device tax will provide medical technology innovators with the long-term certainty necessary to support future job growth and sustainable, cutting-edge R&D that will ultimately lead to the next generation of breakthroughs in patient care and treatment. With any other policy outcome, effective planning for a sustainable future becomes much more difficult.

Thank you again for this opportunity to share our thoughts on behalf of our medical technology companies. We look forward to working with you and your staff on a solution that will allow our members to retain their position as world leaders in developing and manufacturing technology that will improve the lives of patients in the United States.

Sincerely,

Chairman, FMMC
President & CEO
NDH Medical, Inc.

John B. Ray
Executive Director, FMMC

GE Healthcare

9900 Innovation Dr.
Wauwatosa, WI 53226
USA

June 14, 2019

The Honorable Pat Toomey
U.S. Senate
248 Russell Senate Office Building
Washington, DC 20510

The Honorable Bob Casey, Jr.
U.S. Senate
393 Russell Senate Office Building
Washington, DC 20510

Dear Senator Toomey and Senator Casey,

On behalf of over 19,000 GE Healthcare employees in the United States, including nearly 500 in Pennsylvania, thank you for the opportunity to submit comments to the Task Force in response to the Finance Committee's efforts to find long-term solutions for temporary tax policies.

At GE Healthcare, we strive to bring advancements in diagnostics, therapy development, and advanced analytics to our health care provider partners in the U.S. and around the world. As a company we are continually innovating in the areas of cancer, dementia, heart disease, and beyond to improve lives in moments that matter.

Since the medical device tax was first suspended in 2016, GE Healthcare has increased research and development spending in the areas of artificial intelligence, precision health, patient monitoring, and clinical care pathways, while bringing more products to market than any other time in our recent history. We've also entered into many innovative research partnerships with external partners, including health care providers, where we combine the strengths of each organization with the goal of advancing clinical science and ultimately patient care. However, the recurring threat of the medical device tax leads to ongoing financial uncertainty and presents a significant challenge for the advancement of research and development associated with health care technology in the future.

We are very appreciative of your support for repeal of the medical device tax in the past and look forward to working with you toward a permanent solution that removes uncertainty from the health care industry and enables us to continue to invest in developing technologies that improve and help save lives. Please let me know if GE Healthcare can be a resource to you in this endeavor.

Sincerely,

Lee Cooper
President & CEO, GE Healthcare U.S. & Canada

GEORGIA BIO™
The Life Sciences Partnership

June 12, 2019

Senator Pat Toomey
U.S. Senate
Washington, DC 20510

Senator Bob Casey, Jr.
U.S. Senate
Washington, DC 20510

Dear Senator Toomey and Senator Casey,

Thank you for the opportunity to submit comments and recommendations to the Task Force in response to the Finance Committee's efforts to develop long-term solutions to temporary tax policies. On behalf of the medical device members of Georgia Bio, we appreciate your interest in hearing from stakeholders on such an important issue.

Georgia Bio is a non-profit, membership-based organization that promotes the interests and growth of the life sciences industry. Our over 200-member organizations include companies, universities, research institutions, government groups and other industry associations involved in discovery and application of life sciences products and related services that improve the health and well-being of people throughout the world. Additionally, Georgia Bio provides opportunities for undergraduate and graduate students to network with professionals in the life sciences for career enhancement, mentoring, and developing industry contacts through the Georgia BioEd Institute.

Medical device manufacturers in Georgia are committed to bringing breakthrough innovations to patients, but that commitment is threatened by a number of regulations and policies that have increased costs, lengthened timelines, and deterred companies from investing in the next generation of treatments and cures.

Chief among these policies is the 2.3% excise tax on the sale of certain medical technology that was enacted as part of the Affordable Care Act (ACA). Since its enactment, the medical device tax has been a significant drag on medical innovation and resulted in the loss or deferred creation of jobs, reduced R&D, and slowed capital expansion. What is even more troubling is that this tax was imposed without any real policy justification. The medical device tax is not grounded in any health care policy. It is not connected to individual insurance coverage. It was designed purely as a means of raising revenue from the industry to offset the budgetary impact of the ACA.

Medical devices have revolutionized health care. To cite one example, medical technology has helped add more than five years to U.S. life expectancy since 1980. Advances in treatment mean patients experience less-invasive procedures, shorter hospitalizations, reduced recovery times, and lower overall costs. New technologies diagnose illnesses earlier, lowering the impact of care on a person's daily life. Breakthrough concepts reduce the overall cost of health care for patients and the system. All these gains are at risk if the medical device tax is reinstated.

The effects of the tax are felt across the industry, as every dollar of revenue (not income or profit) earned by a company is generally subject to the tax. For large, established companies, the device tax equals tens, if not hundreds, of millions of dollars that could be used to expand research and create jobs.

999 Peachtree Street NE / Suite 1800 / Atlanta, GA 30309 / p 404.221.0617 / f 404.448.3982 / www.gabio.org

For start-up firms, the effect of the tax is two-fold – it deters company growth, since the tax is imposed on the first dollar of revenue earned; and it restricts the ability of established medical technology companies to invest in or acquire start-up companies by limiting the amount of available funds.

Large bipartisan majorities in Congress agree that the medical device tax is bad policy. Thanks in no small part to your leadership and the efforts of the Committee on Finance, Congress has suspended the tax twice for a total of four years. Notably, by the end of this year, Congress will have suspended the tax for longer than it was in effect, with no measurable impact on coverage. Clearly, repeal of the device tax will not have a significant impact on the overall finances of the ACA, despite prior concerns.

Medical technology has improved efficiencies and produced savings to the system through minimally invasive procedures, more precise and accurate diagnostics, and devices that reduce hospitalizations or length of stay. These improvements mean better outcomes and higher-quality care for patients, which lowers cost. Taxing the development and manufacture of medical technology imposes an unnecessary penalty on these savings and erodes the value these technologies provide to the system in the long run.

The current suspension expires on December 31, 2019. Individual companies are already making important planning decisions for the next fiscal year, including how to allocate resources toward research and development as well as employment tied to research and development. As an excise tax, the device tax cannot be addressed retroactively in an effective manner. The longer Congress waits to act, the bigger the impact on the industry's ability to develop the next life-saving, life-enhancing technology.

We strongly encourage the Task Force to recommend full repeal of the medical device excise tax and urge the Committee to move promptly to consider legislation that includes repeal. We stand ready to work with you to advance any legislative vehicle that will address the medical device tax. Permanently repealing the device tax will provide medical technology innovators with the long-term certainty necessary to support future job growth and sustainable, cutting-edge R&D that will ultimately lead to the next generation of breakthroughs in patient care and treatment. With any other policy outcome, effective planning for a sustainable future becomes much more difficult.

Thank you again for this opportunity to share our thoughts on behalf of our medical technology companies. We look forward to working with you and your staff on a solution that will allow our members to retain their position as world leaders in developing and manufacturing technology that will improve the lives of patients in the United States.

Sincerely,

Maria Thacker Goethe

Maria Thacker Goethe, MPH
President & CEO
Georgia Bio / Georgia BioEd Institute
999 Peachtree St. NE, Suite 1800
Atlanta, GA 30309
404-920-2042 | mthacker@gabio.org

ZIMMER BIOMET

June 12, 2019

The Honorable Patrick Toomey (R-PA)
Co-Lead
Health Tax Taskforce
Committee on Finance
United States Senate
Washington, D.C. 20510

The Honorable Robert Casey, Jr. (D-PA)
Co-Lead
Health Tax Taskforce
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Senators Toomey and Casey:

On behalf of Zimmer Biomet Holdings, Inc. ("Zimmer Biomet"), I am writing to support the Senate Finance Committee Health Tax Taskforce's initiative to find a long-term solution to the Medical Device Excise Tax ("device tax") that is suspended from January 1, 2018 through December 31, 2019. Zimmer Biomet supports S. 692, which would repeal the device tax, and acknowledges your leadership and support related to this bill.

Repealing the device tax is a top priority for Zimmer Biomet and the medical device industry. Zimmer Biomet has productively deployed the revenue freed up by the multiyear suspension of the device tax. Suspension has allowed us to reinvigorate new and existing research projects that will help improve musculoskeletal health for patients around the globe, including projects led by Zimmer Biomet Team Members in Exton, PA. Zimmer Biomet has also invested heavily in new plant and equipment in many of our U.S. facilities. These investments have bolstered existing jobs and supported the creation of new, high-quality jobs throughout the country.

These investments, however, will not continue if the device tax is reinstated next year. Suspension has provided only temporary relief and has not eliminated the entire impact of the device tax. Only repeal will allow Zimmer Biomet to make the preferred long-term decisions and move forward confidently with longer-term reinvestments. This is why S.692 is so critical.

As we experienced when the device tax was in place (2013-2015), this tax imposes a significant cost burden on a vibrant industry that contributes positively to the U.S. economy through manufacturing, exports and high-paying jobs, including more than 22,000 medical device jobs in Pennsylvania. The device tax is not a cost that we are able to pass onto our customers. So, Zimmer Biomet will again be forced to consider options to recoup the expected earnings loss because of the device tax, if it is re-imposed. We prefer not to implement these options.

Thank you again for supporting repeal of the device tax and the device industry's efforts to innovate for the benefit of patients in need around the world. Let me know if Zimmer Biomet can be of further assistance to the Committee's Taskforce.

Sincerely,

Chad F. Phipps
Senior Vice President,
General Counsel & Secretary

Zimmer Biomet
345 E Main Street, Warsaw, IN 46580
800.613.6131

HAL QUINN
President & CEO

June 12, 2019

Senator Mike Enzi
Senate Committee on Finance
health_tax_taskforce@finance.senate.gov

Re: Black Lung Excise Tax Rates

Dear Senator Enzi:

In connection with the Health Care Tax Extenders working group's review of various tax provisions, the National Mining Association (NMA) offers the following views on any proposal to increase the Black Lung Excise Tax (BLET) on coal. Any increase would be a repudiation of the intent and purpose of the Tax Cuts and Jobs Act of 2017.

The BLET tax is not an expiring tax provision. The tax continues to be levied on coal production and will provide revenue for the payment of benefits under the program. The tax was increased temporarily in 1986 and, under an agreement reached in 2008, the rates reverted to their original levels of $0.50 per ton of underground coal and $0.25 per ton of surface coal on January 1, 2019. Any action to reimpose the higher tax rates would levy a $200 million annual tax increase at a time when the coal industry is struggling to recover from a series of disabling public policies impairing coal demand and production.

Over the life of the black lung trust fund, taxes paid by the coal industry have *exceeded* benefit payments by $4.4 billion. Despite the excess of tax revenues over benefits paid, the trust fund was forced to incur debt to pay for previously denied claims. Changes to the law allowed the reconsideration of previously denied claims which in turn resulted in more than 23,000 previously denied claimants receiving benefits between 1978-1980. A General Accounting Office (GAO) study found that in most cases the approval of these previously denied claims was based on little or no medical evidence. GAO further observed that the eligibility criteria effectively converted a disability program into a pension program.

In 2010, Congress changed the rules once again by reviving certain presumptions to effectively disconnect eligibility from medical evidence of black lung by providing benefits for miners with a ten-year employment history. These changes, made as part

of the Affordable Care Act, were applied retroactively. These changes added further to the financial stress on the trust fund and perpetuated the conversion of a disability program into a pension program. As you know, coal companies already pay separately for their former and current employees' disability benefits, including black lung, as well as retirement benefits.

In addition to the diversion of coal company black lung excise taxes to pay for debt and interest caused by changes in government policies, program administrative costs continue to increase despite the substantial decrease in beneficiaries. The number of beneficiaries covered by the trust fund has decreased by 85 percent over the last three decades. At the same time, the administrative costs for processing claims has increased from $205 per claim to $2,585 per claim. The current $66 million in administrative costs now accounts for one-third of the total annual costs for benefits and administration of the program.

Increasing the tax rate is unnecessary and fails to address the underlying causes of the current financial condition of the trust fund. In FY 2018, the tax raised $473 million while benefit payments were $177 million. Raising the rate will continue to tax the industry to pay a debt incurred due to changes in government policies that approved claims without medical evidence of disability from black lung. Moreover, a tax hike simply rewards the inefficiencies in the program that divert a growing share of program costs to administration and overhead.

For these reasons, we urge you not to include an increase in the BLET in any tax extenders legislation. Thank you for your consideration of this information and our views.

Sincerely,

Hal Quinn

National Mining Association 101 Constitution Avenue, NW | Suite 500 East | Washington, DC 20001 | (202) 463-2600

June 14, 2019

Senator Pat Toomey
U.S.Senate
Washington, DC 20510

Senator Bob Casey, Jr.
U.S. Senate
Washington, DC 20510

Dear Senator Toomey and Senator Casey:

Thank you for the opportunity to submit comments to the Task Force on Health Tax Extenders in response to the Finance committee's efforts to develop long-term solutions to temporary tax policies. I am writing on behalf of the over 1,400 employees of Siemens Healthineers in Pennsylvania, most of whom are located at our Americas Headquarters in Malvern, in support of a permanent repeal of the medical device excise tax enacted as part of the Affordable Care Act in 2010.

At Siemens Healthineers, our purpose is to enable healthcare providers to increase value by empowering them on their journey toward expanding precision medicine, transforming care delivery, and improving patient experience, all made possible by digitalizing healthcare. An estimated 5 million patients globally benefit every day from our innovative technologies and services in the areas of diagnostic and therapeutic imaging, laboratory diagnostics, and molecular medicine, as well as digital health and enterprise services. We are a leading medical technology company with over 120 years of experience and 18,000 patents globally. Through the dedication of more than 50,000 colleagues in 75 countries, we will continue to innovate and shape the future of healthcare.

I would like to note for your Task Force's record that the medical imaging technology industry is a significant contributor to Pennsylvania's economy. Failure to repeal or to continue the device tax's suspension by December 31 would have a considerable impact on the state. Pennsylvania is home to 45 major medical imaging technology companies. The activities performed at these sites, along with the use of medical imaging equipment and technology at over 1,421 hospitals, urgent care facilities and other major medical clinics and offices located throughout the state, provide over 12,261 full-time equivalent jobs. In addition, suppliers and other companies directly related to the medical imaging industry generate an additional 23,967 full time equivalent positions. When you factor in other medical device companies based in the State, the impact of the medical device excise tax is far higher.

Implemented for two years, and suspended since January 2016, the tax cost Siemens Healthineers tens of millions of dollars, paid in bi-monthly installments, on top of all other taxes owed. During those two years, we had to make the painful choice to lay-off hundreds of employees, delay facility expansions and stop key research and development projects in an effort to cover the cost of the tax. Although having the tax suspended for the last three and one-half years has freed up revenue for major investments in US-based plants and major product launches, we need certainty that the added tax burden will not return, freeing up extended planning into the foreseeable future.

As Siemens Healthineers' fiscal year begins on October 1, like the U.S government, we are now planning our budget for FY 2020 and must soon make the decision whether to account for the medical device tax, which would begin again for product sales in the U.S as of January 1, 2020. In addition, should the tax not be repealed or suspended by this fall, we must rehire the consulting firm and start the accounting process for all device sales. We cannot wait until an end of the year legislative fix to begin this process, again, because we will have to account for the tax as of January 1.

We thank you for your consideration of the impact of this tax on our industry and on Siemens Healthineers.

David Pacitti

President
Siemens Medical Solutions USA Inc.

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Malvern, PA 19355-9998
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June 12, 2019

U.S. Senator Pat Toomey, Co-Lead
U.S. Senator Bob Casey, Co-Lead
Senate Finance Committee Taskforce on Health
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Senators Toomey and Casey:

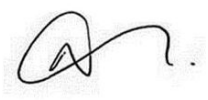
On behalf of Smith & Nephew, Inc.'s more than 6,400 U.S. employees—including over 180 Pennsylvanians—I am writing in response to the Finance Committee's request for comment on long-term solutions to temporary tax policy. We appreciate your leadership on the Health Care Taskforce and are pleased to have two senators who understand the value of a vibrant medical technology industry.

Since acquiring Pittsburgh-based Blue Belt Technologies and its NAVIO Surgical System in 2016, we have increased our focus on robotic-assisted orthopedic surgery and expanded our local footprint by roughly doubling our employee base in Pittsburgh to nearly 100 today. We also are investing in a 46,000 square foot, state-of-the-art robotics R&D center at the new 3 Crossings development in Pittsburgh's Strip District that will allow for additional job growth. In addition, Smith & Nephew is partnering with local start-ups on R&D projects, as well as with the University of Pittsburgh Medical Center on R&D and surgeon education. These investments not only will support our business but also promote advancements in robotics and orthopedics more broadly.

As we consider further investments in robotics R&D, among other priorities, we strongly encourage the Taskforce to recommend full repeal of the medical device excise tax. The continued uncertainty posed by short-term suspensions of the device tax does not allow Smith & Nephew to easily plan for longer-term investments or growth. With the tax scheduled to come back into effect on January 1, 2020, we have to assume there is a real financial risk to our business and plan accordingly. We applaud the leadership that both of you demonstrate on this issue and are hopeful that your efforts can remove this barrier to further innovation and growth in our industry.

I invite you and/or your staff to visit our Pittsburgh facility at your convenience to see the exciting work that is happening to deliver better robotics systems to facilitate successful surgeries. If you have any questions, please contact Paul Seltman in our Washington office at paul.seltman@smith-nephew.com or 202-441-2342.

Sincerely,



Namal Nawana
Chief Executive Officer

June 12, 2019

The Honorable Patrick Toomey
Co-Lead, Health Task Force
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Bob Casey
Co-Lead, Health Task Force
Committee on Finance
United States Senate
Washington, DC 20510

Subject: The AIDS Institute Support of Repealing Medical Device Tax

Dear Senators Toomey and Casey:

The AIDS Institute, a national nonprofit organization dedicated to supporting and protecting health care access for people living with HIV, hepatitis, and other chronic and serious health conditions, is pleased to submit comments to you as you consider examining health-related tax provisions that have expired or will soon expire and possible solutions that would provide long-term certainty in these areas.

As you consider various proposals, we ask that you examine repealing the medical devise tax that was included in the Affordable Care Act (ACA). The United States is the world leader in biomedical innovation, while we strongly support the ACA, we believe the Medical Device Tax restrains the innovation needed to improve the detection and monitoring of viruses like HIV, hepatitis, Ebola, and other viruses not yet discovered.

New medical technologies have allowed Americans and people all around the world to live longer, healthier lives. The Medical Device Tax provides a disincentive for manufacturers to invest in the research and development of new biomedical tools. Additionally, it will lead to increased health care costs that are more often than not borne by patients. We ask that you include the repeal of this tax in your deliberations to make is easier and less expensive for patients to access potentially lifesaving tools.

Should you have any questions or comments, please contact me at (202) 462-3042 or cschmid@theaidsinstitute.org.

Sincerely,

Carl E. Schmid II
Deputy Executive Director

America's Blood Centers®
It's About Life.

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Tel: 202-393-5725 | Fax: 202-899-2621
www.AmericasBlood.org

June 13, 2019

The Honorable Pat Toomey
United States Senate
Washington, DC 20510

The Honorable Bob Casey
United States Senate
Washington, DC 20510

Dear Senators Toomey and Casey:

On behalf of America's Blood Centers, we would like to extend our appreciation for the Senate Finance Committee's examination of temporary tax policies, including the medical device tax. America's Blood Centers (ABC) is North America's largest network of not-for-profit community blood centers, who collectively provide 60 percent of the blood supply in the United States, operate more than 600 blood donation sites, produce over 12 million units of whole blood and blood components, and support over 3,500 hospitals and health care facilities.

Not-for-profit blood centers annually purchase approximately $1.5 billion worth of medical devices to ensure the safety and availability of the nation's blood supply. These items include blood collection devices such as blood bags, devices used in blood processing such as apheresis machines and centrifuges, blood center computers' software systems, and blood screening tests. A rough calculation suggests that the tax could cost blood centers some $11.5 million a year, if passed directly onto customers by manufacturers.

Not-for-profit community blood centers are unique healthcare providers in that they must purchase these medical devices to meet Food and Drug Administration testing protocols and regulatory requirements to ensure the safety of the blood supply. In a fiscal environment that is already constrained for community-based, not-for-profit institutions, an added tax would compromise blood centers' continued efforts to ensure the safety and integrity of the nation's blood supply. This tax would force blood centers to consider which safety measures to prioritize, and may force centers to eliminate certain critical measures entirely.

We thank you for your support of this important issue and look forward to working with you to see it fully repealed. If you have any questions, please contact me at kfry@americasblood.org or 202-654-2911.

Sincerely,

Kate Fry, MBA, CAE
Chief Executive Officer

Dear Members of the Senate Finance Committee Health Tax Task Force:

I understand the Senate Committee on Finance is currently examining temporary tax policies in varying issue areas including health. As the CEO of ALung Technologies in Pittsburgh Pennsylvania, I urge you to ensure the permanent repeal of the Medical Device Tax is included in any of the proposals or recommendations that are produced by this comprehensive exercise. This is especially important as the current suspension of the Medical Device Tax will end December 31 of this year.

The damage this short-sighted policy caused when it was in place from 2013-2015 is well known, and if it goes into effect again it will undoubtedly stifle innovation and patient care. Though currently under a temporary suspension, if the tax is not repealed our company and many others like ours, will be diverting tens of millions of dollars to the IRS instead of investing in innovation and creating new high-tech manufacturing jobs.

ALung Technologies is a medical device company that is focused on the development and commercialization of an artificial lung for the treatment of acute respiratory failure. For complicated devices such as ours it can take hundreds of millions of dollars to evolve the technology to the point of commercialization in the United States. We have struggled over the years to raise the needed capital to advance our efforts. I can tell you from firsthand experience that one of the reasons capital is difficult to raise is the threat that there will be a Medical Device Tax. As I stated earlier, this type of tax stifles innovation and deprives our citizens of advances in the treatment of disease.

We look forward to working with you to put a permanent end to a policy that only served to impede our common goals of growing our country's economy and improving patient care. Additionally, and if interested, we would be honored to host you at ALung Technologies to provide you with a first-hand look at the medical technology ecosystem this country enjoys, and the benefits our innovation, research and development provide to patients and their families.

Sincerely,
Peter M. DeComo
Chairman and CEO
ALUNG
ALung Technologies, Inc.
2500 Jane Street, Suite 1
Pittsburgh, PA 15203-2216
(O) 412.697.3370 X207
(M) 412.475.2262
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www.alung.com

June 13, 2019

Senator Pat Toomey
U.S. Senate
Washington, DC 20510

Senator Bob Casey, Jr.
U.S. Senate
Washington, DC 20510

Dear Senator Toomey and Senator Casey,

Thank you for the opportunity to submit comments and recommendations to the Task Force in response to the Finance Committee's efforts to develop long-term solutions to temporary tax policies. On behalf of BioForward Wisconsin, I appreciate your interest in hearing from stakeholders on such an important issue.

BioForward Wisconsin is a member driven association representing Wisconsin's biohealth industry. Our industry has a major economic impact on the State of Wisconsin from the manufacturing supply chain supporting our national medical device industry, to having a strong concentration of medical technology innovators and companies. Those companies are committed to ensuring patient access to life-saving and life-enhancing devices.

However, this commitment is threatened by a number of regulations and policies that have increased costs, lengthened timelines, and deterred companies from investing in the next generation of treatments and cures. Chief among these policies is the 2.3% excise tax on the sale of certain medical technology that was enacted as part of the Affordable Care Act (ACA). Since its enactment, the medical device tax has been a significant drag on medical innovation and resulted in the loss or deferred creation of jobs, reduced R&D, and slowed capital expansion. What is even more troubling is that this tax was imposed without any real policy justification. The medical device tax is not grounded in any health care policy. It is not connected to individual insurance coverage. It was designed purely as a means of raising revenue from the industry to offset the budgetary impact of the ACA.

Medical devices have revolutionized health care. To cite one example, medical technology has helped add more than five years to U.S. life expectancy since 1980. Advances in treatment mean patients experience less-invasive procedures, shorter hospitalizations, reduced recovery times, and lower overall costs. New technologies diagnose illnesses earlier, lowering the impact of care on a person's daily life. Breakthrough concepts reduce the overall cost of health care for patients and the system. All these gains are at risk if the medical device tax is reinstated.

The effects of the tax are felt across the industry, as every dollar of revenue (not income or profit) earned by a company is generally subject to the tax. For large, established companies, the device tax equals tens, if not hundreds, of millions of dollars that could be used to expand research and create jobs. For start-up firms, the effect of the tax is two-fold – it deters company growth, since the tax is imposed on the first dollar of revenue earned; and it restricts the ability

of established medical technology companies to invest in or acquire start-up companies by limiting the amount of available funds.

Large bipartisan majorities in Congress agree that the medical device tax is bad policy. Thanks in no small part to your leadership and the efforts of the Committee on Finance, Congress has suspended the tax twice for a total of four years. Notably, by the end of this year, Congress will have suspended the tax for longer than it was in effect, with no measurable impact on coverage. Clearly, repeal of the device tax will not have a significant impact on the overall finances of the ACA, despite prior concerns.

Medical technology has improved efficiencies and produced savings to the system through minimally invasive procedures, more precise and accurate diagnostics, and devices that reduce hospitalizations or length of stay. These improvements mean better outcomes and higher-quality care for patients, which lowers cost. Taxing the development and manufacture of medical technology imposes an unnecessary penalty on these savings and erodes the value these technologies provide to the system in the long run.

The current suspension expires on December 31, 2019. Individual companies are already making important planning decisions for the next fiscal year, including how to allocate resources toward research and development as well as employment tied to research and development. As an excise tax, the device tax cannot be addressed retroactively in an effective manner. The longer Congress waits to act, the bigger the impact on the industry's ability to develop the next life-saving, life-enhancing technology.

We strongly encourage the Task Force to recommend full repeal of the medical device excise tax and urge the Committee to move promptly to consider legislation that includes repeal. Permanently repealing the device tax will provide medical technology innovators with the long-term certainty necessary to support future job growth and sustainable, cutting-edge R&D that will ultimately lead to the next generation of breakthroughs in patient care and treatment. With any other policy outcome, effective planning for a sustainable future becomes much more difficult.

Thank you again for this opportunity to share our thoughts on behalf of Wisconsin's biohealth industry and member companies of BioForward Wisconsin.

Sincerely,

Lisa Johnson
CEO, BioForward Wisconsin

COUNCIL *for* CITIZENS AGAINST GOVERNMENT WASTE

Thomas A. Schatz, *President*
1100 Connecticut Ave., N.W., Suite 650
Washington, D.C. 20036
ccagw.org

June 13, 2019

The Honorable Patrick Toomey
The Honorable Robert Casey
The Honorable Michael Enzi
The Honorable Mark Warner
Senate Finance Committee
Health Tax Task Force
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senators Toomey, Casey, Enzi, and Warner,

The Council for Citizens Against Government Waste (CCAGW) appreciates the Senate Finance Committee assembling six task forces to find long-term solutions to 42 temporary tax provisions that have expired or are due to expire by December 31, 2019. Lower taxes help to spur long-term growth of and encourages investment in U.S. businesses across the country.

Since the implementation of the Patient Protection and Affordable Care Act (ACA), CCAGW has called for the repeal of the medical device tax, an extremely harmful measure that adds a 2.5 percent excise tax on the sale of a qualified device. According to the Tax Foundation, between 2013 and 2015 when the medical device tax was in effect, the industry saw a decrease in research and development spending of $34 million and a loss of approximately 21,800 jobs.

Congress suspended the tax in 2016 and AdvaMed, a medical device trade association, reported that 70 percent of device companies increased their hiring; 73 percent stated the climate improved for raising capital; and average research and development funding increased by19 percent. In fiscal years 2018 and 2019 alone, Congress's suspension saved the industry $3.8 billion. However, the continued uncertainty surrounding the excise tax will hurt long-term investment and job creation, particularly as the next suspension deadline approaches. With a little more than six months to go, the industry is facing a $20 billion tax increase over 10 years if the tax is not permanently repealed by December 31, 2019.

Because the tax is based on a company's sales rather than profits, it is particularly destructive to smaller firms that tend to be the most innovative yet the most fiscally tenuous because they may not yet be profitable. The complexity of the tax is also problematic. The Tax Foundation noted that the "tax's retail exemption also creates confusion for medical device firms. The statute gives the U.S. Treasury Secretary broad authority to exempt items from the tax, which creates compliance issues for firms. For instance, the Internal Revenue Service has issued guidance on the sales of medical device kits, which contain both taxable and nontaxable items."

Furthermore, while it is not a direct tax on American consumers and taxpayers, they ultimately pay for it in several ways. Device companies might be able to pass along some of the increased costs through higher prices for providers and payors, including Medicare and Medicaid. But, the medical device industry is very competitive, so many companies may not be able to increase their prices and must instead reduce research and development or the number of their employees. In this case, the consumer pays with the loss of innovation. Usually, it is a combination of these adverse results.

Repealing the medical device tax has had bipartisan support since its inception. CCAGW hopes that your task force will recommend repealing this innovation-killing tax and that the Senate and House of Representatives will agree it is time to do so.

Sincerely,

Thomas Schatz

June 14, 2018

The Honorable Mike Enzi
U.S. Senate

The Honorable Pat Toomey
U.S. Senate

The Honorable Bob Casey
U.S. Senate

The Honorable Mark Warner
U.S. Senate

Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20515

RE: Senate Committee on Finance Extenders Task Force Inputs

Dear Senators Enzi, Toomey, Casey and Warner:

Hitachi Healthcare Americas (HHA) provides the following comments to the task force as you consider legislation this year to extend current tax policy that will, or has, expired.

HHA is a U.S. subsidiary of Hitachi, Ltd., headquartered in Japan. Hitachi, Ltd. delivers innovative solutions that answer society's most pressing challenges by leveraging its operational technology, information technology, and products/systems. The company's consolidated revenues for fiscal 2018 (ended March 31, 2019) totaled $86.2 billion and Hitachi Group Companies employ over 300,000 employees worldwide. In the United States, Hitachi Group Companies employ over 21,000 people at 88 companies, producing approximately $11 billion in revenue last year. North America is the second largest market for Hitachi with 13% of revenues from the region. Our group companies have approximately 1,000 employees in Pennsylvania and 50 employees in Virginia.

Located in Twinsburg, Ohio, HHA offers a broad range of diagnostic imaging equipment including MRI, CT, Ultrasound, and Informatics. HHA's technologies play an important role in the diagnosis and treatment of many diseases. Earlier diagnosis times often translate into decreased healthcare costs and increased patient outcomes, both key objectives in a value-based healthcare environment. We are also committed to the research and development of new products/services for our customers and their patients, but the medical device tax is hampering our ability to deliver potentially life-saving instruments.

The medical device tax, enacted as part of the Affordable Care Act, places a burden on our operations, reduces our ability to invest more into our research efforts, and disproportionately impacts the medical imaging industry. The medical device tax was added to the Affordable Care Act under a belief it would increase usage of medical equipment. While this is may hold true for single-time use devices, it is not true for medical imaging devices. Hospitals and medical offices have a number of reasons to determine when to replace an imaging device that is not related to the tax. The medical device tax on medical imaging devices only increases the cost without the manufacturer seeing the same increase in purchasing that single-use device manufacturers enjoy.

The medical device tax threatens HHA's role as a job-creator. HHA employs 398 Americans, and looks to increase its hiring over the next few years. These jobs are high-paying, high-quality jobs: while the 2018 national median household income was $61,372 according to census tract data, the median income of an HHA employee is $81,763. As with most medical technology companies, the vast majority of jobs at HHA involve a high degree of specialized knowledge and experience, and thus a demand for these higher salaries. And while HHA would like to remain an employer committed to offering high-quality, high-paying jobs, the lingering re-imposition of the medical device tax continues to challenge this commitment.

The medical device tax challenges our commitment to innovation and critical R&D with partner institutions. HHA is working to open the Hitachi Center for Healthcare Innovation, a center that will allow us to co-collaborate with universities and other partners in the development of technologies that will improve patient care and outcomes. This center is designed to harness our strength in operation and information technologies, while utilizing artificial intelligence and machine learning in diagnostic analytics. But, this project's realization is threatened by the onerous and blanket tax.

The blanket tax means that medical imaging devices are hit harder by the 2.3% sales tax because it is payable whether the company has income or not. Tying the tax to sales in this manner stifles innovation, as young companies are dis-incentivized from launching and legacy companies are dis-incentivized from investing in R&D. With less capital to invest in new innovations, and a new barrier to entry for start-ups, the harder it is for the U.S. to maintain its current lead in this development area.

Repealing the medical device tax enjoys bipartisan support across both chambers of Congress, and yet Congressional inaction is leaving medical device manufacturers unable to effectively plan and direct investments towards new products.

We ask that you please include a full repeal in the finance extenders package, or, at the very least, include a multi-year extension of the medical device tax to provide certainty for the industry.

Sincerely,

Yasuhiko Taniguchi
CEO
Hitachi Healthcare Americas

cc: Senator Rob Portman
Senator Sherrod Brown

Hitachi Healthcare Americas
1959 Summit Commerce Park Twinsburg OH 44087 Tel: 800-800-3106 Fax: 330-425-1410
www.hitachihealthcare.com

June 14, 2019

Senator Pat Toomey
U.S. Senate
Washington, DC 20510

Senator Bob Casey, Jr.
U.S. Senate
Washington, DC 20510

Dear Senator Toomey and Senator Casey,

Thank you for the opportunity to submit comments and recommendations to the Task Force in response to the Finance Committee's efforts to develop long-term solutions to temporary tax policies. On behalf of the medical device members of the Massachusetts Medical Device Industry Council (MassMEDIC), we appreciate your interest in hearing from stakeholders on such an important issue.

MassMEDIC represents the interests of the more than 420 medical device companies in the Commonwealth of Massachusetts. Medical devices are an essential part of our economy, representing 1 out of every 4 products exported by the Commonwealth and the industry employs more than 25,000 workers directly. The Commonwealth ranks first in medical device exports, second in patents, venture funding, and total venture deals. However, the impact of this industry stretches far beyond our borders and economic impact, each and every piece of medical technology created in Massachusetts, has the ability to help heal people across the globe.

Medical device manufacturers in Massachusetts are committed to bringing breakthrough innovations to patients, but that commitment is threatened by a number of regulations and policies that have increased costs, lengthened timelines, and deterred companies from investing in the next generation of treatments and cures.

Chief among these policies is the 2.3% excise tax on the sale of certain medical technology that was enacted as part of the Affordable Care Act (ACA). Since its enactment, the medical device tax has been a significant drag on medical innovation and resulted in the loss or deferred creation of jobs, reduced R&D, and slowed capital expansion. What is even more troubling is that this tax was imposed without any real policy justification. The medical device tax is not grounded in any health care policy. It is not connected to individual insurance coverage. It was designed purely as a means of raising revenue from the industry to offset the budgetary impact of the ACA.

Medical devices have revolutionized health care. To cite one example, medical technology has helped add more than five years to U.S. life expectancy since 1980. Advances in treatment mean patients experience less-invasive procedures, shorter hospitalizations, reduced recovery times, and lower overall costs. New technologies diagnose illnesses earlier, lowering the impact of care on a person's daily life. Breakthrough concepts reduce the overall cost of health care for patients and the system. All these gains are at risk if the medical device tax is reinstated.

The effects of the tax are felt across the industry, as every dollar of revenue (not income or profit) earned by a company is generally subject to the tax. For large, established companies, the device tax equals tens, if not hundreds, of millions of dollars that could be used to expand research and create jobs. For start-up firms, the effect of the tax is two-fold – it

deters company growth, since the tax is imposed on the first dollar of revenue earned; and it restricts the ability of established medical technology companies to invest in or acquire start-up companies by limiting the amount of available funds.

Large bipartisan majorities in Congress agree that the medical device tax is bad policy. Thanks in no small part to your leadership and the efforts of the Committee on Finance, Congress has suspended the tax twice for a total of four years. Notably, by the end of this year, Congress will have suspended the tax for longer than it was in effect, with no measurable impact on coverage. Clearly, repeal of the device tax will not have a significant impact on the overall finances of the ACA, despite prior concerns.

Medical technology has improved efficiencies and produced savings to the system through minimally invasive procedures, more precise and accurate diagnostics, and devices that reduce hospitalizations or length of stay. These improvements mean better outcomes and higher-quality care for patients, which lowers cost. Taxing the development and manufacture of medical technology imposes an unnecessary penalty on these savings and erodes the value these technologies provide to the system in the long run.

The current suspension expires on December 31, 2019. Individual companies are already making important planning decisions for the next fiscal year, including how to allocate resources toward research and development as well as employment tied to research and development. As an excise tax, the device tax cannot be addressed retroactively in an effective manner. The longer Congress waits to act, the bigger the impact on the industry's ability to develop the next life-saving, life-enhancing technology.

We strongly encourage the Task Force to recommend full repeal of the medical device excise tax and urge the Committee to move promptly to consider legislation that includes repeal. We stand ready to work with you to advance any legislative vehicle that will address the medical device tax. Permanently repealing the device tax will provide medical technology innovators with the long-term certainty necessary to support future job growth and sustainable, cutting-edge R&D that will ultimately lead to the next generation of breakthroughs in patient care and treatment. With any other policy outcome, effective planning for a sustainable future becomes much more difficult.

Thank you again for this opportunity to share our thoughts on behalf of our medical technology companies. We look forward to working with you and your staff on a solution that will allow our members to retain their position as world leaders in developing and manufacturing technology that will improve the lives of patients in the United States.

Sincerely

Brian Johnson
President
Massachusetts Medical Device Industry Council (MassMEDIC)

June 14, 2019

Senator Pat Toomey
U.S. Senate
Washington, DC 20510

Senator Bob Casey, Jr.
U.S. Senate
Washington, DC 20510

Dear Senator Toomey and Senator Casey,

Thank you for the opportunity to submit comments and recommendations to the Task Force in response to the Finance Committee's efforts to develop long-term solutions to temporary tax policies. On behalf of the medical device members of the Indiana Health Industry Forum (IHIF), we appreciate your interest in hearing from stakeholders on such an important issue.

IHIF is a statewide trade association representing Indiana's bioscience + med tech business community. The diverse members of the Indiana Health Industry Forum generate the collective voice of the state's health and life science industry. Our mission is to connect key stakeholders to: enhance business networks, advocate for member interests, develop workforce skills, and provide strategic vision in the interest of growing the state's health industry economy and reputation.

Medical device manufacturers in Indiana are committed to bringing breakthrough innovations to patients, but that commitment is threatened by a number of regulations and policies that have increased costs, lengthened timelines, and deterred companies from investing in the next generation of treatments and cures.

Chief among these policies is the 2.3% excise tax on the sale of certain medical technology that was enacted as part of the Affordable Care Act (ACA). Since its enactment, the medical device tax has been a significant drag on medical innovation and resulted in the loss or deferred creation of jobs, reduced R&D, and slowed capital expansion. What is even more troubling is that this tax was imposed without any real policy justification. The medical device tax is not grounded in any health care policy. It is not connected to individual insurance coverage. It was designed purely as a means of raising revenue from the industry to offset the budgetary impact of the ACA.

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We strongly encourage the Task Force to recommend full repeal of the medical device excise tax and urge the Committee to move promptly to consider legislation that includes repeal. We stand ready to work with you to advance any legislative vehicle that will address the medical device tax. Permanently repealing the device tax will provide medical technology innovators with the long-term certainty necessary to support future job growth and sustainable, cutting-edge R&D that will ultimately lead to the next generation of breakthroughs in patient care and treatment. With any other policy outcome, effective planning for a sustainable future becomes much more difficult.

Thank you again for this opportunity to share our thoughts on behalf of our medical technology companies. We look forward to working with you and your staff on a solution that will allow our members to retain their position as world leaders in developing and manufacturing technology that will improve the lives of patients in the United States.

Most sincerely,

Kristin Jones
President and CEO
Indiana Health Industry Forum

The Medical Device Competitiveness Coalition

June 12, 2019

The Honorable Patrick Toomey
The Honorable Robert Casey, Jr.
Co-Leads, Senate Finance Committee Taskforce on Health Expiring Provisions
219 Dirksen Senate Office Building
Washington, DC 20510

Submitted via: Health_Tax_Taskforce@finance.senate.gov

Dear Senators Toomey and Casey:

On behalf of the Medical Device Competitiveness Coalition (MDCC), we submit these comments to the Senate Finance Committee's bipartisan health taskforce. MDCC is comprised of the undersigned five medical device manufacturers, each with significant operations throughout the United States.

We are submitting comments to the taskforce regarding the Medical Device Excise Tax ("Device Tax"). Specifically, we are writing to express concern with the impending reinstatement of the Device Tax and the detrimental impact the tax will have on MDCC members' ability to invest in innovations that save and improve lives and create new capital investment and jobs in the medical device industry.

The cost of the device tax places a significant financial burden on the industry and has a corresponding adverse impact on jobs, R&D investment, and U.S. worldwide competitiveness. The Department of Commerce found that the industry lost nearly 29,000 jobs during the time the Device Tax was previously in effect. The Advanced Medical Technology Association (AdvaMed) has also found that reinstating the Device Tax may result in an estimated reduction in R&D investment of about $2 billion each year. This tax is especially burdensome for small companies, which make up a significant part of the industry. Since it is a tax on revenues, not profits, it can cripple smaller, "start-up" device companies, the source of tremendous innovation.

In addition, the uncertainty regarding whether Congress will act to repeal or delay the Device Tax prior to 2020 is causing significant operational burdens for the industry. If not repealed or suspended by the end of 2019, the Device Tax will come into effect in January 2020. As a result, companies have to plan in advance to make payments beginning in January 2020 and on a biweekly basis thereafter. MDCC's members are already incurring costs to ensure processes are in place to report and pay the Device Tax, and reserving funds that would otherwise be invested in their businesses and creating new jobs. These costs increase as we move deeper into 2019.

For the foregoing reasons, we respectfully request that the health taskforce formally support the Protect Medical Innovation Act of 2019 (S. 692), Senator Pat Toomey's (R-PA) legislation to repeal the Device Tax. This bipartisan measure, which counts nine Senate Finance

Committee members amongst its 33 cosponsors, will provide the right long-term solution by repealing this harmful tax. While we believe the best course of action is to repeal the device tax, at a minimum, Congress should act as soon as possible to extend the suspension of the Device Tax beyond 2019 to provide near-term relief from the tax and certainty to the industry.

We very much appreciate the opportunity to provide our perspective on the Device Tax, and we would be happy to meet with the task force to discuss this critical issue and answer any questions you may have.

Sincerely,

Abbott Laboratories
BD (Becton, Dickinson and Co.)
Edwards Lifesciences Corp.
Medtronic, Inc.
Zimmer Biomet

cc: Chairman Charles Grassley
Ranking Member Ron Wyden
Senator Mike Enzi, Health Taskforce Member
Senator Mark Warner, Health Taskforce Member

mhpa Medicaid Health Plans of America

The Health Insurance Tax Affects Medicaid, Too!

Think the Health Insurance Tax (HIT) doesn't affect Medicaid? Think again.

Medicaid managed care plans must pay the HIT. Over 75 percent of Medicaid beneficiaries are enrolled in Medicaid managed care plans. The HIT is a tax on a public health care program relied on by our most vulnerable citizens for health coverage and care.

The HIT has significant and serious implications for state Medicaid programs and Medicaid beneficiaries that include:

- **INCREASED COVERAGE COST PER ENROLLEE**
  According to a recent Oliver-Wyman report, the HIT is likely to drive up the per enrollee cost of Medicaid coverage. In the managed Medicaid insurance market, ***an anticipated increase of $157 per enrollee annually*** is expected.
- **INCREASED GOVERNMENT COSTS.** A 2014 Milliman study found that the Medicaid managed care portion of the HIT ***will cost the government about $38.4 billion over a 10-year period***. The cost to states will be $13.6 billion and the cost to the federal government will be $24.8 billion.
- **REDUCED MEDICAID FUNDS**. Reductions in Medicaid funds due to the expense of paying the HIT negatively impacts states, beneficiaries, and taxpayers.
  - The HIT increases the states' share of Medicaid spending. States could be forced to cut essential programs and services (education, infrastructure, etc.) because of budget shortfalls due to the HIT.
  - Beneficiaries may be impacted if states are forced to reduce optional and/or wraparound Medicaid benefits due to the availability of fewer Medicaid dollars.

State Medicaid programs need to retain these dollars in order to provide care for low-income, vulnerable populations that rely on the program for affordable, high-quality health coverage and care.

In past years, HIT abatement has enjoyed wide-ranging, bipartisan support. MHPA urges Congress to work towards a solution that will fully repeal (H.R.2447/S.80) or suspend (H.R.1398/S.172) the HIT as soon as possible in order to provide immediate relief to state Medicaid programs, beneficiaries, and taxpayers.

MHPA | 1575 Eye Street, NW | Suite #300 | Washington, DC 20005 | 202.857.5720 | info@mhpa.org | medicaidplans.org | medicaidconference.org

June 13, 2019

The Honorable Pat Toomey
Chairman, Health Care Subcommittee, Senate Finance Committee
248 Russell Senate Office Building
Washington, DC 20510

The Honorable Bob Casey
393 Russell Senate Office Building
Washington, DC 20510

The Honorable Michael Enzi
379 A Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
703 Hart Senate Office Building
Washington, DC 20510

Re: Senate Finance Health Tax Extenders Task Force Stakeholder Feedback

Dear Senators Toomey, Casey, Enzi and Warner:

As the leading trade association representing the manufacturers of medical imaging devices and radiopharmaceuticals, the Medical Imaging and Technology Alliance (MITA) commends the Senate Finance Committee Health Tax Task Force for addressing the medical device excise tax as part of its process to provide long-term certainty to expiring tax provisions and urges the Task Force to advance legislation that includes full and immediate repeal of the tax. Repeal of the medical device tax would allow MITA Members to continue the development of innovative cutting-edge imaging systems for the good of the millions of Americans who need them every year. The tax has resulted in the loss of more than 28,000 jobs among device manufacturers and related industries between 2013 and 2015 and threatens to deplete thousands more if not repealed. Permanently abolishing this burdensome tax promises to promote job growth and protect patient access to innovative medical imaging technologies.

One survey of leading medical device manufacturers revealed that almost 71 percent of businesses are more likely to hire employees, and 79 percent would invest resources in additional research and development spending, if the device tax were permanently repealed. Repeal of the tax would support economic growth in a state like Pennsylvania, where the medical imaging industry's growing contribution to the state's economy now supports an estimated 36,228 jobs both directly and indirectly – a significant increase of about 11,746 positions since data was last reported in June of 2015 according to report released earlier this month by John Dunham & Associates. In addition, the report found that 11 new medical technology companies have begun

operations in Pennsylvania since the last study, bringing the total to 45 major medical operations throughout the state that earn $2.78 billion in total wages and benefits for employees each year. Almost $10 billion in economic activity can be attributed to direct production and other commercial linkages, or about 1.3 percent of Pennsylvania's annual total state production.

The American medical technology industry employs more than 2 million Americans nationwide and provides an average salary 40 percent higher than the national average ($58,000 vs. $42,000). Fueled by innovative companies, the majority of these businesses are small – 80 percent have fewer than 50 employees. Without repeal, the device tax will continue to negatively impact this dynamic sector by directing resources away from investment in these well-paid American jobs.

As you know, the two-year suspension of the medical device tax is scheduled to expire on December 31, 2019. If the tax is allowed to restart for any period of time, it will disrupt the medical imaging industry's state of constant innovation which brings exciting new advances each year in reducing radiation dose and improving imaging clarity. Medical device manufacturers need predictability to begin making economic investment decisions for 2020 and the existence of the medical device tax is a major factor in whether we can continue to build on investments already made since the tax was suspended.

We look forward to working with the Tax Task Force and your colleagues in Congress to repeal the medical device tax and to provide enhanced patient access to medical imaging services.

Please do not hesitate to contact Andy Dhokai, MITA Senior Director of Government Relations at adhokai@medicalimaging.org (703) 841-3247 if we can be of any assistance to the Task Force efforts.

Sincerely,

Dennis Durmis
Chairman, MITA Board of Directors
Head of Americas Region, Bayer Radiology
Indianola, PA

MITA is the collective voice of medical imaging equipment and radiopharmaceutical manufacturers, innovators and product developers. It represents companies whose sales comprise more than 90 percent of the global market for medical imaging technology. These technologies include: magnetic resonance imaging (MRI), medical X-Ray equipment, computed tomography (CT) scanners, ultrasound, nuclear imaging, radiopharmaceuticals, radiation therapy equipment, and imaging information systems. Advancements in medical imaging are transforming health care through earlier disease detection, less invasive procedures and more effective treatments. The industry is extremely important to American healthcare and noted for its continual drive for innovation, fast-as-possible product introduction cycles, complex technologies, and multifaceted supply chains. Individually and collectively, these attributes result in unique concerns as the industry strives toward the goal of providing patients with the safest, most advanced medical imaging currently available.

OraSure Technologies, Inc.

June 12, 2019

Dear Members of the Senate Finance Committee Health Tax Task Force:

Thank you for your leadership on patient care issues and your interest in facilitating innovation in healthcare. I write today on behalf of OraSure Technologies, Inc., and the communities that we serve to ask that you please advance a permanent repeal of the Medical Device Tax through any of the proposals or recommendations that are produced by the Task Force's current effort to examine temporary tax policies.

OraSure is based in Bethlehem, PA, and we are a national company with a global healthcare reach. OraSure is a leader in the development, manufacture and distribution of point-of-care diagnostic tests, molecular collection devices and other technologies designed to detect or diagnose critical medical conditions. OraSure's portfolio of products is utilized globally by various clinical laboratories, hospitals, clinics, community-based organizations and other public health organizations, research institutions, distributors, government agencies, physicians' offices, commercial and industrial entities, and patients.

Implementation of the Medical Device Tax has been routinely delayed by Congress with the current stop-gap measure set to expire at the end of the fiscal year. A more permanent solution is needed to avoid the current state of uncertainty so planning can be more accurate and resources can be directed to core activities. Moreover, if the tax were to be implemented again, it would undermine innovation and disrupt service to the community in notable ways. Appreciating the complexity of the task at hand, please prioritize permanently repealing the Medical Device Tax.

Please consider OraSure a resource in this regard. Thank you again for working on this important and timely issues.

Sincerely,

Stephen S. Tang, Ph.D.
President and Chief Executive Officer
OraSure Technologies Inc.

/jlm

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LIFE SCIENCE WASHINGTON

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June 13, 2019

Senator Pat Toomey
U.S. Senate
Washington, DC 20510

Senator Bob Casey, Jr.
U.S. Senate
Washington, DC 20510

Dear Senator Toomey and Senator Casey,

Thank you for the opportunity to submit comments to the Task Force in response to the Finance Committee's efforts to develop long-term solutions to temporary tax policies. On behalf of the over 300 medical device companies in Washington State, Life Science Washington, encourages the Task Force to prioritize repealing the Medical Device Tax, which has been suspended several times.

Companies have been relieved each time the Medical Device Tax has been suspended, but the uncertainty and last minute nature of the suspensions has made it impossible for companies to plan for and commit to making long-term R&D invests with the funds being held back to pay the Medical Device Tax. While short-term suspensions do save jobs and R&D projects that would have to be scaled back if the tax went back into effect, repealing the tax would allow those same funds to be used for longer-term, higher impact projects that can't be started and stopped on an annual basis.

Life Science Washington represents over 500 life science companies in Washington State. Our medical device sector includes over 300 companies and is home to one of the strongest medical imaging clusters in the country dating back to technology that came out of the University Washington in the 1970's, which revolutionized the medical ultrasound industry. The broader medical device industry includes hundreds of additional companies working on products ranging from portable defibrillators, which have dramatically curtained deaths from heart attacks in our state, to a revolutionary new device that can instantly assess ear infections in children and differentiate when and when not to prescribe antibiotics.

Due to the structure and uncertainly of the Medical Device Tax, it has become a significant impediment to medical device companies looking to invest in R&D to bring new products to market. The 2.3% excise tax on the sale of certain medical technology that was enacted as part of the Affordable Care Act (ACA). Since its enactment, the medical device tax has been a significant drag on medical innovation and resulted in the loss or deferred creation of jobs, reduced R&D, and slowed capital expansion.

Medical devices have revolutionized health care. To cite one example, medical technology has helped add more than five years to U.S. life expectancy since 1980. Advances in treatment mean patients experience less-invasive procedures, shorter hospitalizations, reduced recovery times, and lower overall costs. New technologies diagnose illnesses earlier, lowering the impact of care on a person's daily life. Breakthrough concepts reduce the overall cost of health care for patients and the system. All these gains are at risk if the medical device tax is reinstated.

The effects of the tax are felt across the industry, as every dollar of revenue (not income or profit) earned by a company is generally subject to the tax. For large, established companies, the device tax equals tens, if not hundreds, of millions of dollars that could be used to expand research and create jobs. For start-up firms, the effect of the tax is two-fold – it deters company growth, since the tax is imposed on the first dollar of revenue earned; and it restricts the ability of established medical technology companies to invest in or acquire start-up companies by limiting the amount of available funds.

Large bipartisan majorities in Congress agree that the medical device tax is bad policy. Thanks in no small part to your leadership and the efforts of the Committee on Finance, Congress has suspended the tax twice for a total of four years. Notably, by the end of this year, Congress will have suspended the tax for longer than it was in effect, with no measurable impact on coverage. Clearly, repeal of the device tax will not have a significant impact on the overall finances of the ACA, despite prior concerns.

Medical technology has improved efficiencies and produced savings to the system through minimally invasive procedures, more precise and accurate diagnostics, and devices that reduce hospitalizations or length of stay. These improvements mean better outcomes and higher-quality care for patients, which lowers cost. Taxing the development and manufacture of medical technology imposes an unnecessary penalty on these savings and erodes the value these technologies provide to the system in the long run.

The current suspension expires on December 31, 2019. Individual companies are already making important planning decisions for the next fiscal year, including how to allocate resources toward research and development as well as employment tied to research and development. As an excise tax, the device tax cannot be addressed retroactively in an effective manner. The longer Congress waits to act, the bigger the impact on the industry's ability to develop the next life-saving, life-enhancing technology.

We strongly encourage the Task Force to recommend full repeal of the medical device excise tax and urge the Committee to move promptly to consider legislation that includes repeal. We stand ready to work with you to advance any legislative vehicle that will address the medical device tax. Permanently repealing the device tax will provide medical technology innovators with the long-term certainty necessary to support future job growth and sustainable, cutting-edge R&D that will ultimately lead to the next generation of breakthroughs in patient care and treatment. With any other policy outcome, effective planning for a sustainable future becomes much more difficult.

Sincerely,

Marc Cummings
Vice President for Public Policy
Life Science Washington

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

June 14, 2019

The Honorable Pat Toomey
Co-Lead
Health Task Force
Committee on Finance
United States Senate
248 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Bob Casey
Co-Lead
Health Task Force
Committee on Finance
United State Senate
393 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Mike Enzi
Health Task Force
Committee on Finance
United States Senate
379-A Russell Senate Office Building
Washington, D.C. 20510

The Honorable Mark Warner
Health Task Force
Committee on Finance
United State Senate
703 Hart Senate Office Building
Washington, D.C. 20510

Dear Co-Leads Toomey and Casey and Senators Enzi and Warner:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide additional information regarding a tax provision that is within the scope of your task force on temporary tax provisions that expired, or will expire, between Dec. 31, 2017 and Dec. 31, 2019 (Task Force). Specifically, BCBSA wishes to discuss the temporary suspension of the excise tax on covered entities that are engaged in the business of providing health insurance for U.S. health risks (e.g., the Health Insurance Providers Fee or Health Insurance Tax (HIT)) that is in place for the 2019 calendar year.

BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies that collectively provide healthcare coverage for one in three Americans. For 90 years, Blue Cross and Blue Shield companies have offered quality healthcare coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid.

Enacted as section 9010 of the Patient Protection and Affordable Care Act (ACA), the HIT imposes a “fee” on businesses that provide health insurance with respect to U.S.-situs health risks. While labeled as a fee, section 9010 is an excise tax on health insurance providers in both form and substance. The tax is fixed each year and increases for inflation. Insurance providers are apportioned their share of the fixed amount of the tax based generally upon a ratio that reflects the insurer’s relative share of the U.S. health insurance market.

It is important to note that economists are in agreement that the HIT effectively operates as a sales tax on health insurance, and that the costs of the HIT are directly passed through to consumers (i.e., persons who pay health insurance premiums, such as insured individuals or plan-sponsoring employers). Thus, the HIT directly raises healthcare costs for consumers and its suspension (or elimination) reduces healthcare costs.

The HIT has twice been suspended by Congressional action. Section 201 of Title II of the Consolidated Appropriations Act of 2016 suspended collection of the HIT for the 2017 calendar year. Similarly, Division D of H.R. 195 (115th Congress) suspended the collection of the HIT for the 2019 calendar year. Thus, like the Task Force's consideration of the temporary suspension of the imposition of the medical device tax, BCBSA requests that the Task Force explicitly consider the policy ramifications of the HIT (and its temporary suspension) as part of its policy recommendations.

BSBSA is committed to reducing costs for consumers and applauds the bipartisan and bicameral efforts to-date in the 116th Congress to permanently eliminate or delay the HIT. In the Senate, Senator John Barrasso introduced legislation (the "Jobs and Premium Protection Act," S. 80) that would permanently repeal the HIT (effective as of the enactment of the legislation). In his efforts, Senator Barrasso has been joined by his colleagues from both sides of the aisle, including Senators Cory Gardner, Kyrsten Sinema, Kevin Cramer, Martha McSally (R-AZ), Marsha Blackburn and Rob Portman. A companion bipartisan bill is also pending before the House of Representatives (H.R. 2447).

In addition, Senator Gardner has introduced legislation to delay the HIT for two years (the "Health Insurance Tax Relief Act of 2019," S. 172). This bipartisan measure currently has 26 cosponsors. The House version (H.R. 1398) currently has over 100 bipartisan cosponsors.

BCBSA respectfully requests that the Task Force support the approach taken by the "Jobs and Premium Protection Act" to reduce healthcare costs on consumers by permanently eliminating the misguided HIT.

We stand available as a resource to the Task Force as you consider this vital policy issue and welcome the opportunity to discuss our comments (and this issue). If you have any questions on our recommendations, please contact Philip Hays (Philip.hays@bcbsa.com or Andrew Patzman (Andrew.patzman@bcbsa.com.

Sincerely,

Justine Handelman

Cc: The Honorable Chuck Grassley, ex officio Task Force Member
The Honorable Ron Wyden, ex officio Task Force Member
The Honorable Pat Roberts, Co-Lead, Task Force on Individual, Excise & Other Expiring Policies
The Honorable Robert Menendez Co-Lead, Task Force on Individual, Excise & Other Expiring Policies
The Honorable Steve Daines, Member, Task Force on Individual, Excise & Other Expiring Policies
The Honorable Maggie Hassan, Member, Task Force on Individual, Excise & Other Expiring Policies
Mark Warren, Chief Republican Tax Counsel, Senate Finance Committee
Tiffany Smith, Chief Democratic Tax Counsel, Senate Finance Committee

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June 14, 2019

The Honorable Bob Casey, Jr.
United States Senate
393 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Pat Toomey
United States Senate
248 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Casey and Senator Toomey:

As co-chairs of the U.S. Senate Finance Committee's Health Tax Taskforce, thank you for the opportunity to submit comments and recommendations in your efforts to find long-term solutions to temporary tax policies. On behalf of Life Sciences PA and the entire life sciences community in the Commonwealth, your work and interest in obtaining feedback from stakeholders on these important issues is greatly appreciated.

Pennsylvania is home to more than 330 medical device and diagnostic establishments and Life Sciences PA is honored to represent these innovative companies in our advocacy efforts. These medical technology companies provide 22,200 jobs to Pennsylvanians and the industry contributes $13.1 billion to the state's economy. More important, these companies are researching and developing new devices and diagnostics that transform healthcare – earlier disease detection, less invasive procedures and more effective treatments all help patients live longer, healthier lives.

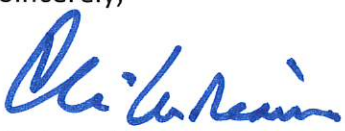
However, as Pennsylvania's medical technology economy has grown, we often hear concerns from our member companies about the structure of the medical device excise tax and its uncertainty. This 2.3 percent tax, enacted as part of the Affordable Care Act (ACA), is particularly burdensome to small companies as it forces them to pay the government regardless of whether they are profitable and months before they may receive payment from a health system. Additionally – this is also important for larger manufacturers – the temporary suspension approach makes it very difficult for all companies as they develop business plans 5 and 10 years into the future. Interestingly, this policy was not grounded in any health policy related to its passage as part of the ACA and it is not connected to individual insurance coverage. Rather, it was simply a way to increase revenues and offset the budgetary costs of the ACA.

Thankfully, and due in part to your leadership in the Senate and on the Finance Committee, the tax has been suspended for the previous four years. However, it was in effect for a short time – 2013 to 2015 – and resulted in resources being diverted to the IRS rather than being invested in our communities. Unfortunately, the continued uncertainty around its permanency force companies to reduce investments in research

and development, limit capital expansion projects and postpone the hiring of new employees. A survey of over 100 med tech innovators by the Medical Device Manufacturers Association (MDMA) shows that 88 percent of innovators will slow down hiring and/or have to eliminate jobs, and 83 percent will decrease investments in R&D if the device tax is reinstated. Any of these difficult choices would be crippling to our state's economy and, ultimately, to patients.

Given these reasons and that the current moratorium on the medical device excise tax will end December 31, 2019, we are thankful that this taskforce will be closely examining the effects this short-term policy will have for the industry's long-term success. We look forward to working with you to put a permanent end to a policy that inhibits innovation and impedes our common goals of growing Pennsylvania's economy and improving patient care. Life Sciences PA and our 840 member companies remain committed to advocating for a predictable environment that supports the medical technology ecosystem, and the benefits its research and development provide to patients and their families.

Sincerely,



Christopher P. Molineaux
President and CEO

RESEARCH AMERICA 30 YEARS 1989-2019

June 14, 2019

The Honorable Pat Toomey
Senate Finance Committee
Co-Lead, Health Taskforce
Washington, DC 20510

The Honorable Bob Casey
Senate Finance Committee
Co-Lead, Health Taskforce
Washington, DC 20510

241 18th Street South
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E info@researchamerica.org

Dear Senator Toomey and Senator Casey,

On behalf of Research!America, the nation's largest not-for-profit advocacy and public education alliance committed to faster medical and public health progress, we appreciate the opportunity to provide input as you examine health-related tax policies.

We are writing to urge you to move swiftly to repeal the medical device excise tax this year.

From diagnostics that empower early detection of disease and appropriate care, to restorative devices that enhance sight, hearing and mobility, new medical technologies play a pivotal role in propelling medical and public health progress. These devices also hold tremendous potential for driving down healthcare costs. For example:

- New diagnostics that enable early and accurate diagnosis are crucial to saving lives and dollars. Diagnostic errors lead to misdirected, costly healthcare, they are the leading cause of medical malpractice lawsuits, and they contribute to one in twenty hospital deaths. In fact, the costs of unnecessary harm, tests and legal payouts due to misdiagnoses total over $100 billion annually.

- Cutting edge prosthetics and assistive devices, sophisticated wound care, and continuously refined tools for rapid, onsite healthcare delivery provide a more successful path to health and independence for wounded warriors and others who sustain serious injuries.

- Medical devices are lifelines for individuals with cardiovascular disease, diabetes, ALS, COPD, kidney disease and a host of other life-threatening illnesses, and foster mobility and improved quality of life for those with conditions such as muscular dystrophy, paralysis, osteoarthritis and bone cancer.

Our goal as a nation should be to accelerate progress in the medical device arena. Unfortunately, the medical device excise tax has the opposite effect. In a 2018, analysis of U.S. investments in medical and health R&D commissioned by Research!America and developed by the analytics firm TEConomy, estimated investment in new medical technologies slowed significantly after the medical device excise tax went into effect, and steadily increased when the tax was suspended.

Repealing the medical device excise tax is a pragmatic means of decreasing healthcare costs and bolstering medical innovation to the benefit of patients now and in the future. Congress has twice acted on a bipartisan basis to suspend this tax. It is time for full repeal.

Thank you for your leadership and for considering our views.

Sincerely,

Mary Woolley
President and CEO

Todd M. Fruchterman, MD, PhD
President
Medical Solutions Division

3M Health Care Business Group

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651 733 7603 Office
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June 14, 2019

The Honorable Pat Toomey
248 Russell Senate Office Building
Washington, DC 20510

The Honorable Bob Casey
393 Russell Senate Office Building
Washington, DC 20510

Dear Senator Toomey and Senator Casey:

Thank you for your commitment to find long-term solutions to the many expired or expiring temporary tax provisions that will be considered by the Senate Finance Committee in 2019. We appreciate the opportunity to provide comments to the Health Tax Taskforce that is under your leadership and are eager to work with the Committee on this effort. Specifically, we bring to your attention the importance of permanently repealing the medical device tax because of its harmful impacts on American jobs and American innovation.

3M is one of the world's leading innovative and science-based companies, headquartered in Minnesota with approximately 37,000 employees in the United States, the vast majority of whom are in manufacturing and R&D jobs. Today, more than 60,000 3M products are used in homes, businesses, schools, hospitals and other industries. One third of our sales come from products invented within the past five years, thanks to innovations from the thousands of researchers and scientists we employ. The medical device tax threatens this ingenuity.

3M Health Care makes innovative products from stethoscopes and surgical preps to sterile drapes and wound dressings. Our products work to prevent infections, heal wounds, and monitor patients throughout their continuum of care. 3M Health Care works to enhance patient safety and help improve patient outcomes, thereby reducing the overall cost of care. We view a tax on innovative technology and solutions as incompatible with the goals of a better, less costly health care system. For your review, we have attached some examples of 3M products that are used every day in hospitals across this country that are subject to this onerous tax.

When the medical device tax was in effect from 2013-2015, 3M's ability to reinvest in jobs and R&D (that would lead to improving patient care) was significantly impacted. 3M paid more than $20 million per year over a three-year period, which impacted our ability to make investments in plant upgrades and expansions and forced certain divisions of 3M to freeze headcount and jobs. In contrast, since the tax has been suspended, 3M Health Care has invested $200 million in R&D over the past three years and has increased U.S. employment by more than 10%, including in manufacturing and production. We have invested these dollars in R&D, capital equipment, and jobs to create new and improved technologies and solutions that are on the market today.

Todd M. Fruchterman, MD, PhD
President
Medical Solutions Division

3M Health Care Business Group

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If the device tax were to go back into effect in 2020, we now anticipate having to pay greater than $25 million to comply with the tax – which would once again harm our ability to make the investments in jobs, R&D, and manufacturing-related activities. Furthermore, please recall that this tax is paid bi-weekly and is a tax on sales, *not* profit. Accordingly, if a company has a tight profit margin (i.e., start-up medical device manufacturers that make up a large portion of the industry), it would be disproportionately impacted by the tax.

We encourage the Health Tax Taskforce to permanently repeal this tax because temporary suspensions breed uncertainty and undercut critically needed investments. In 2017, Congress failed to act on the medical device tax prior to its two-year suspension expiring, leaving companies wondering if they were liable to pay the tax to the Internal Revenue Service (IRS) starting January 1, 2018. Congress did not sign into law H.R. 195, the continuing resolution to fund the government, which included an additional two-year suspension of the device tax until January 22, 2018, creating confusion for companies as to what was owed and if fines were going to start being levied by the IRS.

As one of the world's leading innovative and R&D companies, we experienced firsthand the realistic implications of this tax. Multiple studies and reports in recent years have confirmed the job losses and the impact this tax has on future growth of an industry that is creating life-saving technologies. We stand ready to work with the Committee and the rest of Congress to permanently repeal this flawed policy so that the necessary R&D dollars are available for investments in next generation technologies that will yield meaningful solutions.

Again, thank you for providing an opportunity to submit comments to the Senate Finance Committee on this longstanding issue. Please see the attached addendum for additional information.

Sincerely,

Todd M. Fruchterman, MD, PhD

Todd M. Fruchterman, MD, PhD
President
Medical Solutions Division

3M Health Care Business Group

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Addendum

3M Health Care makes innovative products that help improve patient outcomes. The following list includes just a few examples of 3M products impacted by the medical device tax:

- Surgical preps that kill bacteria and sterile surgical drapes that help prevent surgical complications such as costly and harmful infections;
- Patient warming systems that actively maintain a patient's normal temperature during surgery, proven to help reduce infection risk, reduce blood loss and speed recovery;
- Instrument sterilization and monitoring systems that help prevent infection and increase turnaround time for instruments used in the Operating Room;
- Clear IV wound dressings, skin friendly medical tapes and securement systems for holding critical tubing and other instruments in place;
- Littmann brand stethoscopes, the world leading, most iconic, patient assessment device used by doctors and nurses every day.

AMERICAN ASSOCIATION OF
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President
GANESH RAO, MD
Houston, Texas

June 14, 2019

The Honorable Patrick Toomey
United States Senate
248 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Robert Casey, Jr.
United States Senate
393 Russell Senate Office Building
Washington, D.C. 20510

Submitted via: Health_Tax_Taskforce@finance.senate.gov

Subject: Health Tax Taskforce Comments

Dear Senators Toomey and Casey,

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), we appreciate the opportunity to submit comments regarding the medical device excise tax to the health tax taskforce examining temporary tax provisions. Neurosurgery is a medical specialty that is highly dependent on advances in medical technology. As such, repealing the medical device tax is among neurosurgery's top legislative priorities.

Since its inception, the AANS and the CNS have long called for the repeal of the 2.3 percent medical device excise tax due to our concerns that the tax will adversely affect medical innovation and patient care. Because of medical technology, patients are living longer, healthier and more productive lives. Over the past three decades, rapid technological advances have helped increase life expectancy in the U.S., rates for major diseases have been reduced significantly, and America continues to be a leader in the development of new therapies and tools for treating deadly or debilitating neurologic conditions such as stroke, degenerative spine disease, brain aneurysms, chronic pain, traumatic brain injury, Parkinson's Disease, spinal cord injury, brain tumors and epilepsy.

Furthermore, it makes economic sense to repeal the medical device tax permanently. For example, according to a recent report, as many as 195,000 jobs may be lost due to the tax, either through layoffs or forgone jobs that would have been created.

Clearly, our health care system needs innovation to improve patient care and save lives. Unfortunately, this tax stifles innovation and reduces patient access to new lifesaving technologies. The AANS and the CNS agree with Chairman Grassley and Ranking Member Wyden that it is "time for Congress to end its bad habit of waiting until the last minute to extend temporary tax policy" and that extending "tax incentives for a year or two at a time is no way to craft public policy."

WASHINGTON OFFICE
KATIE O. ORRICO, *Director*
25 Massachusetts Avenue, NW, Suite 610, Washington, DC 20001
Phone: 202-628-2072 Fax: 202-628-5264 E-mail: korrico@neurosurgery.org

We, therefore, look forward to working with you to develop permanent policy solutions that better support medical innovation and increase treatment options for our patients.

Sincerely,

Christopher I. Shaffrey, President
American Association of Neurological Surgeons

Ganesh Rao, MD, President
Congress of Neurological Surgeons

Staff Contact:
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Thomas Evers
Vice President
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June 12, 2019

The Honorable Patrick Toomey
The Honorable Robert Casey, Jr.
Co-Leads, Senate Finance Committee Taskforce on Health Expiring Provisions
219 Dirksen Senate Office Building
Washington, DC 20510

Submitted via: Health_Tax_Taskforce@finance.senate.gov

Re: Senate Finance Committee Taskforce on Health Taxes Request for Comment; Impact of the Medical Device Tax

Abbott commends the Committee for forming a bipartisan taskforce to address health taxes. This letter is in response to the taskforce's work on the 2.3% excise tax on medical devices, which will be reinstated effective Jan. 1, 2020. Abbott supports a full repeal of the medical device tax to preserve innovation that helps people live healthier lives.

At Abbott, we are creating the future of healthcare through life-changing technologies and products that drive breakthroughs in prevention, diagnosis and treatment. Innovation is the essence and lifeblood of Abbott, and we help people live longer and healthier lives at all ages through our technologies. Abbott is headquartered in the United States and employs 30,000 people around the country, approximately 4,500 of which are scientists, engineers and other research staff who are dedicated to developing breakthrough technologies to improve healthcare. Each year, Abbott invests over $2 billion in research and development, with medical device investment comprising a major share of that total figure.

Through its leadership in advanced medical devices, Abbott is now developing the next generation of healthcare technology through connected care, which closely integrates new digital technologies with the patient experience. Connected care enables physicians to better monitor patients' conditions in real time, allowing for more effective and efficient care. Abbott's FreeStyle Libre continuous glucose-monitoring system delivers fast, reliable glucose levels through a small sensor applied to the back of the arm, without the pain and inconvenience of fingersticks. Our Confirm Rx is an implantable device that tracks the heart's rhythm remotely, 24-hours a day, and sends data directly to the patient's doctor through a mobile application. This information allows doctors to accurately diagnose abnormal heart rhythms and make better treatment decisions for their patients. These are just some of the innovative technologies we are developing to help people live healthier lives and generate efficiencies and cost savings for the healthcare system.

The medical device tax is a significant barrier to innovation that diverts resources away from research and development, and negatively impacts the U.S. economy. The medical technology industry employs almost 2 million Americans[1] with an average salary of $84,100 annually –1.85 times the national average.[2] The U.S. medical technology industry saw its jobs ranks fall by nearly 29,000 while the medical device excise tax was in effect (2013 – 2015), according to data from the U.S. Department of Commerce.[3]

Additionally, the medical technology industry is a strategic industry for the U.S. economy, and should be a focus for economic growth. The United States remains the largest medical device market in the world, with a market size of approximately $156 billion, representing about 40 percent of the global medical device market in 2017.[4] The medical technology industry has consistently run a trade surplus and accounts for $53 billion of U.S. exports with a positive trade balance.[5] The U.S. needs to prioritize industries that are highly competitive, particularly the medical technology industry, where we face significant threats from our global competitors.

Reinstatement of the medical device tax will harm patients, employees, U.S. innovation, and all device companies (particularly U.S. companies who benefit from a strong U.S. medical technology market). It is imperative that Congress fully repeal this onerous tax. Permanent repeal of the medical device tax will provide the medical technology industry with the certainty to plan for long-term investment in research and development, job creation and other capital improvements to create the next generation of treatments and cures. Short-term delays, while preferable to implementation of the tax, do not unlock the full benefit of investment and innovation, as companies cannot make long-term investments and plan through short-term delays.

We thank the committee for their continued attention to such an important matter for U.S. patients, employees and innovative companies.

Sincerely,

TE:taw

cc: The Honorable Chuck Grassley, Chairman
The Honorable Ron Wyden, Ranking Member

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[1] https://www.lifechanginginnovation.org/jobs-by-state
[2] http://www.chi.org/uploadedFiles/Industry_at_a_glance/BattelleFinalAdvaMedEconomicImpactReportMarch2012.pdf
[3] https://www.advamed.org/newsroom/press-releases/medtech-industry-lost-nearly-29k-jobs-while-device-tax-effect
[4] https://www.selectusa.gov/medical-technology-industry-united-states
[5] Data provided by the U.S. Department of Commerce and the International Trade Commission, April 2018

CHAMBER OF COMMERCE
OF THE
UNITED STATES OF AMERICA

NEIL L. BRADLEY
EXECUTIVE VICE PRESIDENT &
CHIEF POLICY OFFICER

1615 H STREET, NW
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June 14, 2019

The Honorable Patrick Toomey
United States Senate
Washington, DC 20510

The Honorable Robert Casey, Jr.
United States Senate
Washington, DC 20510

The Honorable Michael Enzi
United States Senate
Washington, DC 20510

The Honorable Mark Warner
United States Senate
Washington, DC 20510

Dear Senators Toomey, Casey, Enzi, and Warner:

The U.S. Chamber of Commerce appreciates the bipartisan work of the Senate Finance Committee and the committee's health tax task force to address temporary health care tax policies instituted by the Affordable Care Act (ACA). The Medical Device Tax, the Health Insurance Tax, as well as the "Cadillac Tax," have a harmful effect on jobs, health insurance premiums and employer sponsored health care coverage. The Chamber strongly supports proposals to fully repeal these taxes, and supports further suspending them in the meantime.

The employer-sponsored health care system provides invaluable benefits to employees and employers alike. More than 180 million Americans currently rely on the health coverage and benefits offered by employers. The employer-sponsored system must be permitted to allow employers to customize the benefits offered to best serve the needs of their workforce and appropriately manage cost growth in health care.

Medical Device Tax (MDT)

The 2.3% tax on the sale of virtually all medical devices leads to increased health care costs, undercutting one of the primary goals of ongoing health care reform efforts. From routine preventative services, to advanced diagnostic technology, to emergency medical equipment essential for first-responders, medical devices are a ubiquitous component of the care continuum. Structured to act as an ad valorem tax, the MDT jeopardizes the progress Americans have made to achieve outcomes-based care delivery by discouraging greater use of precision medicine.

Furthermore, by driving up the cost of medical technology, this tax undermines America's global leadership position in product innovation, clinical research, and patient care. According to a 2017 report published by the Medicare Payment Advisory Commission, most companies within the industry are small businesses, as "approximately 73% of all medical device firms have fewer than 20 employees and 88% have fewer than 100 employees."

The Medical Device Manufacturers Association found in an industry survey that 72% of their members "slowed or halted job creation" to pay for the tax, and if the tax were eliminated, "80% would increase R&D investments in the cures and therapies." Full repeal of the device tax would provide critical long-term relief to the medical technology industry and would spur the innovation necessary to find next generation treatments that Americans deserve.

Health Insurance Tax (HIT)

Permanently repealing the HIT would provide critical and timely relief from the ACA's perverse and harmful tax on health insurance premiums, which would provide immediate assistance to millions of Americans struggling to afford coverage in the individual and small group health insurance markets. According to one recent study by Oliver Wyman, imposing the tax in 2020 would hit families in the small group market, which serves small business across the country, with an increase in premiums of $479.00 and seniors enrolled in Medicare Advantage would face a 55.7% increase in costs from $393.05 in 2018 to $612.09 in 2019.

Further, due the implementation of this provision, the HIT will levy an estimated $16.0 billion fee on insurers. The regulations subject all premiums collected by the health insurers to federal income tax, including the amount that is collected to be passed onto the IRS to pay the tax. Therefore, in order to pay the IRS the statutorily dictated amount, even more must be collected in premiums before the insurers pay income tax on that amount. As a result, the impact of the tax is significant and extends well beyond those in the individual market, increasing premiums for scores of small business owners, employees, and senior citizens covered by Medicare Advantage as well as Medicare Part D prescription drug coverage.

Cadillac Tax

Though scheduled to be imposed in 2022, this tax is already affecting employers' health benefit offerings now. Its imposition looms over employers' negotiations with unions on multi-year labor contracts as well as employers' health benefit offerings just around the corner.

Equal to 40% of the value of group health plans that exceed a projected amount of $11,100 for individual coverage and $29,750 for family plans in 2020, the Cadillac Tax is applicable to employer and employee premium contributions for fully insured or self-funded businesses that offer robust, flexible health coverage to their employees. In addition, the tax is also applicable to contributions made towards health savings accounts, health reimbursement arrangements, and flexible spending accounts. This undermines health reform efforts by discouraging flexible employer plan offerings and indirectly drives up out of pocket costs for employees in the form of higher payroll taxes, deductibles and co-pays.

Moreover, because of the way the Cadillac Tax provision was drafted, it will eventually affect all plans and essentially fine employers for offering health coverage to their employees. As annual increases are tied to general inflation using the consumer price index, the tax neglects to account for the pace of rising medical costs, effectively penalizing employers and their employees for economic forces beyond their control.

Compounding the issue of affordability even further, the tax is likely to have an adverse effect on working Americans who live in high-cost areas of the country. Employers are unlikely to increase wages as a result of this tax or to off-set benefit reductions. Instead, in order to avoid the tax, employers may either cut benefits or shift more of the costs onto the worker in the form of higher deductibles, or co-pays.

According to the Kaiser Family Foundation Health Tracking Poll released June 11, 2019, "at least one-fourth of insured adults reporting it is difficult to afford to pay their deductible (34 percent), the cost of health insurance each month (28 percent), or their co-pays for doctor visits and prescription drugs (24 percent). These trends correspond with the ongoing trend of rising premiums, deductibles, and other types of cost sharing in the employer-sponsored insurance market."

Conclusion

The Chamber firmly believes that greater innovations in employer-sponsored coverage will continue to provide the reduced costs, expanded access, and improved quality that hardworking Americans deserve, and we look forward to working with you to support health care reform efforts that achieve these goals, as well as protecting American jobs. We urge you to preserve the longstanding tax treatment of employer-sponsored coverage for employers and employees alike by supporting permanent repeal of these harmful taxes.

Sincerely,

Neil L. Bradley

AFL-CIO

LEGISLATIVE ALERT

June 14, 2019

The Honorable Patrick Toomey
Co-Lead, Health Tax Taskforce
United States Senate Committee on Finance
Washington, DC 20510

The Honorable Bob Casey
Co-Lead, Health Tax Taskforce
United States Senate Committee on Finance
Washington, DC 20510

Dear Senators Toomey and Casey:

We write to alert you to an area of tax policy that demands immediate attention: repeal of the 40 percent "Cadillac" tax on workers' health benefits.

Congress has acted twice to delay this tax – its current effective date is January 1, 2022 – but the uncertainty surrounding the possible impact of the tax is already pushing employers to hollow out the health care benefits of their workers. It is important that the excise tax on high premium health plans be permanently repealed to reverse the pronounced trend of increasing out-of-pocket costs for individuals with employment-based health insurance.

When this tax was enacted, proponents of the tax argued that it would incentivize employers to move away from "overly generous" health care coverage and to higher deductibles, copayments, and coinsurance for workers. Forcing workers to have more "skin in the game," they argued, would reduce "overutilization" of health care services as people would be pushed to consider the financial implications of seeking care. Surveys of employers over the years have shown that they have indeed reduced coverage under their health plans in anticipation of the tax.

In the decade since the tax was enacted, however, it is clear that the health care affordability crisis now affects millions of individuals with employment-based coverage. From 2008 - 2018, the general annual deductible for family coverage has increased 212 percent, while workers' earnings have only increased 26 percent, barely edging the 17 percent inflation rate over the same span, according to the Kaiser Family Foundation. Similarly, from 2006 - 2016, workers' spending on coinsurance as increased nearly 50 percent, according to the Peterson-Kaiser Health System Tracker.

Unsurprisingly, this explosion in out-of-pocket costs has coincided with growing evidence that the affordability crisis is harming workers' health and financial security. For example, a May 2019 Kaiser Family Foundation/LA Times survey of adults with employment-based coverage found that out-of-pocket costs are taking an alarming toll on America's working families. Forty percent of respondents reported that someone in their family had difficulty affording a health care or insurance cost -- with meeting deductibles, addressing unexpected medical bills, and paying co-pays presenting the greatest problems. About half said someone in their family went without care or postponed treatment in the last year because of cost. Seventeen percent indicated they had to make a difficult choice in order to afford care, such as increasing their debt, skipping meals, or canceling a vacation.

This tax is clearly having a negative impact on working families, and its repeal is overdue. We believe that permanent repeal of the 40 percent tax should take priority over many of the "tax extenders" that are targeted at corporations making abundant profits. We hope that we will have opportunities to discuss the benefits of repealing the 40 percent health benefits tax with you as part of the Health Tax Taskforce process.

Sincerely,

William Samuel
Director, Government Affairs

Elizabeth P. Hall
Vice President, Federal Affairs
Head of Washington, DC Office
(202) 628-7840
Elizabeth.Hall@Anthem.com

June 14, 2019

Committee on Finance
United States Senate
219 Russell Senate Office Building
Washington, D.C. 20510

Submitted via email: Health_Tax_Taskforce@finance.senate.gov

Re: Taskforce on Health Related Tax Extenders Request for Comments

Dear Senators Toomey, Casey, Enzi, and Warner:

Anthem, Inc. (Anthem) appreciates the opportunity to provide comments to the U.S. Senate Committee on Finance taskforce on health related tax extenders. Anthem is one of the nation's leading health benefits companies, serving over 74 million consumers through its affiliated companies, including more than 40 million within its family of health plans. As a committed participant in the commercial, Medicare and Medicaid managed care markets, we have significant experience in coordinating and delivering health care. We support the Senate Finance Committee's bipartisan efforts to examine temporary health care related tax provisions that have expired, or will expire, between December 31, 2017 and December 31, 2019, and look forward to working with you as you seek solutions that will provide long-term financial certainty to millions of Americans who rely on access to quality, affordable health care coverage.

Anthem appreciates the Committee's inclusion of the "annual fee on health insurance providers (sec. 9010 of the Patient Protection and Affordable Care Act)" in the May 16, 2019 report entitled "Background Related to Certain Temporary and Disaster Relief Tax Provisions." We strongly urge the Committee to advance legislation that would extend the current moratorium on the Affordable Care Act's (ACA's) Health Insurance Tax (HIT) in 2019 to cover 2020 and 2021, as soon as possible. As you know, Congress previously approved bipartisan legislation to place a moratorium on the HIT for calendar years 2017 and 2019. We believe there is no more immediate and direct way for Congress to lower premiums for consumers, protect benefits for Medicare Advantage (MA) beneficiaries, and lower costs for states that utilize managed care to serve all or segments of their respective Medicaid populations, than by extending the HIT moratorium. As health plans finalize their products and prices for 2020 in the coming months, it is important that Congress take legislative action to extend the HIT moratorium as soon as possible.

Anthem strongly supports bipartisan legislation (S. 172) introduced by U.S. Sens. Cory Gardner (R-CO), Jeanne Shaheen (D-NH), John Barrasso (R-WY), and Doug Jones (D-AL) that would extend the HIT moratorium through 2020 and 2021. If the HIT moratorium is not extended, an additional three to five percent will be added to the cost of premiums for individuals and small businesses, benefits will be reduced for MA beneficiaries, and costs will be added to state budgets in 2020. An August 2018 Oliver Wyman analysis found that if the tax were to return in 2020, premiums would increase, on average, $196 for individuals in the non-group market, $154 for individuals and $479 for families in the small group market, $158 for individuals and $458 for families in the large group market. Further, a return of the tax in 2020 would lead to a negative impact of $241 on each MA enrollee in the form higher premiums and/or less benefits and increase the cost of coverage by $157 for each Medicaid beneficiary served by managed care.

Congressional action to further delay the moratorium on the HIT through 2020 and 2021 will provide continued financial relief for millions of American individuals and families, small businesses, and seniors with health insurance coverage. We urge the Committee taskforce to follow the successful bipartisan approach Congress has taken twice before and pass legislation to extend the HIT moratorium for 2020 and 2021, as soon as possible.

Additionally, Anthem supports Congress providing further relief from the ACA's 40-percent excise tax on employer-provided health benefits (Cadillac Tax). Taxes impacting health benefits result in higher monthly premiums for consumers and create destabilizing incentives to the employer-provided health care market. As a result of bipartisan support in Congress, the Cadillac Tax has twice been delayed from taking effect. Unless Congress takes action again, the Cadillac Tax is scheduled to go into effect on January 1, 2022. While the tax is in part intended to discourage rich benefits, it does not contain all of the appropriate adjustments, and a large share of the consumers with employer-provided health coverage will end up paying for this tax.

Thank you for your consideration of our recommendations to extend the moratorium on the ACA's health insurance tax to cover 2020 and 2021, and for providing further relief from the Cadillac Tax. Anthem respectfully requests the opportunity to participate in any stakeholder feedback sessions related to the Committee taskforce's ongoing work. Should you have any questions or wish to discuss our comments further, please contact Samuel Marchio, Regional Vice President of Federal Affairs at (202) 628-7831 or Samuel.Marchio@Anthem.com.

Sincerely,

Elizabeth P. Hall
Vice President, Federal Affairs

700 6th Street NW
Suite 400
Washington DC 20001
bd.com

June 14, 2019

The Honorable Pat Toomey
U.S. Senate
248 Russell Senate Office Building
Washington, DC 20510

The Honorable Bob Casey, Jr.
U.S. Senate
393 Russell Senate Office Building
Washington, DC 20510

Dear Senators Toomey and Casey:

BD appreciates the opportunity to submit comments to support the work of the Senate Finance Committee's bipartisan health taskforce. We urge the task force to support the full and immediate repeal of the medical device tax by ensuring the Protect Medical Innovation Act (S. 692) is included in legislation that is considered by the Committee.

Our nation's medical technology industry contributes more than $380 billion to the economy, and employs over 519,000 people. I have the privilege of working alongside nearly 24,000 BD associates in the U.S. who work passionately every day to advance the world of health by improving medical discovery, diagnostics and the delivery of care. Our innovations help customers enhance outcomes, lower costs, increase efficiencies, improve safety and expand access to health care.

In order for innovation to thrive, there must be an ecosystem that supports continued investment. Unfortunately, the 2.3% excise tax on medical device sales places significant pressure on the innovation ecosystem. The tax impacts our ability to invest in research and development as well as infrastructure. In fact, many medical technology companies reduced their research and development expenditure by a combined $34 million in the first year the tax took effect. Additionally, according to the U.S. Department of Commerce, the med tech industry lost 29,000 jobs while the excise tax was in effect.

In January of last year, Congress acted in a bipartisan way to once again temporarily suspend the medical device tax for two years. While efforts to temporarily suspend the tax are a welcomed reprieve, BD and other life sciences leaders need to be able to plan for the future with an understanding of the landscape several years out. Only a permanent repeal of the tax would give us the confidence we need to invest in future innovation that will drive improvements in health care and support a successful medical device industry. Congress must act now to end the medical device tax to boost investment and innovation in medical technology.

The value of permanent repeal can be seen in the impact the first suspension had on BD. We were able to invest the savings generated from the suspension in an array of exciting and promising projects that will yield benefits to patients, providers and research communities served by the medical device industry. Without the predictability and certainty provided by a full repeal of the tax, we will not be able to sustain a robust pipeline of cutting-edge technologies such as these into the future.

Enactment of S. 692 will ensure the long-term success of this vital industry, for the hundreds of thousands of people in the U.S. working in medical technology, and the countless patients that reap the benefits of new innovative technology produced every day. If this does not happen, the medical device tax will return at the end of this year, and with it the barrier to bringing critical, new products to patients and ensuring a healthy economy fueled by innovation.

Thank you for your interest in this matter, and we look forward to our continued engagement with the Committee on ways that will help us to continue *advancing the world of health*.

Sincerely,

Elizabeth Woody
Vice President, Public Affairs

BIOCOM

June 13, 2019

The Honorable Pat Toomey
U.S. Senate
248 Russell Senate Office Building
Washington, DC 20510

The Honorable Bob Casey, Jr.
U.S. Senate
393 Russell Senate Office Building
Washington, DC 20510

Re: Medical Device Tax Repeal

Dear Senator Toomey and Senator Casey:

Biocom is the largest, most experienced leader and advocate for California's life science sector, which includes biotechnology, pharmaceutical, medical device, genomics and diagnostics companies of all sizes, as well as research universities and institutes, clinical research organizations, investors and service providers. With more than 1,200 members dedicated to improving health and quality of life, Biocom drives public policy initiatives to positively influence the state's life science community in the research, development, and delivery of innovative products. California's life sciences industry generates over $346 billion in annual economic output, boosts the state's total gross product by $195.8 billion, supports almost 1.3 million jobs, and increases labor income by more than $104 billion per year[1].

Biocom appreciates the efforts the Senate Committee on Finance is undertaking to examine certain tax provisions and find long-term solutions and, specifically, your leadership leading the taskforce on health care. **We welcome the opportunity to provide comments and would like to highlight the importance of permanently repealing the medical device excise tax, which enjoys bipartisan support in both houses of Congress.**

The 2.3 percent excise tax on the sale of medical devices created by the Affordable Care Act (ACA) increases the effective tax rate for the medical technology industry and stifles innovation by taking financial resources away from research and development (R&D), job creation, capital expansion, and other investments. It is especially burdensome for small companies that are not yet profitable because it is a tax on revenue, not profit. Of the 6,500 medical device manufacturers in the United States, approximately 80 percent employ fewer than 50 employees.

[1] *Biocom 2019 Economic Impact Report Databook*

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Thanks in no small part to your leadership and the efforts of the Committee on Finance, Congress has suspended the tax twice for a total of four years. Notably, by the end of this year, Congress will have suspended the tax for longer than it was in effect, with no measurable impact on coverage. Despite prior concerns that repealing the tax would negatively affect the ACA, its suspension clearly demonstrates that it will not have a significant impact on the overall finances of the health care law. Indeed, the tax does not have any real policy justification, is not connected to individual insurance coverage, and serves as a mere revenue raiser to offset the budgetary impact of the ACA. On the contrary, the suspension of the tax has led to increased investments in R&D, capital expansion, and hiring, which benefits biomedical research and development.

Over the past decades, the medical device industry has given patients access to cutting edge, life-saving technologies, from insulin pumps and heart valves to pacemakers and artificial limbs, which have helped increase life expectancy while reducing the burden of chronic diseases. Medical technology has improved efficiencies and produced savings to the system through minimally invasive procedures, more precise and accurate diagnostics, and devices that reduce hospitalizations and recovery times. These improvements mean better outcomes and higher-quality care for patients, which also lowers cost in the long run.

All these gains are at risk if the medical device tax is not repealed. Taxing the development of medical technology imposes an unnecessary penalty on these savings and erodes the value these technologies provide to the health care system. The current suspension of the tax expires on December 31, 2019. Reinstating the tax will reduce future investments in R&D, which will put the discovery of new breakthrough medical technologies at risk and ultimately hurt patients.

The medical device tax puts innovation, economic growth, and jobs in jeopardy. The medical device industry needs certainty to plan for long-term investments in R&D. Biocom encourages the taskforce to recommend full repeal of the medical device excise tax and urges the Committee on Finance to move promptly to consider legislation that includes repeal to ensure that medical technology manufacturers have the resources to develop the breakthrough products and technologies of tomorrow.

Biocom is dedicated to improving patient access to innovative technologies and thanks you again for the opportunity to provide these comments. We look forward to a continued dialogue with the taskforce. If you have any questions about these comments, please contact Laure Fabrega, Director of Federal Policy and Government Affairs at lfabrega@biocom.org.

Sincerely,

Joe Panetta
President and CEO
Biocom

BIOUTAH

PO Box 58531
Salt Lake City, UT 84158

www.bioutah.org

June 14, 2019

The Honorable Pat Toomey
United States Senate
Washington, DC 20510

The Honorable Bob Casey, Jr.
United States Senate
Washington, DC 20510

Dear Senator Toomey and Senator Casey,

BioUtah is pleased to provide comments to the Task Force in response to the Senate Finance Committee's efforts to develop meaningful solutions to temporary tax policies. Specifically, BioUtah, on behalf of our state's numerous medical device companies, writes to express our strong support for permanent repeal of the 2.3% excise tax on the sale of medical devices, as provided in S.692, the *Protect Medical Innovation Act of 2019*. We appreciate your leadership in seeking input from stakeholders.

BioUtah is an independent 501(c)(6) trade association serving Utah's life sciences industry. Its members are diverse, with strengths in medical device manufacturing and services, biotechnology, pharmaceuticals, diagnostics and healthcare IT. Together, we form an ecosystem that fosters collaboration, promotes innovation, and advances healthcare.

Ending the device tax is of paramount importance to Utah's medical device companies. Patients rely on the cutting-edge products that these companies provide. Medical devices have revolutionized health care—diagnosing disease sooner, improving patient outcomes and reducing costs. Industry innovation allows patients to experience less-invasive procedures and shorter recovery times.

Although the tax is currently delayed until January 1, 2020, repeated suspensions afford little certainty to companies that must plan for the long term and decide how much to invest in research and development, capital improvements and expansion. Many companies are even now in the throes of preparing budgets that extend well beyond the expiration of the current moratorium. Action to repeal the tax before year's end will give companies visibility in planning for the future.

Stability is essential to drive the next generation of medical breakthroughs. The tax harms companies both large and small. For large, established companies, the device tax equals tens, if not hundreds, of millions of dollars that could be used to further innovation and create jobs. Since the tax is imposed on the first dollar of revenue earned, smaller companies who have not yet achieved profitability or are only marginally profitable, are hit especially hard.

The tax also has implications for investment. The tax seriously dilutes interest in investing in medical device startups because the investment community realizes the government will receive 2.3% of top-line sales long before these companies become profitable.

Medical device manufacturers in Utah are committed to bringing innovations to patients. We appreciate your support in the past to continue to delay the tax. Repeal, however, is long overdue, with large bipartisan majorities agreeing that the tax should be rescinded.

In Utah, medical device companies, when combined with other life sciences sectors such as pharmaceuticals, diagnostic and biotech, account for a significant segment of the state's growing life sciences industry, which, overall, supports 130,000 jobs and creates $13 billion in state GDP. Ultimately, the device tax is a punitive tax on innovation and growth, which results in opportunity costs and negative effects on both patients and jobs.

In closing, BioUtah appreciates the opportunity to share our views and urges the Task Force to recommend, and the Finance Committee to pass, full repeal legislation. We look forward to working with you to move expeditiously on this critical issue.

For questions and additional information, please contact me by email at Kelvyn@bioutah.org or by phone at 801-580-4523.

Sincerely,

Kelvyn Cullimore
President and CEO

BETTER MEDICARE ALLIANCE

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BetterMedicareAlliance.org
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June 14, 2019

The Honorable Patrick Toomey
United States Senate
Co-Lead, Health Tax Task Force
248 Russell Senate Office Building
Washington, DC 20510

The Honorable Robert Casey, Jr.
United States Senate
Co-Lead, Health Tax Task Force
393 Russell Senate Office Building
Washington, DC 20510

The Honorable Michael Enzi
United States Senate
Health Tax Task Force
379A Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
United States Senate
Health Tax Task Force
703 Hart Senate Office Building
Washington, DC 20510

RE: BMA Comments Urging Long-Term Solution to the Health Insurance Tax

Dear Senator Toomey, Senator Casey, Senator Enzi, and Senator Warner:

As the Senate Finance Committee Health Tax Taskforce considers long-term solutions to temporary tax policy, the Better Medicare Alliance (BMA) appreciates the opportunity to provide input regarding the annual fee on health insurance providers, known as the Health Insurance Tax (HIT), which is due to be reinstated in 2020, unless Congress acts.

As the leading Medicare Advantage advocacy coalition representing 134 organizations providing care for the 22 million Medicare beneficiaries under Medicare Advantage, BMA advocates on policies that will further strengthen Medicare Advantage as a high-quality, cost-effective choice for seniors and individuals with disabilities. Delaying or permanently repealing the HIT is a top priority for BMA, precisely because failure to do so will lead to a spike in premiums for Medicare Advantage beneficiaries, many of whom cannot afford a nearly $250 annual increase in health costs.[1]

Given your leadership on the Health Tax Taskforce announced last month by the Senate Finance Committee Chairman Charles Grassley and Ranking Member Ron Wyden, we strongly urge that as you review health-related tax policies, you seek to permanently repeal or, at a minimum, delay the HIT through 2021.[2]

BMA supports S. 172, legislation that delays the HIT through 2021, and S. 80, legislation that permanently repeals the HIT. If Congress does not take timely action to suspend the HIT, millions of American seniors and others with health insurance coverage could face a major premium increase of more than $20 billion[3] when the HIT returns.

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[1] *"Analysis of the Impacts of the ACA's Tax on Health Insurance in Year 2020 and Later,"* Oliver Wyman; August 28, 2018. Web.

[2] *Grassley, Wyden Announce Taskforces to Find Long-Term Solutions to Temporary Tax Policy*, Press Release, U.S. Senate Committee on Finance. May 16, 2019. Web.

[3] *"Analysis of the Impacts of the ACA's Tax on Health Insurance in Year 2020 and Later," Oliver Wyman; August 28, 2018. Web.*

BETTER MEDICARE ALLIANCE

As it is, many current and future retirees are at risk of not being able to afford the costs of health care in retirement. Nearly half of Medicare Advantage enrollees live on less than $24,000 per year.[4] According to a recent analysis, 62% of retirees age 65+ years old, as well as about three out of four non-retired adults age 50 to 64, have less in total retirement savings than what experts recommend saving for health care costs alone.[5]

For these reasons and more, America's seniors are increasingly choosing Medicare Advantage. They appreciate the focus on prevention and disease management and the offering of enhanced benefits and services, such as vision, hearing, fitness and wellness, and dental coverage, as well as the cap on out-of-pocket costs. These beneficiaries rely on Medicare Advantage for the high-value, integrated care it provides, offering the right care in the most appropriate setting.

We appreciate the decision Congress made to delay the HIT for 2019, but the threat of the HIT remains. According to a recent analysis, without the delay of the HIT for 2019 the nationwide annual premium could have increased from $393.05 in 2018 to $612.09 in 2019, or 55.7%.[6] Had Congress allowed the HIT to take place in 2019, the result could well have been an alarming spike in premiums, causing severe financial hardship for the millions of Medicare beneficiaries who rely on Medicare Advantage.

Delay or permanent repeal of the HIT is one of the most direct ways for Congress to provide financial relief for seniors and individuals who are eligible for Medicare due to disabilities, while maintaining access to the quality, affordable health care they have chosen.

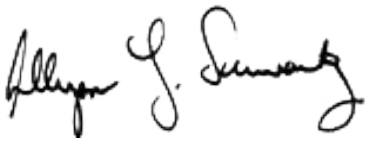
It is our hope that the Health Tax Taskforce will address the HIT swiftly and move to permanently repeal or, at a minimum, delay this harmful tax. BMA understands that the Taskforce is interested in hosting listening sessions with stakeholders over the coming days and weeks. **BMA would appreciate an opportunity to participate in any such discussion and to further engage on this critical issue.**

Thank you for your consideration of our views on the HIT. Should you have any questions or need further information, please do not hesitate to contact our Director of Government Affairs, Lisa Hunter, at lhunter@bettermedicarealliance.org or (202) 758-3157.

[4] Analysis of 2016 Medicare Current Beneficiary Survey (MCBS) data, provided by Anne Tumlinson Innovations, LLC.
[5] *"Preparing for Health Care Costs in Retirement: An America's Health Rankings Issue Brief,"* United Health Foundation and Alliance for Aging Research; May, 2017. Web.
[6] *"New Analysis: How the 2019 Moratorium on the ACA's HIT Kept Medicare Advantage Premiums Down,"* Oliver Wyman; January, 16, 2019. Web.

BETTER MEDICARE
ALLIANCE

Sincerely,



Congresswoman Allyson Y. Schwartz
President & CEO
Better Medicare Alliance

CC: U.S. Senate Finance Committee Chairman Charles Grassley
U.S. Senate Finance Committee Ranking Member Ron Wyden

June 14, 2019

Senator Pat Toomey
U.S. Senate
Washington, DC 20510

Senator Bob Casey, Jr.
U.S. Senate
Washington, DC 20510

Dear Senator Toomey and Senator Casey,

On behalf of the Colorado BioScience Association and our medical device members, thank you for the opportunity to submit comments to the Task Force in response to the Finance Committee's efforts to develop long-term solutions to temporary tax policies.

The Colorado BioScience Association is a statewide, nonprofit organization that serves as the hub of Colorado's thriving bioscience sector by connecting innovators to funding, infrastructure, research, and talent. We advocate on behalf of Colorado's 720 bioscience companies and their 30,000 employees, working to ensure an innovation-friendly environment that allows our members to deliver value to patients and our state's economy, while creating next generation treatments and cures.

Today Colorado is home to a bustling medical device industry, which directly employs nearly 10,000 people and contributes $6.4 billion to the total economic activity. Our device manufacturers are committed to delivering breakthrough innovations to patients, but that commitment has been threatened by a number of policies that have increased costs, lengthened timelines, and deterred companies from investing in innovative research and development.

One of the biggest concerns for our members is the 2.3% excise tax on the sale of certain medical technology that was enacted as part of the Affordable Care Act (ACA). Since its enactment, the medical device tax has had a significant negative impact on medical innovation and has resulted in the loss or delayed creation of jobs, reduced research and development, and slowed capital expansion. Information drawn from data assembled by the U.S. Department of Commerce showed that the medical technology sector saw a loss of nearly 29,000 jobs while the device excise tax was in effect. The damaging consequences of this tax have directly impacted a dynamic and innovative sector that provides quality manufacturing jobs, at above average wages, here in Colorado and across the country.

The effects of the device tax are truly felt across the industry, as every dollar of revenue (not income or profit) earned by a company is generally subject to the tax. For larger, established companies, that means a loss of tens or hundreds of millions of dollars that could be used to expand research and create jobs. For start-up firms and early-stage companies, which comprise more than two-thirds of our membership at the Colorado BioScience Association, the effect of the tax is felt in multiple ways. It deters company growth, since the tax is imposed on the first dollar of revenue earned; it also makes it harder for those companies to raise capital, since the tax reduces return on investment and makes investment in other industries more appealing. The long-term impact of capital flowing out of the medical device space will quickly result in a lack of innovation in the field, decreasing the number of lifesaving technologies that are delivered to patients in the future.

Medical technology innovation is responsible for some of the most cutting-edge advancements in health care today. Many have seen the viral videos where adults and children alike hear for the first time due to advancements in cochlear implants. New exoskeletons are allowing the brave men and women who have been paralyzed in combat and other horrific circumstances to walk again and regain independence through the use of robotics. These amazing inventions build on the proud history of more commonly-known medical technologies such as pacemakers, stents and artificial joints that so many of our loved ones depend on to remain healthy and active. All these gains are at risk if the medical device tax is reinstated.

Medical technology has also improved efficiencies and produced savings to the system through minimally invasive procedures, more precise and accurate diagnostics, and devices that reduce hospitalizations or length of stay. These improvements mean better outcomes and higher-quality care for patients, which ultimately lowers cost. Taxing the development and manufacture of medical technology imposes an unnecessary penalty on these savings and erodes the value these technologies provide to the system in the long run.

When we look at the infinite potential medical technology innovation can have in the 21st century healthcare ecosystem, it becomes frustrating that a policy exists that diverts billions of dollars away from additional research and development, the engine that drives advancements in health care. Surveys have shown that if the medical device tax was repealed, approximately 80 percent of innovators would increase investments in the treatments of tomorrow.

Large bipartisan majorities in Congress agree that the medical device tax is bad policy. Thanks to your leadership and the efforts of the Senate Committee on Finance, Congress has suspended the tax twice for a total of four years. In fact, by the end of this year, Congress will have suspended the tax for longer than it was in effect, with no measurable impact on coverage. Clearly, repeal of the device tax will not have a significant impact on the overall finances of the ACA, despite prior concerns.

The current suspension expires on December 31, 2019. Colorado companies are already making important planning decisions for the next fiscal year, including how to allocate financial and staff resources toward research and development. As an excise tax, the device tax cannot be addressed retroactively in an effective manner. The longer Congress waits to act, the bigger the impact on the industry's ability to develop the next life-saving, life-enhancing technology.

We strongly encourage the Task Force to recommend full repeal of the medical device excise tax and urge the Finance Committee to move promptly to consider legislation that includes repeal. Permanently repealing the device tax will provide Colorado's innovators with the long-term certainty they need support future job growth and sustainable, cutting-edge R&D that will ultimately lead to new innovative technologies that improve the lives of patients.

Thank you again for this opportunity to share our thoughts on behalf of Colorado's device companies. We look forward to working with you and your staff on a solution that will promote and foster research, development, investment and innovation in the medical technology sector.

Sincerely,

Jennifer Jones Paton

Jennifer Jones Paton
President and CEO
Colorado BioScience Association

June 14, 2019

The Honorable Patrick Toomey
Co-Lead, Health Tax Task Force
Senate Finance Committee
Washington, D.C. 20510

The Honorable Robert Casey, Jr.
Co-Lead, Health Tax Task Force
Senate Finance Committee
Washington, D.C. 20510

Dear Senators Toomey and Casey:

On behalf of the California Life Sciences Association (CLSA), thank you for the opportunity to submit comments to the Health Tax Task Force in response to the Senate Finance Committee's efforts to examine temporary tax provisions that expired, or will expire, between December 31, 2017 and December 31, 2019. Recognizing that you will receive many worthy requests from a wide range of stakeholders, we strongly urge the Task Force to recommend a full and permanent repeal of the 2.3 percent medical device excise tax. As you know, the medical device excise tax is slated to go back into effect on December 31, 2019, unless Congressional action is taken. The medical device excise tax, both during the period in which it was in effect as well as when its return is threatened, has a documented stifling effect on job creation and retention, and threatens innovation in new treatments and cures for patients who need them.

CLSA is the premier statewide public policy and business leadership organization representing California's life sciences innovators, including medical device, diagnostic, biotechnology and pharmaceutical companies, research universities and private, non-profit institutes, and venture capital firms. California is home to over 1,800 medical technology companies – more than any other state in the nation.[1] Additionally, the approximately 81,000 medical device jobs in California represent over 19 percent of the total U.S. medical technology workforce.[2] Given the size and scope of the medical device sector's presence in California, the excise tax has had a disproportionate impact on our state and our companies' ability to innovate.

At a time when we should be doing everything we can to encourage investment, innovation, and job creation, the medical device excise tax instead discourages and threatens important research and development. During the three years in which the medical device tax was in effect, medical technology sector jobs in California and across the country were put at risk. According to data from the U.S Department of Commerce, nearly 29,000 jobs were lost while the medical device excise tax was in effect – a decrease of 7.2 percent for the time period.[3] Conversely, since Congress first suspended the tax in December of 2015, the sector has seen an uptick in investment. The results of a January 2017 membership survey from the Advanced Medical Technology Association (AdvaMed) showed that 23 percent of respondents reported increasing investment in start-up companies since the tax was suspended, 33 percent reported investing in a

[1] *California Life Sciences 2019 Industry Report.* California Life Sciences Association/PwC, 15 Nov. 2018, https://info.califesciences.org/2019report .
[2] Ibid.
[3] *MedTech Industry Lost Nearly 29k Jobs While Device Tax In Effect*. Advanced Medical Technology Association (AdvaMed), 8 Feb. 2017, www.advamed.org/newsroom/press-releases/medtech-industry-lost-nearly-29k-jobs-while-device-tax-effect.

new research facility, lab, or research infrastructure, 73 percent increased or avoided reducing employment, and 83 percent reported increasing R&D or avoided reducing R&D funding.[4]

CLSA is grateful that Congress has previously enacted two short-term suspensions of the excise tax. In order to continue to lead the world in life sciences research and development, however, the medical device sector in California needs certainty of their financial obligations so that they may appropriately budget and plan. Since the current medical device excise tax suspension will expire in less than six months, companies are already planning their fiscal year 2020 budgets based on the assumption that the tax will return on January 1, 2020. The expectation of the medical device tax returning drastically affects the ability of small and medium companies – which make up 73 and 88 percent of the medical device sector respectively – to innovate, but it also impedes the ability of large companies to invest in bringing the technology discovered by smaller companies to market.[5] Ultimately, it's the patients who desperately need these new technologies who will suffer.

In the section below, we offer several case studies from companies in California, describing the impact of the medical device excise tax on their companies, as well as specific ways in which companies have supported investment in innovation and job creation during the periods in which the device tax was suspended:

- Edwards Lifesciences, an Irvine headquartered, patient-focused company developing medical innovations for structural heart disease, critical care, and surgical monitoring, has used savings from the last suspension of the tax in 2018 to invest and accelerate R&D into initiatives such as their transcatheter aortic valve replacement (TAVR) program. However, if the tax is not repealed, there will be a significant financial burden to Edwards, which will adversely impact jobs and hinder their ability to invest in innovations that save and improve lives.
- Organogenesis is a high growth stage, highly innovative company that produces a pioneering cell therapy used to treat hundreds of thousands of patients suffering from serious diabetes ulcers and a novel cell-based product for severe burns. Due to the implementation of the tax, Organogenesis had to pause the completion of a new manufacturing facility, halt development of a clinical stage product, and scale back the scope of an R&D program. Since the suspension of the tax, the company was able to successfully complete development of their burn treatment that recently received FDA approval, and it plans to ramp up hiring in their La Jolla facility to support the upcoming launch. However, the possibility of the return of the tax causes financial uncertainty, and will translate directly to the loss of 40-50 high paying jobs or the equivalent dollars in infrastructure development, at a time when the company needs to ramp up their production and delivery of this very important treatment to get it to surgeons and patients.

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[4] *New Data Shows MedTech Industry Poised for Greater Investment & Growth with Full Device Tax Repeal.* Advanced Medical Technology Association (AdvaMed), 10 Jan. 2017, www.advamed.org/newsroom/press-releases/new-data-shows-medtech-industry-poised-greater-investment-growth-full-device.

[5] *Report to the Congress: Medicare and the Health Care Delivery System*. MedPAC, June 2017, www.medpac.gov/docs/default-source/reports/jun17_ch7.pdf?sfvrsn=0.

- ResMed, a company pioneering new and innovative solutions to treat people with sleep apnea, chronic obstructive pulmonary disease (COPD), and other key chronic diseases, had to offset the tax through cuts to its other expenditures. Since suspension of the tax, ResMed has been able to invest more in expanding the number of employees hired to work in their software-focused development facility in San Diego, to work on digital health solutions to reduce healthcare costs and improve the quality of patient care.
- Boston Scientific, with 1,650 manufacturing and R&D jobs in California, has reinvested hundreds of millions of dollars since the tax's suspension into developing new therapies that address unmet patient needs. Their innovation collaboration with the Mayo Clinic and Emory University has been so successful they are seeking to expand the pioneering program to other centers of excellence, should tax relief continue.

In closing, we note that legislation to permanently repeal the medical device excise tax has consistently enjoyed significant bipartisan support in both the House and the Senate. In the 116th Congress, the House legislation (H.R. 2207) currently has 239 bipartisan cosponsors, including 24 bipartisan cosponsors from the California congressional delegation. We further note that by the end year, the excise tax will have been suspended longer than it was ever in effect, but with no measurable impact on health coverage. This should assuage any concerns that repeal of the excise tax will have a significant impact on the funding of the Affordable Care Act.

On behalf of CLSA, and our state's medical device innovators, thank you for considering our views. Should you have any questions or comments, of if you would like to discuss our views further, please do not hesitate to contact Molly Fishman, CLSA's Director of Federal Government Relations, at mfishman@califesciences.org or (202) 743-7560.

We thank you for your attention to this important issue.

Sincerely,

Jennifer Nieto

Jennifer Nieto
Vice President – Federal Government Relations & Alliance Development
California Life Sciences Association – CLSA

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June 13, 2019

The Honorable Patrick J. Toomey, Co-Lead
U.S. Senate Finance Committee
Health Care Tax Extender Task Force
SD-219
Washington, D.C. 20510

The Honorable Bob Casey, Co-Lead
U.S. Senate Finance Committee
Health Care Tax Extender Task Force
SD-219
Washington, D.C. 20510

The Honorable Michael B. Enzi
U.S. Senate Finance Committee
Health Care Tax Extender Task Force
SD-219
Washington, D.C. 20510

The Honorable Mark Warner
U.S. Senate Finance Committee
Health Care Tax Extender Task Force
SD-219
Washington, D.C. 20510

Transmitted via e-mail: Health_Tax_Taskforce@finance.senate.gov

Dear Senators Toomey, Co-Lead; Casey, Co-Lead; and Senators Enzi and Warner:

Thank you for the opportunity to provide comments as the Senate Finance Committee's Health Care Tax Extender Task Force considers issues before the Committee. I am writing to draw your attention to the medical device excise tax, and the negative impact it has on the economy, our community, and most importantly on patients.

The medical device excise tax continues to be a dark cloud hanging over an otherwise promising part of the U.S. economy. As you are aware, the medical device excise tax was included in the 2010 Affordable Care Act, and it is a tax of 2.3 percent on the gross sales of medical devices in the U.S. The tax was in effect for three years (2013-2015), and has been suspended for two, two-year increments since then, the most recent suspension lasting until the end of December 2019.

While 2.3 percent may not sound like much, it is huge. The tax comes off the top, not on earnings, and whether a manufacturer makes a profit or not, the excise tax applies. When the tax was in effect for those three years, it increased our effective tax rate to 42 percent—a more

than 25 percent increase. Unfortunately, Cook was not alone in feeling the adverse impact of the device tax. The device industry is dominated by small companies, with profit margins of between 6 and 10 percent, pre- income tax. At 2.3 percent, the device tax can represent one third of a company's income. To compensate for the revenue lost to the tax, Cook—like all other medical device manufacturers—faced an array of unattractive choices. We could lay off workers, freeze plans for growth, or halt planned, new product development. None of these are good options for the U.S. economy or for patients.

For Cook, a company which has never instituted layoffs in the U.S. in our 56 years of business, the decision was made to freeze capital expenditures, freeze new hiring, and take steps to manufacture new product lines in our facilities in Ireland. Fortunately, very little manufacturing was moved abroad before the tax was suspended.

And with the recent two, two-year suspensions, we have been able to move forward with our plans for building new facilities in the U.S. In Winston-Salem, North Carolina, we have acquired property that will enable us to significantly increase the size of our operations there over the next ten years. We are also proceeding with plans to expand in Pennsylvania and Indiana. If we are to follow through on what we are starting, it is critical that Congress take action to prevent the tax from going back into effect in January 2020.

Over the years, we have heard many misguided arguments in favor of the tax, which I'd like to briefly address.

1. Device manufacturers will pass along the amount of the tax—FALSE

   Hospitals—the majority of our customers—are under tremendous cost pressures. They have many suppliers to choose from. If one company were to attempt to pass along the cost of the tax to a hospital, the hospital would say no, knowing that they could find another company from which to buy the product. The medical device industry is very competitive, and it is simply not true that the cost of the device tax can be passed on to others.

2. With an increase in insured patients, sales of medical technologies will increase—FALSE

   Increased insurance coverage did not lead to increased sales of medical technologies. Over 70 percent of the newly insured from the Affordable Care Act are younger than 45 years of age and simply do not need sophisticated medical technologies. Like so many others, Cook did not see an unusual growth in sales due to expansion of coverage from the Affordable Care Act. We specifically studied states with large newly insured populations, like Texas and California, and observed no increase. This is consistent with studies done on sales in Massachusetts, after

that state established universal health care. As with the expansion from the Affordable Care Act, the was no increase in the rate of sales growth in Massachusetts compared to the rest of the nation.

3. With the new tax reform law, relief from the device tax is unnecessary—FALSE

   Due to the structure of our company, Cook does not currently benefit from the recently passed tax reform law. Under the new tax laws, our tax burden will increase. Coupled with the possible reimposition of the medical device excise tax, this represents a substantial increase in our tax rate.

We are grateful for the leadership of Senators Toomey, Casey, and so many others who have signed onto legislation to permanently repeal the medical device tax. Now is the time to get that done.

I'd like to leave you with two stories that encapsulate why we do what we do, focusing on the patients we serve and the communities we call home.

- Several years ago, I was approached by an employee who said that the lives of two members of her family had been saved, thanks to Cook products. One product was a stent graft for an aortic aneurysm, which saved her father's life. The second is a device called the Bakri balloon, which stops potentially fatal bleeding for mothers after they give birth. This technology saved her step-daughter's life. I am so grateful that these products were able to save these two lives. I am grateful for the millions of other lives that Cook technologies have impacted. And I am hopeful that we can continue to positively impact future patients, for many generations to come.

- Our late founder, Bill Cook, believed in giving back to the community and investing in America. He grew up in the small town of Canton, Illinois. Before the medical device excise tax, Bill decided to open up a manufacturing plant in the small community in Canton, Illinois, which at the time had very high unemployment due to the closing of an International Harvester plant. More than 1,000 applicants applied for the initial 30 jobs at that factory, which makes catheters. One of the new employees at that Canton plant shared with us that prior to her job at Cook, she was a single mother, living on welfare in a small, subsidized apartment. She could not afford to get married and lose her government benefits. The job at the Canton plant gave her access to a 401(k), profit-sharing, health insurance, and a steady income. She got off welfare and finally married her boyfriend. She bought a house. We are proud of the part we played in bringing this woman and her family self-reliance and hope for a better future.

We need your continued leadership on this issue. Partisan politics must be put aside. I urge you to permanently repeal the tax, to give us the certainty we need to focus on growing our company and improving patients' lives.

Thank you.

Sincerely,

Stephen L. Ferguson
Chairman of the Board

Cc: Senate Finance Committee Chairman Grassley (R-IA) and Ranking Member Wyden (D-OR)

About Cook:

Cook is the largest, family-owned medical device manufacturer in the world. We are best known as a pioneer in the field of interventional medicine. Our products benefit patients by providing doctors with a means of diagnosis and intervention, using minimally invasive techniques, as well as by providing innovative products for surgical applications. Cook sells more than 12,000 different products worldwide. These devices are used by physicians in the more than 40 medical disciplines and range from simple wire guides, needles and catheters, to grafts, drug-eluting stents and tissue engineering.

Cook is headquartered in Bloomington, Indiana with its U.S. manufacturing plants in Indiana, Pennsylvania, North Carolina, Illinois, and California. We also have manufacturing facilities in Ireland, Denmark, and Australia. Our company employs about 12,000 people around the world, with approximately 8,000 of these employees based in the United States. While nearly 56 percent of our sales are outside of the U.S, we manufacture about 70 percent of our products in the U.S.

FUJIFILM
Value from Innovation

FUJIFILM Medical Systems U.S.A., Inc.
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June 14, 2019

Senator Patrick Toomey
Co-Leader, Senate Finance Committee
Health Tax Taskforce
U.S. Senate
Washington, DC 20510

Senator Robert Casey, Jr.
Co-Leader, Senate Finance Committee
Health Tax Taskforce
U.S. Senate
Washington, DC 20510

Senator Michael Enzi
Member, Senate Finance Committee
Health Tax Taskforce
U.S. Senate
Washington, DC 20510

Senator Mark Warner
Member, Senate Finance Committee
Health Tax Taskforce
U.S. Senate
Washington, DC 20510

Via Email at: Health_Tax_Taskforce@finance.senate.gov

Dear Senator Toomey, Senator Casey, Senator Enzi and Senator Warner,

Thank you for the opportunity to submit comments and recommendations to the Task Force in response to the Finance Committee's efforts to develop long-term solutions to temporary tax policies. On behalf of FUJIFILM Medical Systems U.S.A., Inc. ("Fujifilm"), I appreciate your interest in hearing from stakeholders on such an important issue.

FUJIFILM Medical Systems U.S.A., Inc. is a leading provider of diagnostic imaging products and medical informatics solutions that meet the evolving needs of healthcare facilities. From an unrivaled selection of digital X-ray systems (DR: detectors, mobiles, and rooms), to the comprehensive Synapse® Enterprise Imaging portfolio, to full-field digital mammography systems with digital breast tomosynthesis, and computed tomography solutions, Fujifilm has products that are ideal for any size imaging environment.

Fujifilm also supplies high quality, technologically advanced endoscopic imaging solutions and devices to the medical field and Fujifilm's TeraMedica Division, is the leading provider of vendor neutral, enterprise-wide solutions for unrestricted medical image management and the core to the Synapse Enterprise Imaging portfolio, enabling improved interoperability by connecting imaging content across the entire care continuum. FUJIFILM Medical Systems U.S.A., Inc. is headquartered in Lexington, Massachusetts.

Fujifilm would like to bring to the Health Tax Taskforce's attention the 2.3% excise tax on the sale of certain medical technology that was enacted as part of the Affordable Care Act (ACA) which is known at the medical device tax. The medical device tax has been a significant concern at Fujifilm regarding efforts on medical innovation and reduced R&D and slowed capital expansion. Its suspension over the last four years has enabled Fujifilm to initiate important research and development projects in women's health and imaging content management.

However, these are all short-term investments because of the uncertainty over whether Fujifilm will have to being to pay the medical device tax on January 1, 2019. Because this is an excise tax on sales, Fujifilm will have to pay the tax in "real-time," if it is not repealed prior to January 1, 2019. Given that the current suspension expires on December 31, 2019, Fujifilm is already making decisions regarding how to deal with the tax as it would begin again in our current fiscal year.

I strongly encourage the Health Tax Task Force to recommend full repeal of the medical device excise tax and urge the Committee to move promptly to consider legislation that includes repeal to provide medical technology innovators with the long-term certainty necessary to support future job growth and sustainable, cutting-edge R&D.

FUJIFILM Medical Systems U.S.A., Inc. greatly appreciates this opportunity to share our thoughts with the Health Tax Taskforce. We look forward to working with you and your staff on a solution that will allow us to retain our position as a leading provider of diagnostic imaging products and medical informatics solutions.

Sincerely,

Takaaki Ueda
President and CEO of FUJIFILM Medical Systems U.S.A., Inc.

GENOMIND®

June 14, 2019

Dear Members of the Senate Finance Committee Health Tax Task Force:

I understand the Senate Committee on Finance is currently examining temporary tax policies in varying issue areas, including health. As the CEO of GenOmind Inc., based in King Of Prussia, PA, I urge you to ensure the permanent repeal of the Medical Device Tax is included in any of the proposals or recommendations that are produced by this comprehensive exercise. This is especially important as the current suspension of the Medical Device Tax will end December 31 of this year. I had mistakenly thought this had been fully repealed and not temporarily, otherwise I would have been more active sooner on this issue.

We have clear evidence of the damage this short-sighted policy caused when it was in place from 2013-2015, and if it goes into effect again it will undoubtedly stifle innovation and more importantly, patient care. Though currently under a temporary suspension, if the tax is not repealed our company and many others like ours, will be diverting tens of millions of dollars to the IRS instead of investing in innovation and creating new high-tech manufacturing jobs.

GenOmind is a leading mental health company helping patients get on medications that are more likely to be tolerated and beneficial, versus allowing the mental health patients go through trial and error therapy options unsuccessfully for months, even years, which leads to increased costs to the system. In a large Aetna study, our mental health genetic test demonstrated over a $ 1,900 savings in 6 months per tested member.

Today depression is the number 3 driver of medical costs, and according to the CDC, it will be the number 1 driver of medical costs by the end of this decade.

We need to help you help the 20% of Americans who suffer from mental health conditions on a given day. Take actions that will allow GenOmind and others, develop solutions to reduce the economic burden and improve the lives of over 50 million Americans every day who suffer from mental health.

We look forward to working with you to put a permanent end to a policy that only served to impede our common goals of growing our country's economy and improving patient care. Additionally, and if interested, we would be honored to host you at GenOmind to give you a first-hand look at the medical technology ecosystem this country enjoys, and the benefits our innovation, research and development provide to patients and their families.

Sincerely,

Shawn Patrick O'Brien

President and CEO

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June 14, 2019

Hon. Pat Toomey
248 Russell Senate Office Building
United States Senate
Washington, DC 20510

Hon. Bob Casey, Jr.
393 Russell Senate Office Building
United States Senate
Washington, DC 20510

Dear Senator Toomey and Senator Casey:

On behalf of the HealthCare Institute of New Jersey (HINJ), which represents New Jersey's research-based biopharmaceutical and medical technology companies, I write to express our appreciation for the opportunity to submit comments and recommendations to the Senate Finance Committee's Task Force as it seeks to develop long-term solutions to temporary tax policies.

One of New Jersey's true innovator industries is medical technology. Our approximately 660 medical technology companies generate approximately $12.6 billion annually in economic activity for our state, employing nearly 23,700 people and supporting, directly and indirectly, approximately 67,000 high-quality jobs in the Garden State.

Medical device manufacturers in New Jersey are committed to bringing breakthrough innovations to patients, but that commitment is threatened by regulations and policies that have increased costs, lengthened timelines and deterred companies from investing in the next generation of treatments and cures.

Chief among these policies is the 2.3% excise tax on the sale of certain medical technology that was enacted as part of the Affordable Care Act (ACA). Since its enactment, the medical device tax has been a significant drag on medical innovation and has resulted in the loss or deferred creation of jobs, reduced R&D and slowed capital expansion. What is even more troubling is that this tax is not grounded in any health care policy. It is not connected to individual insurance coverage. It was designed as a means of raising revenue from the industry to offset the budgetary impact of the ACA.

Medical devices have revolutionized health care. To cite one example, medical technology has helped add more than five years to U.S. life expectancy since 1980. Advances in treatment mean patients experience less-invasive procedures, shorter hospitalizations, reduced recovery times, and lower overall costs. New technologies diagnose illnesses earlier, lowering the impact of care on a person's daily life. Breakthrough concepts reduce the overall cost of health care for patients and the system.

Medical technology has improved efficiencies and produced savings to the system through minimally invasive procedures, more precise and accurate diagnostics, and devices that reduce hospitalizations or length of stay. These improvements mean better outcomes and higher-quality care for patients, which lowers cost.

All these gains are at risk if the medical device tax is reinstated. Taxing the development and manufacture of medical technology imposes an unnecessary penalty on these savings and erodes the value these technologies provide to the system in the long run.

The effects of the tax are felt across the industry, as every dollar of revenue (not income or profit) earned by a company is generally subject to the tax. For large, established companies, the device tax equals tens, if not hundreds, of millions of dollars that could be used to expand research and create jobs. For start-up firms, the effect of the tax is two-fold – it deters company growth, since the tax is imposed on the first dollar of revenue earned, and it restricts the ability of established medical technology companies to invest in or acquire start-up companies by limiting the amount of available funds.

Large bipartisan majorities in Congress agree that the medical device tax is bad policy. Thanks in no small part to your leadership and the efforts of the Committee on Finance, Congress has suspended the tax twice for a total of four years. Notably, by the end of this year, Congress will have suspended the tax for longer than it was in effect, with no measurable impact on coverage. Clearly, repeal of the device tax will not have a significant impact on the overall finances of the ACA, despite prior concerns.

The current suspension expires on December 31, 2019. Individual companies are already making important planning decisions for the next fiscal year, including how to allocate resources toward research and development as well as employment tied to research and development. As an excise tax, the device tax cannot be addressed retroactively in an effective manner. The longer Congress waits to act, the bigger the impact on the industry's ability to develop the next lifesaving, life-enhancing technology.

We strongly encourage the Task Force to recommend full repeal of the medical device excise tax and urge the Committee to move promptly to consider legislation that includes repeal. We stand ready to work with you to advance any legislative vehicle that will address the medical device tax. Permanently repealing the device tax will provide medical technology innovators with the long-term certainty necessary to support future job growth and sustainable, cutting-edge R&D that will ultimately lead to the next generation of breakthroughs in patient care and treatment. With any other policy outcome, effective planning for a sustainable future becomes much more difficult.

Thank you again for this opportunity to share our thoughts on behalf of our medical technology companies. We look forward to working with you and your staff on a solution that will allow our members to retain their position as world leaders in developing and manufacturing technology that will improve the lives of patients in the United States.

For further information, please contact Steve Issenman, HINJ's Senior Vice President – Federal and External Affairs, at (732) 729-9621 or via email at issenman@hinj.org.

Respectfully,

Dean J. Paranicas
President and Chief Executive Officer

BETTER MEDICARE ALLIANCE

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BetterMedicareAlliance.org
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May 6, 2019

The Honorable Mitch McConnell
Majority Leader, U.S. Senate
Washington, DC 20510

The Honorable Charles Schumer
Minority Leader, U.S. Senate
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker, House of Representatives
Washington, DC 20515

The Honorable Kevin McCarthy
Minority Leader, House of Representatives
Washington, DC 20515

Dear Leader McConnell, Leader Schumer, Speaker Pelosi, and Leader McCarthy:

As the leading Medicare Advantage advocacy coalition representing 131 organizations providing care for the 22 million Medicare beneficiaries under Medicare Advantage, Better Medicare Alliance (BMA) advocates on policies that will further strengthen Medicare Advantage as a high-quality, cost-effective choice for seniors. We write to you on behalf of our alliance and specifically the organizations that are listed below that are deeply concerned about the harmful effects of the Health Insurance Tax (HIT) that is due to be reinstated in 2020, unless Congress acts.

We strongly urge you to support H.R. 1398 / S. 172, legislation that will delay the HIT through 2021. If Congress does not take timely action to suspend the HIT, millions of American seniors and others with health insurance coverage could face a major premium increase of more than $20 billion[1] when the HIT returns.

Access to health care is of paramount importance to American seniors and individuals with disabilities who depend on Medicare for health services, financial security, and peace of mind. This is especially critical to those living on fixed incomes, many of whom rely on Medicare Advantage for its high-quality care, affordability, simplicity and additional benefits.

While much of the public's attention has focused on the HIT's harmful effects on individuals and consumers in the employer group markets, we want to share with you the serious negative economic effects of the HIT as it applies to seniors and disabled Americans in Medicare Advantage. The return of the HIT in 2020 could equate to more than $500 in additional annual premiums for the typical Medicare Advantage couple[2] — a sum that far too many simply cannot afford.

As it is, many current and future retirees are at risk of not being able to afford the costs of health care in retirement. More than half of Medicare Advantage enrollees live on less than $30,000 annually. According to a recent analysis, 62% of retirees age 65+ years old, as well as about three out of four non-

[1] *"Analysis of the Impacts of the ACA's Tax on Health Insurance in Year 2020 and Later,"* Oliver Wyman; August 28, 2018. Web.
[2] *Ibid.*

retired adults age 50 to 64, have less in total retirement savings than what experts recommend saving for health care costs alone.[3]

For these reasons and more, America's seniors are increasingly choosing Medicare Advantage. They appreciate the focus on prevention and disease management and the offering of enhanced benefits and services, such as vision, hearing, fitness and wellness, and dental coverage. These beneficiaries rely on Medicare Advantage for the high-value, integrated care it provides, offering the right care in the most appropriate setting.

We appreciate the decision Congress made to delay the HIT for 2019, but the threat of the HIT remains. It is why we urge you to support H.R. 1398 / S. 172 to delay the HIT through 2021. According to a recent analysis, without the delay of the HIT for 2019 the nationwide annual premium could have increased from $393.05 in 2018 to $612.09 in 2019, or 55.7%.[4] Had Congress allowed the HIT to take place in 2019, the result could well have been an alarming spike in premiums, causing severe financial hardship for the millions of Medicare beneficiaries who rely on Medicare Advantage.

Delay of the HIT is one of the most direct ways for Congress to provide financial relief for seniors and Medicare beneficiaries, while maintaining access to the quality, affordable health care they have chosen.

Thank you for your consideration of our views on this important issue. Should you have any questions or need further information, please do not hesitate to contact our Director of Government Affairs, Lisa Hunter, at lhunter@bettermedicarealliance.org or (202) 758-3157.

Sincerely,

American Physical Therapy Association
Area Agency on Aging Palm Beach / Treasure Coast, Inc.
Association for Behavioral Health and Wellness
Better Medicare Alliance
ChenMed
Coalition of Texans with Disabilities
Commerce and Industry Association of New Jersey
Connecticut Association of Health Underwriters
Consumer Action
Council for Affordable Health Coverage
Direct Primary Care Coalition
Einstein Healthcare Network

[3] "*Preparing for Health Care Costs in Retirement: An America's Health Rankings Issue Brief*," United Health Foundation and Alliance for Aging Research; May, 2017. Web.
[4] "*New Analysis: How the 2019 Moratorium on the ACA's HIT Kept Medicare Advantage Premiums Down*," Oliver Wyman; January, 16, 2019. Web.

BETTER MEDICARE ALLIANCE

Greater Philadelphia Business Coalition on Health
Healthcare Leadership Council
International Council on Active Aging
Iora Health
MANNA
Martin's Point Health Care
Meals on Wheels America
National Association of Dental Plans
National Association of Health Underwriters
National Association of Hispanic Nurses
National Association of Nutrition and Aging Services Programs
National Hispanic Council on Aging
National Hispanic Medical Association
National Medical Association
National Minority Quality Forum
New Jersey State Nurses Association
Northwell Health
Nurse Practitioner Association New York State
Oak Street Health
Philadelphia Corporation for Aging
Pittsburgh Business Group on Health
Population Health Alliance
Prevea Health
Public Sector Healthcare Roundtable
SilverSneakers by Tivity
SNP Alliance
Summa Health System (Ohio)
Teachers' Retirement System of Kentucky
The Latino Coalition
Visiting Nurse Service of New York

MDMA
MEDICAL DEVICE MANUFACTURERS ASSOCIATION

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June 14, 2019

Senator Pat Toomey
U.S. Senate
Washington, DC 20510

Senator Bob Casey, Jr.
U.S. Senate
Washington, DC 20510

Dear Senator Toomey and Senator Casey,

On behalf of the hundreds of innovative medical technology companies represented by the Medical Device Manufacturers Association (MDMA), I am writing to thank you for your consistent leadership on the repeal of the medical device tax and encourage you to prioritize its full and immediate repeal as part of your work on the recently convened Senate Finance Committee's Taskforce on Health Tax Extenders.

MDMA represents nearly 300 medical device companies across the United States, and our mission is to ensure that patients have access to the latest advancements in medical technology. We are the leading voice in Washington for the small, research-driven companies who constitute the majority of the medical device industry. According to the Department of Commerce, nearly 80% of the medical device firms operating across the U.S. have 50 or fewer employees and 98% have fewer than 500 employees. These start-up and early-stage firms tend to develop the most novel and disruptive medical technologies; technologies that are often acquired by larger companies with more sophisticated manufacturing and distribution capabilities. This interdependence between large and small companies fuels innovation and has helped make the U.S. the global leader in medical technology. Disastrous policies like the medical device excise tax strip all companies of important resources to fund the cures and therapies of tomorrow, and put our continued global leadership at risk.

Since the medical device tax was first proposed in 2009, MDMA shared our grave concerns with Congress about the negative impact this policy would have on job creation, research and development (R&D), and patient care. Unfortunately, much of what we predicted came true. While the tax was in place from 2013 through 2015, thousands of good paying jobs were lost, R&D projects were abandoned, and patients were denied new treatments. US Department of Commerce Census Data shows that the industry lost 29,000 jobs during the three years that the tax was in effect, and recent reports suggest that a reinstatement of the tax could result in an additional loss of 21,000 jobs.

It should be noted that the medical device industry is not advocating for industry specific tax incentives or special breaks. Instead, medical device companies are simply asking Congress to put them on a level playing field and allow them to pay the statutory corporate income tax rate. Under the medical device excise tax, device firms are exposed to the regular federal taxation of profits AND an extra 2.3% tax on the sale of their devices irrespective of profitability. In far too many cases, while the tax was in effect, emerging companies with sales but operating at a loss had to borrow money to pay the tax, diverting critical resources away from getting cures to patients. In addition, hospitals and other purchasers of medical devices rarely pay invoices at the time of sale. In fact, payment processing can lag by weeks or months, but device makers must pay the excise tax on those sales to the IRS every two weeks which further strains companies. Policy makers have seen the insidious impact of the tax on the manufactures in their states and have acted.

Members of Congress from both parties joined together in late 2015 to suspend the tax from 2016 through 2017 and again in 2018 to delay it through 2019. The suspension of the tax has resulted in improvements to the ecosystem in the short-term, and has enabled companies to reinvest in R&D, make new hires, and provide new benefits to their employees like company-wide raises and increased 401(k) matches. Still, companies are holding off on long-term investments to prepare for the possible reinstatement of the tax at the end of this year. Fortunately, there is overwhelming bipartisan support for full repeal of the medical

device tax in Congress.

More recently, some critics have suggested that the lower corporate tax rate enacted in the 115th Congress somehow obviates the need for additional action from medical device tax and that medical device companies now have more resources to address the tax. Those that hold that position are mistaken. The benefits of corporate tax reform in the medical device industry were mixed. Medical technology development is an extremely risky and expensive enterprise. Many companies fail, and it takes years to reach profitability for those that successfully commercialize a new medical device. That's why 88% of MDMA's members reported that the full repeal of the medical device tax would have a more material impact on their business than the recently passed corporate tax reform.

In the same survey of over 100 medical device companies, MDMA sought to assess the impact of a future reinstatement of the tax. The troubling findings showed that:

- **85 percent** of respondents would **cut or freeze R&D investments** to address the tax
- Of those respondents, the average **cut to their R&D budget is 15.8 percent**
- **56 percent** of companies with revenues that responded would **cut or freeze salaries** for their employees as well to address the medical device tax

MDMA strongly believes that the reason for such broad, bipartisan support for repealing the medical device tax is the recognition that we need to protect and support this proud American industry. Our members are on the leading edge of scientific discovery and product development, and are responsible for many of the novel treatments for the most debilitating and costly diseases we face such as cancer, heart disease, stroke, obesity, diabetes and more. At a time where we need more high-tech manufacturing and solutions to the challenges facing the health care system, it is critical that we have policies in place that will support innovation and empower entrepreneurs. Repealing the medical device tax will do just that.

Both the Senate and the House have voted overwhelmingly in the past in support of a fully and permanent repeal of the medical device tax, and MDMA remains dedicated to working with Congress to finally repeal it this year. Thank you once again for your bipartisan leadership on this important policy goal.

Sincerely,

Mark Leahy
President & CEO, MDMA

Liam Kelly
President and CEO

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June 13, 2019

Senator Patrick Toomey (R-PA)
Senator Robert Casey, Jr. (D-PA)
Senator Michael Enzi (R-WY)
Senator Mark Warner (D-VA)

Dear Senators Toomey, Casey, Enzi and Warner:

I understand the Senate Committee on Finance is currently examining temporary tax policies in varying areas including health. As the President and CEO of Teleflex Incorporated (NYSE:TFX), in Wayne, PA, I urge you to ensure the permanent repeal of the Medical Device Tax is included in any of the proposals or recommendations that are produced by this exercise. This is especially important as the current suspension of the Medical Device Tax will end on December 31, 2019.

The damage this policy caused when it was in place from 2013-2015 is well known, and if it goes into effect again it will undoubtedly stifle innovation and patient care. Though currently under a temporary suspension, our company and many others like ours, will be diverting tens of millions of dollars to the IRS instead of investing in innovation and creating new jobs if the tax is not repealed.

Let me provide you with specifics of how the Medical Device Tax (an excise tax to revenues) impacted innovation and patient care here at Teleflex. Teleflex is a global, diversified medical technology company that employs nearly 3,700 people in the United States. We manufacture products that improve, and in many cases save, human life. When the tax was put into place in 2013, we amalgamated two business and reduced spending on research and development in order to pay the Medical Device Tax. This had the impact of a slowdown in our ability to innovate new lifesaving products. Following the temporary repeal of the Medical Device Tax, we have increased our investment in three areas that have a positive impact on patient care, this includes clinical research, post market clinical follow up and clinical education. To support increased research and development, we built a new R&D center right here in our home state of Pennsylvania that created jobs from the construction teams who built the facility to the scientists and engineers that are still employed there today. Teleflex investment in Clinical and R&D will continue to evolve alongside healthcare with a focus and commitment to patient safety.

If we do not have resolution soon, any public company will have to assume in its guidance that the Medical Device Tax is in play. This will serve to create some confusion about expected 2020 results, and something of a headache to estimate that impact on earnings.

While I am sure many companies benefited from the recently enacted Tax Cuts and Jobs Act, those benefits are quite uneven from company to company and in some cases may be negative. As a rule of thumb, the more global a company's revenue, the less likely they are to benefit. It would be a serious miscalculation to assume that because of changes in the corporate tax rate, companies can absorb the Medical Device Tax. For some companies, resumption of the Medical Device Tax will be like throwing salt into the wound.

We look forward to working with you to put a permanent end to a policy that only served to impede our common goals of growing our country's economy and improving patient care. Additionally, and if interested, we would be honored to host you at Teleflex to give you a first-hand look at the lifesaving devices we manufacture, the passionate people we employ, and the benefits our innovation, research and development provide to patients and their families.

Sincerely,

Liam Kelly
President and CEO

DDIFO®
Dunkin' Donuts Independent Franchise Owners

June 13, 2019

Office of Senator Deb Fischer
Office of Senator Angus King
United States Senate
Washington, DC 20510

RE: The Paid Family Leave Pilot Extension Act

Dear Senator Fischer and Senator King,

On behalf of the members of the Dunkin' Donuts Independent Franchise Owners, Inc. (DDIFO) and hundreds of other small businessmen and women who own Dunkin' franchises across the country, I write in support of the Paid Leave Pilot Extension Act.

This legislation extends the two-year Paid Family Leave Tax Credit Pilot Program, created by the Tax Cuts and Jobs Act (TCJA) at the end of 2017. Notwithstanding significant delays in its implementation, (IRS and Treasury Guidance was not issued until September, 2018 - 9 months after its creation), the pilot program's expiration date is still set for December 31, 2019 – a timeframe insufficient to generate the broad employer participation envisioned or to produce the data necessary for the GAO and Congress to accurately measure the program's effectiveness.

In the face of an historically tight labor market and an ever-growing plethora of federal, state and local government mandates for additional employee benefits, the Paid Family Leave Tax Credit Pilot Program effectively uses the carrot of a meaningful tax credit to encourage creation of employer sponsored (vs. government dictated) paid leave policies – policies that inure to the benefit of the business (with a happier, healthier workforce) as well as the lower-income employees.

Small business owners in 2019 want a happy and healthy workforce. They want to provide their employees with compensation and benefits sufficient to meet their needs and those of their families. But, small business owners also want to keep their businesses open and successful. Their challenges great, their margins are tight and their drive is strong, but they need help to grow their business, to accomplish their goals and to achieve and share their American dream. Passage of the Paid Family Leave Pilot Extension Act will go a long way to meeting that need!

Again, I urge Congress to pass the Paid Family Leave Pilot Extension Act and thank you for your support of this legislation.

Sincerely,

Edwin J. Shanahan
Executive Director

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Alliance FOR AGING RESEARCH
Catalyzing Innovation for Healthy Aging

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June 13, 2019

Senator Pat Toomey
Russell Senate Office Building 248
Washington, DC 20510

Senator Bob Casey
Russell Senate Office Building 393
Washington, D.C. 20510

Dear Senator Toomey and Senator Casey,

The Alliance for Aging Research is the leading non-profit organization dedicated to accelerating the pace of scientific discoveries and their application to improve the experience of aging and health. The Alliance believes that advances in research help people live longer, happier, more productive lives and reduce health care costs over the long term. We support policies that advance medical research and innovation and address the needs of aging patients. For this reason, the Alliance for Aging Research supports S. 692, the *Protect Medical Innovation Act of 2019*, a bill that amends the Internal Revenue Code to repeal the excise tax on medical devices. We applaud your leadership in introducing the bill in the Senate.

We believe the tax will negatively impact the United States medical technology industry's ability to develop new products that could improve the detection and treatment of age-related diseases and conditions, as well as the way we provide care for the aging population. The 2.3% medical device tax places an unnecessary burden on the medical device industry. Research has shown that medical device companies offset the decreases in profitability by cutting investments into research and development (R&D). In 2013, when the excise tax was active, R&D spending by the industry decreased by $34 million[1]. Additionally, there are some projections that as many 25,000[2] jobs could be lost by 2021 if the tax becomes active once again.

The unmet health challenges of older adults present an enormous financial and human burden. More resources—not less—are needed to address these challenges. Your support of this legislation will ensure that the American medical device industry remains at the forefront of innovations that will improve the living experiences of aging Americans. If you have any questions, please contact our Vice President of Public Policy, Missy Jenkins at (202) 293-2856 or at mjenkins@agingresearch.org.

Sincerely,

Susan Peschin

Susan Peschin, MHS
President and CEO

[1] Daeyong Lee, "Impact of the Excise Tax on Firm R&D and Performance in the Medical Device Industry: Evidence from the Affordable Care Act," Research Policy 47(5), June 2018, 854-871

[2] Book, Robert A. "Employment Effects of the Medical Device Tax." American Action Forum, 2 Mar. 2017,

MEDICAL ALLEY ASSOCIATION

June 14, 2018

Senator Patrick Toomey
248 Russell Senate Office Building
Washington D.C. 20510

Senator Mike Enzi
379A Russell Senate Office Building
Washington D.C. 20510

Senator Robert Casey
393 Russell Senate Office Building
Washington D.C. 20510

Senator Mark Warner
703 Hart Senate Office Building
Washington D.C. 20510

Dear Senators:

We are a group of small- and medium-sized medical device companies writing on behalf of the greater Medical Alley community today to strongly encourage the Senate Finance Task Force on Health Taxes to recommend full repeal of the medical device excise tax and urge the Committee to move promptly to consider any legislative vehicle that will address this tax. Large bipartisan majorities in Congress agree this tax is bad policy and, by the end of the year, it will have been suspended longer than it was in effect. Repealing this tax will ensure American patients continue to have access to the most innovative, life-saving medical technologies.

The medical device industry is a true American success story: Its birthplace and modern epicenter are both in Minnesota. More than 34,000 people are employed by the medical device industry in Minnesota alone. One-third of all complex medical devices have been designed and approved here. The health technology industry – of which medical device is a large part – has a $23 billion annual impact on our state's economy. However, because of the medical device industry's strength here, our state is disproportionately affected by this tax: 25 percent of the total device tax burden was paid by Minnesota companies when it was in effect.

The Medical Device Excise Tax has a downstream impact on the entire medical technology innovation ecosystem. This is due to it being levied on revenues rather than profits, making it particularly onerous for small- and medium-sized device companies like us, many of which generate revenue but no profit. These companies make up 80 percent of the industry and are the source of much of its innovation. We note, too, that no other industry has been singled out in this manner.

We greatly appreciate the continued suspension of the Medical Device Excise Tax enacted by Congress earlier this year. Unfortunately, this did not eliminate uncertainty around this tax, which continues to deter companies from making long-term investments necessary for growth. Repealing this tax will provide the certainty necessary to support sustainable investments in R&D, resulting in job creation and leading to better care for patients.

Medical devices have improved efficiencies and quality of care and outcomes for patients, resulting in overall cost savings. Minimally-invasive procedures, more accurate diagnostics, and reduction in hospitalizations and lengths of stay are just some of positive impacts on the healthcare industry from innovations in medical devices. Taxing the development and manufacture of these technologies imposes unnecessary penalties on them and diminishes the cost-savings they otherwise would have produced.

We thank you for your consideration and support.

Brett Landrum, CTO & Sr. Vice President, Global R&D, Smiths Medical
Steffen Hovard, President, Global Urology, Coloplast
Angela Zavoral Conley, CEO, AbiliTech Medical
Brad Fox, President & CEO, ACIST Medical Systems & HLT
Wayne Paterson, CEO, Admedus
Barbara Roth, Co-Founder & COO, Ativa Medical Corporation
Michael Carrel, President & CEO, Atricure
John Romans, CEO, Biomedix
Steve Goedeke, President & CEO, Cardionomic, Inc.
Curtis A. Corum, Co-Founder & President, Champaign Imaging, LLC
Nadim Yared, CEO, CvRX
James P. Moore, President & CEO, Dymedix Diagnostics
Brent Lucas, CEO, Envoy Medical
Vineel Vallapureddy, Vice President, Global R&D, Galil Medical
Juliana Elstad, President & CEO, Impleo Medical
Steve Wedan, CEO, Imricor Medical Systems
Jeff Killion, Chief Marketing Officer & VP of Business Development, Interrad Medical, Inc.
Andreas Pfanhl, CEO, Kobara Medical, Inc.
Paul Buckman, President, North America, General Manager – TMVR, LivaNova
Lothar Krinke, CEO, Magstim Group, Inc.
Todd Austin, CEO, MGC Diagnostics
Chris Pulling, CEO, MicroOptx
Martin J. Emerson, President & CEO, Monteris Medical
Steve Anderson, CEO, Preceptis Medical, Inc.
Carl Schwartz, CEO, Predictive Oncology, Inc.
Bryce Beverlin, II, Founder & CEO, Quench Medical
Kevin Hykes, President & CEO, Relievant Medisystems
Peter Sommerness, CEO, Respicardia
Tim Scanlan, President & CEO, Scanlan Group
Darryl Barnes, CEO, Sonex Health, LLC
Mark Stultz, Senior Vice President, Market Development, SPR Therapeutics
Philip A. Messina, COO, St. Teresa Medical
Gary Maharaj, President & CEO, SurModics, Inc.
Brady Hatcher, Co-Founder & Principal, Switchback Medical
Brian J. Buscher, Executive Chairman of the Board, 3DBiopsy, Inc.
Jerry Mattys, CEO, Tactile Medical
John Nealon, CEO, UroCure, LLC

June 14, 2019

Senator Pat Toomey
U.S. Senate
Washington, DC 20510

Senator Bob Casey, Jr.
U.S. Senate
Washington, DC 20510

Dear Senator Toomey and Senator Casey,

Thank you for the opportunity to submit comments and recommendations to the Task Force in response to the Finance Committee's efforts to develop long-term solutions to temporary tax policies. On behalf of the medical device members of the *Michigan Biosciences Industry Association, d/b/a MichBio,* we appreciate your interest in hearing from stakeholders on such an important issue.

Michigan's medical device sector employs over 11,600 people in more than 300 companies, contributes more than $14 billion to the economy, and sustains some of the highest paying jobs in the state. By some estimates, Michigan's device industry now ranks as the 11th largest in the U.S. Suffice to say that the medical devices sector in Michigan is a major contributor to state's economy.

We've heard firsthand from medical device manufacturers across the state that a number of regulations and policies have increased costs, lengthened timelines, and deterred companies from investing in the next generation of treatments and cures. All this threatens their ability to bring breakthrough innovations to market and the patients that need them.

The most onerous of these policies is the 2.3% excise tax on the sale of certain medical technology that was enacted as part of the Affordable Care Act (ACA). Since its enactment, the medical device tax has been a significant drag on medical innovation and resulted in the loss or deferred creation of jobs, reduced R&D, and slowed capital expansion. What is even more troubling is that this tax was imposed without any real policy justification. The medical device tax is not grounded in any health care policy. It is not connected to individual insurance coverage. It was designed purely as a means of raising revenue from the industry to offset the budgetary impact of the ACA.

Medical devices have revolutionized health care. To cite one example, medical technology has helped add more than five years to U.S. life expectancy since 1980. Advances in treatment mean patients experience less-invasive procedures, shorter hospitalizations, reduced recovery times, and lower overall costs. New technologies diagnose illnesses earlier, lowering the impact of care on a person's daily life. Breakthrough concepts reduce the overall cost of health care for patients and the system. All these gains are at risk if the medical device tax is reinstated.

The effects of the tax are felt across the industry, as every dollar of revenue (not income or profit) earned by a company is generally subject to the tax. For large, established companies, the device tax

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equals tens, if not hundreds, of millions of dollars that could be used to expand research and create jobs. For start-up firms, the effect of the tax is two-fold – it deters company growth, since the tax is imposed on the first dollar of revenue earned; and it restricts the ability of established medical technology companies to invest in or acquire start-up companies by limiting the amount of available funds.

Large bipartisan majorities in Congress agree that the medical device tax is bad policy. Thanks in no small part to your leadership and the efforts of the Committee on Finance, Congress has suspended the tax twice for a total of four years. Notably, by the end of this year, Congress will have suspended the tax for longer than it was in effect, with no measurable impact on coverage. Clearly, repeal of the device tax will not have a significant impact on the overall finances of the ACA, despite prior concerns.

Medical technology has improved efficiencies and produced savings to the system through minimally invasive procedures, more precise and accurate diagnostics, and devices that reduce hospitalizations or length of stay. These improvements mean better outcomes and higher-quality care for patients, which lowers cost. Taxing the development and manufacture of medical technology imposes an unnecessary penalty on these savings and erodes the value these technologies provide to the system in the long run.

The current suspension expires on December 31, 2019. Individual companies are already making important planning decisions for the next fiscal year, including how to allocate resources toward research and development as well as employment tied to research and development. As an excise tax, the device tax cannot be addressed retroactively in an effective manner. The longer Congress waits to act, the bigger the impact on the industry's ability to develop the next life-saving, life-enhancing technology.

We strongly encourage the Task Force to recommend full repeal of the medical device excise tax and urge the Committee to move promptly to consider legislation that includes repeal. We stand ready to work with you to advance any legislative vehicle that will address the medical device tax. Permanently repealing the device tax will provide medical technology innovators with the long-term certainty necessary to support future job growth and sustainable, cutting-edge R&D that will ultimately lead to the next generation of breakthroughs in patient care and treatment. With any other policy outcome, effective planning for a sustainable future becomes much more difficult.

Thank you again for this opportunity to share our thoughts on behalf of our medical technology companies. We look forward to working with you and your staff on a solution that will allow our members to retain their position as world leaders in developing and manufacturing technology that will improve the lives of patients in the United States.

Sincerely,

Stephen Rapundalo

Stephen Rapundalo, PhD
President and CEO

NATIONAL ASSOCIATION OF Manufacturers

Robyn Boerstling

Vice President
Infrastructure, Innovation, and Human Resources Policy

June 14, 2019

The Honorable Pat Toomey
U.S. Senate
Washington, DC 20510

The Honorable Bob Casey, Jr.
U.S. Senate
Washington, DC 20510

Dear Senator Toomey and Senator Casey:

On behalf of the National Association of Manufacturers (NAM), the largest manufacturing association in the United States representing 14,000 manufacturers in every industrial sector and in all 50 states, I urge for long-term delay of the medical device tax, health insurance tax and so-called "Cadillac Tax"

Every year employers must undergo the important process of renewing benefit offerings for employees. Already, negotiations are underway for health plan benefits for next year. Immediate action is necessary to ensure health care tax burdens are not added to employee plan costs. For example, the health insurance tax is set to go into effect next year and is projected to cause family health plan premiums to increase by almost $500 in the small group market. Additionally, manufacturers have already begun plan preparations for the 40 percent tax-hike on "high-cost" health benefits, commonly referred to as the Cadillac Tax, even though it does not go into effect until 2022.

In addition, the 2.3 percent medical device tax will also go into effect in 2020. Uncertainty over whether the tax will be repealed or not has slowed investment in research and development and stifled innovation. During a short period when the medical device tax was in effect, the tax caused 29,000 job losses or deferments within the industry. Start-stop efforts to delay and repeal these onerous taxes have only exacerbated uncertainty and cost in an already complex health care market.

Manufacturers consistently rank the rising cost of health care as a primary business challenge in the NAM's Quarterly Outlook Survey. Despite the challenge, approximately 98 percent of NAM members provide health insurance to employees. The manufacturing industry is committed to providing quality health benefits to employees to maintain a healthy workforce, attract and retain talent and because it is the right thing to do.

However, the constant threat of looming health care taxes raises the cost of providing quality benefits to employees. To provide greater certainty and address an unfair burden, it is important that Congress act quickly to provide manufacturers long-term relief from the upcoming medical device tax, health insurance tax and "Cadillac" tax.

Sincerely,

Robyn M. Boerstling

CC: The Honorable Mike Enzi, U.S. Senate
CC: The Honorable Mark Warner, U.S. Senate

ncbioscience.org

ncbio
inspiring science.
delivering hope.

June 14, 2019

Senator Pat Toomey
U.S. Senate
Washington, DC 20510

Senator Bob Casey, Jr.
U.S. Senate
Washington, DC 20510

Dear Senator Toomey and Senator Casey,

Thank you for the opportunity to submit comments and recommendations to the Task Force in response to the Finance Committee's efforts to develop long-term solutions to temporary tax policies. On behalf of the medical device members of the North Carolina Biosciences Organization (NCBIO), we appreciate your interest in hearing from stakeholders on such an important issue.

NCBIO is the trade association for the life science industry in North Carolina. While our members include companies from all segments of North Carolina's life science sector, a significant number of our members are medical device companies that are subject to the federal excise tax ("Medical Device Tax," or "Tax") on medical devices enacted as part of the Accountable Care Act ("ACA"), often referred to as Obama Care.

Medical device manufacturers in North Carolina are proud of their steadfast work to bring breakthrough innovations to patients. However, the ability of these companies to successfully commercialize new medical devices is materially impeded by the Medical Device Tax. Since is enactment, the Tax has been a significant drag on medical technology innovation.

This impairment should be no surprise considering the structure of the Tax. The Medical Device Tax requires medical device companies to pay over to the government an amount equal to 2.3% of revenues for the sale of medical devices. The tax is due for the first dollar of product sold. The tax is payable regardless of the companies' profitability. It is due whether the company has one product on the market or a thousand.

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A tax such as the Medical Device Tax is therefore a direct hinderance to the recovery of venture and other forms of equity investment raised by medical device companies to finance their commercialization activities. The tax takes – straight from the top line – money that would ordinarily go to make payroll, repay investors their investment, invest in new manufacturing facilities, and fund additional research and development.

Thus, the effects of the Tax are felt across the industry. For large, established companies, the device tax equals tens, if not hundreds, of millions of dollars that could be used to expand research and create jobs. For start-up firms, the effect of the tax is two-fold – it slows company growth and deters private equity investment in new product development.

Perhaps the most troubling aspect of the Tax is that it was imposed without any real policy justification. The Medical Device Tax is not grounded in any health care policy. It is not connected to individual insurance coverage. It is designed purely as a means of raising revenue from the industry to offset the budgetary impact of the ACA.

Medical devices have revolutionized health care. To cite one example, medical technology has helped add more than five years to U.S. life expectancy since 1980. Advances in treatment mean patients experience less-invasive procedures, shorter hospitalizations, reduced recovery times, and lower overall costs. New technologies diagnose illnesses earlier, lowering the impact of care on a person's daily life. Breakthrough concepts reduce the overall cost of health care for patients and the system. All these gains are at risk if the medical device tax is reinstated.

Since the Tax's enactment, large bipartisan majorities in Congress have agreed that the medical device tax is bad policy. Thanks in no small part to your leadership and the efforts of the Committee on Finance, Congress has suspended the Tax twice for a total of four years. Notably, by the end of this year, Congress will have suspended the Tax for longer than it was in effect, with no measurable impact on coverage. Clearly, repeal of the Medical Device Tax will not have a significant impact on the overall finances of the ACA, despite prior concerns.

Medical technology has improved efficiencies and produced savings to the American health care system through minimally invasive procedures, more precise and accurate diagnostics, and devices that reduce hospitalizations or length of stay. These improvements mean better outcomes and higher-quality care for patients, which lowers cost. Taxing the development and manufacture of medical technology imposes an unnecessary penalty on these savings and erodes the value these technologies provide to the system in the long run.

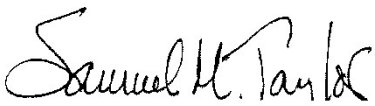
The current suspension of the Tax expires on December 31, 2019. Individual companies are already making important planning decisions for the next fiscal year, including how to allocate resources toward research and development as well as employment tied to research and development. As an excise tax, the device tax cannot be addressed retroactively in an

effective manner. The longer Congress waits to act, the bigger the impact on the industry's ability to develop the next life-saving, life-enhancing technology.

For all these reasons, we strongly encourage the Task Force to recommend full repeal of the Medical Device Tax and urge the Committee to move promptly to consider legislation that includes repeal. We stand ready to work with you to advance any legislative vehicle that will address the Tax. Permanently repealing the Medical Device Tax will provide medical technology innovators with the long-term certainty necessary to support future job growth and sustainable, cutting-edge R&D that will ultimately lead to the next generation of breakthroughs in patient care and treatment. With any other policy outcome, effective planning for a sustainable future becomes much more difficult.

Thank you again for this opportunity to share our thoughts on behalf of our medical technology companies. We look forward to working with you and your staff on a solution that will allow our members to retain their position as world leaders in developing and manufacturing technology that will improve the lives of patients in the United States.

Sincerely



Samuel M. Taylor
President

June 14, 2019

The Honorable Pat Toomey
248 Russell Senate Office Building
Washington, DC 20510

The Honorable Michael Enzi
379 A Russell Senate Office Building
Washington, DC 20510

The Honorable Bob Casey
393 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
703 Hart Senate Office Building
Washington, DC 20510

Re: Senate Finance Health Tax Extenders Task Force Stakeholder Feedback

Dear Senators Toomey, Casey, Enzi and Warner:

I write in support of permanently repealing the medical device tax and urge you to include repeal in any tax extenders legislative package created by the Finance Committee this year.

The 2.3 percent medical device excise tax reduces investment into research and development for innovative medical technology, which is concerning for any patient, regardless of their diagnosis.

Twice already we've seen wise bipartisan congressional action to suspend the medical device tax. However, we also saw when the medical device tax was in effect from 2013 to 2015, even in that short period, the impact on research and development was significant. Research has shown that, in 2013, the medical device tax reduced research and development spending on innovative technologies by $34 million.

This tax is also poorly constructed and the policy doesn't make sense. The tax is assessed on sales, not profits, which disproportionally impacts smaller firms. This creates an incredibly challenging environment for start-up companies and entrepreneurship in the medical device industry. Higher barriers to entry and fewer producers ultimately inhibit medical innovation from reaching end consumer-patients.

Patients want their care teams to be able to evaluate and adapt treatment plans quickly to take advantage of clinical trials or medical innovation. When we impose a sin tax on sales, – as the device tax does – its research and development that suffers.

I urge you to support medical technology research and development as well as patient access to medical innovation by permanently repealing the medical device tax – once and for all.

Sincerely,

Erika Hansen Brown
Founder, COLONTOWN
Right Scan Right Time Advocate

intact®
vascular

June 14, 2019

The Honorable Bob Casey, Jr.
United States Senate
393 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Pat Toomey
United States Senate
248 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Casey and Senator Toomey:

I want to begin by thanking you for your bipartisan work to examine how Congress can address various temporary tax provisions that require a permanent and reasonable solution. As a medical technology innovator, it is critical that we have predictability as we develop the cures and therapies of tomorrow. When Congress is able to remove barriers to success, everyone benefits. I write to share my concerns about the impact of a 2.3 percent medical device excise tax on innovation, patient care and job creation in Pennsylvania. As you know, Congress recognized the negative impact caused by this onerous policy and has provided for two suspensions of the tax beginning in 2016 and running through the end of 2019. However, if nothing is done, the medical device tax will be reinstated in 2020, diverting billions of dollars of investments that would otherwise be used to advance the development of life and cost saving technologies, improve patient care and expand the number of high paying jobs that are routinely associated with medical technology companies. While the suspensions of the device tax have certainly helped boost innovation, as your Committee has acknowledged by undertaking this work, the lack of predictability severely limits the ability to invest and plan for tomorrow. We cannot allow the medical device tax to cause any more harm, and I applaud the Committee's work to help ensure that it does not.

The history of the medical device tax is by now well known, but what is often forgotten is the unique footprint of the medical technology industry. We are a vibrant ecosystem that is predominantly made up of small, single-product companies that are working on solutions to discreet challenges that patients are facing. Federal data shows that 98 percent of medical device companies have less than 500 employees, and in my professional experience, I can attest to the amazing work that our industry is engaged in. I have personally been involved in the creation and growth of small, start-up companies that developed important new device-based treatments for heart failure, depression, arterial disease and venous disease. All of these companies are making outsized contributions to patient care and have collectively poured hundreds of millions of dollars into our economy through job growth, manufacturing, product development, and clinical trial conduct.

While many patients and physicians are familiar with numerous medical devices, from orthopedic implants, pacemakers, defibrillators and much more, what they often don't know is the myriad of regulatory, reimbursement and market access hurdles it requires to get access to life-saving and life-changing products. While it is not the focus of this Committee's work today, it is a tremendous investment of time and resources by engineers, physicians, clinical teams, manufacturers and more which can often take 5-7 years for most products, and much longer for truly novel, first-of-its-kind

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therapies. A company developing an innovative product to treat a large unmet need will routinely consume $80 million to $100 million in invested capital in order to complete development and satisfy the numerous requirements imposed by the FDA prior to market entry. In spite of all these difficulties and the long journey, the medical technology ecosystem is full of passionate and dedicated employees whose work is guided by the desire to help patients. However, the presence of a policy like the medical device tax punishes innovation and stifles the innovative work performed by these professionals.

The lessons of the medical device tax are clear. While this policy was in place, the Department of Commerce showed that our industry lost 28,000 jobs. According to past surveys by the Medical Device Manufacturers Association, 88 percent of innovators would slow down hiring or have to eliminate jobs if the device tax returned, and 83 percent reported they would have to decrease investments in R&D. I, unfortunately, have seen first-hand the negative consequences of this destructive policy, both as the CEO of a young and rapidly growing company, and at the start-up level.

The negative impact of this tax on the small companies that constitute the bulk of our industry is greatly amplified by the structure of the tax. As enacted, the medical device excise tax forces companies to pay the government shortly after invoicing a customer. The tax ignores the fact that it routinely takes months for a hospital to pay a company for the products it buys, so the company is forced to pay a tax on an income stream that may not materialize for months. The tax also ignores the company's ability to pay – there is no safe harbor for small companies that have yet to reach profitability. All of this combines to force small innovators to send money to Washington that they do not have. That cash has to come from somewhere and it comes at the expense of investment in product development and jobs.

My current company, Intact Vascular in Wayne, PA, is a great example. We spent $83 million over an eight-year period to develop an innovative vascular implant that can spare patients from the development of chronic leg pain, gangrene and ultimately avoid amputation. We received Pre-Market Approval from the FDA in April of this year and are launching our product as I write this. It will take us years to reach profitability, but if the medical device tax is not repealed, we will be forced to begin making tax payments in 2020. These payments will have to come out of cash that was invested in our company to drive its development. That translates to less growth, less hiring and less development of other innovations. In addition, more mature companies with established businesses also have addressed the impact of the device tax by making significant cuts to the next generation of products.

Simply put, regardless of the stage of development or size of a company, diverting billions of dollars of resources away from investments into the cures and therapies of tomorrow is senseless. It greatly prolongs a company's ability to reach profitability despite years and years of hard work, and at the same time depletes the ability of existing companies to bring new and innovative products to the marketplace.

There is no question that many challenges remain for the United States' health care delivery system. We need to improve patient outcomes while getting them back to a productive quality of life faster. Much of this work can be accomplished by minimizing stays in the hospital, developing less invasive surgeries, detecting diseases and managing chronic conditions more efficiently, and providing novel solutions to traditional standards of care. This is all accomplished with advancement in medical technology. Applying a 2.3 percent medical device excise tax in no way helps innovators accomplish the goal of improving patient care, and as global competition increases, this onerous policy makes it more difficult for America, a pioneer in this industry, to remain the world leader. I believe this is why strong bipartisan majorities in both the Senate and the House of Representatives have voted numerous times over the years to fully and permanently repeal the device tax. This is why Congress overwhelmingly agreed twice in the past 4 years to suspend it. This is why now is the time to put a permanent end to this punitive policy once and for all.

Sincerely,

Bruce Shook
President & CEO
Intact Vascular, Inc and Vesper Medical, Inc.
1285 Drummers Lane, Suite 200
Wayne, PA 19087

June 14, 2019

Senator Patrick Toomey
Co-Leader, Senate Finance Committee
Health Tax Taskforce
U.S. Senate
Washington, DC 20510

Senator Robert Casey, Jr.
Co-Leader, Senate Finance Committee
Health Tax Taskforce
U.S. Senate
Washington, DC 20510

Senator Michael Enzi
Member, Senate Finance Committee
Health Tax Taskforce
U.S. Senate
Washington, DC 20510

Senator Mark Warner
Member, Senate Finance Committee
Health Tax Taskforce
U.S. Senate
Washington, DC 20510

Via Email at: Health_Tax_Taskforce@finance.senate.gov

Dear Senator Toomey, Senator Casey, Senator Enzi and Senator Warner,

Thank you for the opportunity to submit comments and recommendations to the Task Force in response to the Finance Committee's efforts to develop long-term solutions to temporary tax policies. On behalf of FUJIFILM SonoSite, Inc. ("SonoSite") and the 600+ people we employ in Washington State, I appreciate your interest in hearing from stakeholders on such an important issue.

A manufacturer of high quality, portable ultrasound systems located in Bothell, Washington, SonoSite, Inc. is an American business success story. Created under a DARPA grant in the mid- 1990's, SonoSite's first mission was to create an ultrasound machine that could be carried into battle and used to make time-critical medical decisions under the most grueling conditions. The concept was simple: get treatment to a trauma victim within the first 60 minutes of being injured by giving a frontline clinician an ultrasound machine that could easily be brought to the patient's side.

Built to military specifications, all SonoSite ultrasound machines are tested at battle-grade durability standards. With more than 125,000 SonoSite machines, installed worldwide, but all manufactured in the United States in Bothell, WA, we continue to partner with clinicians to bring the benefits of ultrasound to the patient's point-of-care.

For years, Washington State – and the Puget Sound area in particular – has been a national example of the economic power of medical innovation and development. Unlike others who outsource manufacturing to lower labor cost markets abroad, our companies have been developing life-saving imaging technologies such as ultrasound right here in Washington State for more than 50 years. Unfortunately, our ability to sustain this high level of investment in research and development (R&D) and manufacturing technology is threatened by the lingering specter of the medical device tax.

The medical technology industry is also a crucial provider of high-quality, high-paying jobs. In our state alone, the medical imaging technology industry supports an estimated 12,157 jobs, with more than $1.03 billion in wages and benefits. And, these are good paying jobs. The jobs directly created by the medical technology industry have average wages and benefits of over $118,200, while those supplying goods and services to the industry have average wages of roughly $69,400 per year.

Starting in 2015, patients, providers and manufacturers experienced a temporary reprieve when a bipartisan group of lawmakers, worked across the aisle to twice pass legislation that suspended the tax for two years. But with the current suspension set to expire on December 31, 2019, the pressure for medical device companies to reduce their costs of cover the tax has returned in full force. The uncertainty caused by these continual two-year delays has hampered our ability to prioritize investment in jobs and innovation. Without a tax policy that's conducive to widespread R&D investment, we simply are not able to continue creating opportunities to further expand and invigorate our state and local economies. We need Congress under the leadership of your Taskforce and the Finance Committee to secure repeal of the medical device tax as soon as possible.

Repealing this tax will help to unleash private sector investment in medical R&D, which will facilitate access to life-saving technologies and drive much-needed economic development and increase jobs in Washington State and in the United States, in general. SonoSite, Inc. greatly appreciates this opportunity to share our thoughts with the Health Tax Taskforce. We look forward to working with you and your staff on a solution that will allow us to retain our position as world leaders in developing and manufacturing point-of-care ultrasound systems that will improve the lives of patients in the United States.

Sincerely,

Richard Fabian
President and Chief Operating Officer
FUJIFILM SonoSite, Inc.

CC: Senator Patty Murray
Senator Maria Cantwell

June 14, 2019

Senator Pat Toomey
U.S. Senate
Washington, DC 20510

Senator Bob Casey, Jr.
U.S. Senate
Washington, DC 20510

Dear Senator Toomey and Senator Casey,

Thank you for the opportunity to submit comments and recommendations to the Task Force in response to the Finance Committee's efforts to develop long-term solutions to temporary tax policies. On behalf of the medical device members of Virginia Bio, we appreciate your interest in hearing from stakeholders on such an important issue.

Virginia Bio is the statewide trade association of companies, researchers, developers, investors, who do life science commercialization across the state. Among our 250 member companies and institutions are many in the medical device field. Virginia Business magazine, the state's leading statewide business publication, ran its May cover story profiling the medical device industry: *Favorable prognosis the state's medical device industry is thriving!*

Medical device manufacturers in Virginia are committed to bringing breakthrough innovations to patients, but that commitment is threatened by a number of regulations and policies that have increased costs, lengthened timelines, and deterred companies from investing in the next generation of treatments and cures.

Chief among these policies is the 2.3% excise tax on the sale of certain medical technology that was enacted as part of the Affordable Care Act (ACA). Since its enactment, the medical device tax has been a significant drag on medical innovation and resulted in the loss or deferred creation of jobs, reduced R&D, and slowed capital expansion. What is even more troubling is that this tax was imposed without any real policy justification. The medical device tax is not grounded in any health care policy. It is not connected to individual insurance coverage. It was designed purely as a means of raising revenue from the industry to offset the budgetary impact of the ACA.

Medical devices have revolutionized health care. To cite one example, medical technology has helped add more than five years to U.S. life expectancy since 1980. Advances in treatment mean patients experience less-invasive procedures, shorter hospitalizations, reduced recovery times, and lower overall costs. New technologies diagnose illnesses earlier, lowering the impact of care on a person's daily life. Breakthrough concepts reduce the overall cost of health care for patients and the system. All these gains are at risk if the medical device tax is reinstated.

The effects of the tax are felt across the industry, as every dollar of revenue (not income or profit) earned by a company is generally subject to the tax. For large, established companies, the device tax equals tens, if not hundreds, of millions of dollars that could be used to expand research and create jobs. For start-up firms, the effect of the tax is two-fold – it deters company growth, since the tax is imposed on the first dollar of revenue earned; and it restricts the ability of established medical technology companies to invest in or acquire start-up companies by limiting the amount of available funds.

Large bipartisan majorities in Congress agree that the medical device tax is bad policy. Thanks in no small part to your leadership and the efforts of the Committee on Finance, Congress has suspended the tax twice for a total of four years. Notably, by the end of this year, Congress will have suspended the tax for longer than it was in effect, with no measurable impact on coverage. Clearly, repeal of the device tax will not have a significant impact on the overall finances of the ACA, despite prior concerns.

Medical technology has improved efficiencies and produced savings to the system through minimally invasive procedures, more precise and accurate diagnostics, and devices that reduce hospitalizations or length of stay. These improvements mean better outcomes and higher-quality care for patients, which lowers cost. Taxing the development and manufacture of medical technology imposes an unnecessary penalty on these savings and erodes the value these technologies provide to the system in the long run.

The current suspension expires on December 31, 2019. Individual companies are already making important planning decisions for the next fiscal year, including how to allocate resources toward research and development as well as employment tied to research and development. As an excise tax, the device tax cannot be addressed retroactively in an effective manner. The longer Congress waits to act, the bigger the impact on the industry's ability to develop the next life-saving, life-enhancing technology.

We strongly encourage the Task Force to recommend full repeal of the medical device excise tax and urge the Committee to move promptly to consider legislation that includes repeal. We stand ready to work with you to advance any legislative vehicle that will address the medical device tax. Permanently repealing the device tax will provide medical technology innovators with the long-term certainty necessary to support future job growth and sustainable, cutting-edge R&D that will ultimately lead to the next generation of breakthroughs in patient care and treatment. With any other policy outcome, effective planning for a sustainable future becomes much more difficult.

Thank you again for this opportunity to share our thoughts on behalf of our medical technology companies. We look forward to working with you and your staff on a solution that will allow our members to retain their position as world leaders in developing and manufacturing technology that will improve the lives of patients in the United States.

Sincerely

Jeffrey M. Gallagher
CEO

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite Five Hundred
Washington, DC 20004

Matthew Eyles
President and CEO

June 14, 2019

The Honorable Patrick Toomey
United States Senate
248 Russell Building
Washington, DC 20510

The Honorable Robert Casey
United States Senate
393 Russell Building
Washington, DC 20510

The Honorable Mike Enzi
United States Senate
379A Russell Building
Washington, DC 20510

The Honorable Mark Warner
United States Senate
703 Hart Building
Washington, DC 20510

Dear Senators Toomey, Casey, Enzi, and Warner:

On behalf of America's Health Insurance Plans (AHIP), I am writing to express our strong support for legislative action to provide relief to the American people from both the health insurance tax and the Cadillac tax on employer-provided health coverage, and to provide recommendations on reauthorization legislation for the Patient-Centered Outcomes Research Institute (PCORI).

We urge you, as leaders of the Senate Finance Committee's Health Tax Task Force, to work with your Senate colleagues to pass legislation that delays and eventually repeals these taxes that harm hardworking American families. The need for relief from the health insurance tax is particularly urgent, as this tax will impose a heavy burden on consumers beginning in January 2020, in the absence of congressional action.

Health Insurance Tax

We strongly support a bipartisan Senate bill (S. 80) that would fully repeal the health insurance tax and another bipartisan bill (S. 172) that would suspend the health insurance tax for both 2020 and 2021. We appreciate that 28 senators have cosponsored at least one of these bills.

Under current law, the health insurance tax has been suspended for 2019. An August 2018 analysis by Oliver Wyman estimates that if the health insurance tax is allowed to resume in 2020, it would have a premium impact next year (on a per enrollee basis) of $196 for individuals in the non-group market, $154 for individuals and $479 for families in the small group market,

$158 for individuals and $458 for families in the large group market, $241 for Medicare Advantage enrollees, and $157 for each enrollee covered by Medicaid managed care programs.[1] With 40% of adults not able to cover $400 of emergency expenses, these costs would be even more devastating to these families.[2]

Another Oliver Wyman analysis, released in January 2019, focuses specifically on the tax's impact on Medicare Advantage enrollees.[3] This study estimates that national average Medicare Advantage premiums may have increased by up to 56% if the health insurance tax had not been suspended for 2019.

Relief from the health insurance tax would provide real savings to the American people. We strongly urge Congress to provide additional relief from the health insurance tax, beginning with a two-year suspension for 2020 and 2021.

Excise Tax on Employer-Provided Coverage

We strongly support a bipartisan Senate bill (S. 684) that would fully repeal the Cadillac tax, a 40% excise tax that will apply to the cost of employer-provided health coverage that exceeds a statutory dollar amount. We appreciate that 40 senators have cosponsored this important legislation.

Our members are seriously concerned that implementation of this tax would be harmful to the 180 million Americans who rely on employer-provided health coverage. This tax will hurt businesses and families of all income levels, and result in many Americans paying more money for less health coverage.

The impact of the Cadillac tax goes far beyond high-income workers and employee health plans offering "rich" benefits. A survey by United Benefit Advisors estimates that 74% of employer-provided health plans will be affected by the tax when it takes effect in 2022.[4] Another analysis, by Towers Watson, estimates that 82% of employer-provided health plans will be subject to the tax by 2023.[5] Additional research, published in the *International Journal of Health Services*, cautions that the Cadillac tax "will hit the middle class hardest" and "will disproportionately harm families with (2009) incomes between $38,550 and $100,000."[6]

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[1] http://www.stopthehit.com/wp-content/uploads/2018/08/Oliver-Wyman-2018-Analysis-of-Health-Insurance-Tax.pdf
[2] https://www.federalreserve.gov/publications/files/2017-report-economic-well-being-us-households-201805.pdf
[3] https://www.oliverwyman.com/content/dam/oliver-wyman/blog/hls/featured-images/2019/jan/MA-Addendum-to-HIT-Analysis-FINAL.pdf
[4] http://blog.ubabenefits.com/news/three-out-of-four-u.s.-employers-to-be-hit-with-cadillac-tax-by-2022
[5] https://www.towerswatson.com/en-US/Press/2014/09/nearly-half-us-employers-to-hit-health-care-cadillac-tax-in-2018-with-82-percent-by-2023
[6] https://journals.sagepub.com/doi/abs/10.1177/0020731416637163?journalCode=joha

It is clear that such a tax imposes higher costs on working families and undermines our shared goal of making health care more affordable. We strongly urge Congress to approve legislation to fully repeal this burdensome tax.

Patient-Centered Outcomes Research Institute (PCORI) Reauthorization

PCORI plays an important role in funding clinical effectiveness research that compares two or more available health care options to determine what works best for which patients and under what circumstances. PCORI's work is supported largely by user fees paid by health insurance providers and self-insured employers. The cost of PCORI is not insignificant for payers and to date it has been difficult to measure the success or utility of its output.

As Congress considers PCORI reauthorization legislation, we believe there are significant opportunities to strengthen the program. We recommend changes in three areas: (1) increasing the representation of payers on the PCORI Board of Governors; (2) requiring PCORI to establish an accelerated, evidence-based process for setting the research agenda and funding studies; and (3) allowing PCORI to consider the relative cost and value in evaluating and comparing health outcomes and the clinical effectiveness, risks and benefits of two or more medical treatments or services.

Thank you for your leadership in seeking solutions to make health care more affordable for the American people. We look forward to working with you to address these priorities and advance other strategies for lowering health care costs.

Sincerely,

Matthew Eyles
President and CEO

Humana Inc.
500 W. Main St.
Louisville, KY 40202-2946
www.humana.com

Humana

June 17, 2019

The Honorable Patrick J. Toomey
Co-Lead, Senate Finance Committee Health Care Tax Extenders Working Group
248 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Robert Casey Jr.
Co-Lead, Senate Finance Committee Health Care Tax Extenders Working Group
154 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Michael Enzi
Senate Finance Committee Health Care Tax Extenders Working Group
397-A Russell Senate Office Building
Washington, D.C. 20510

The Honorable Mark Warner
Senate Finance Committee Health Care Tax Extenders Working Group
703 Hart Senate Office Building
Washington, D.C. 20510

Dear Senators Toomey, Casey, Enzi, and Warner,

Thank you for your leadership in serving on the Senate Finance Committee Health Care Tax Extenders Working Group. In particular, Humana supports the working group's interest in examining the impact of the Health Insurance Tax (HIT), (Section 9010 of the Affordable Care Act).

Humana is an integrated health and wellness company focused on providing value to seniors by operating a holistic, health outcomes-driven model that is beneficiary-centric, focuses on chronic care and contains locally-integrated health capabilities. We currently provide Medicare coverage for more than 8.4 million seniors across all 50 states, with approximately 4 million Medicare Advantage (MA) members and 4.4 million Medicare Prescription Drug Plan (PDP) members.

- In Pennsylvania, Humana provides health care coverage to over 195,000 seniors (approximately 55,000 MA/MAPD beneficiaries and 141,000 PDP beneficiaries).
- In Wyoming, Humana provides health care coverage to approximately 19,750 seniors (approximately 250 MA/MAPD beneficiaries and 19,500 PDP beneficiaries).

- In Virginia, Humana provides health care coverage to over 295,000 seniors (approximately 150,000 MA/MAPD beneficiaries and 143,000 PDP beneficiaries).

In recognition of the HIT's negative impact on over 156 million Americans through higher health insurance premiums and/or diminution of the value of their health coverage due to reductions in benefits, Congress has twice passed bipartisan legislation to delay the tax. The moratoriums were respectively signed into law under President Obama and President Trump. Nearly one in two Americans are impacted by the tax including families and individuals with a wide variety of health coverage, including coverage through small business employers; Affordable Care Act exchange plans; and Medicaid plan offerings.

In addition, over 20 percent of the tax falls directly on seniors who rely on quality, affordable Medicare coverage through MA and Part D. Presently, according to the Centers for Medicare and Medicaid Services (CMS), over 22 million beneficiaries – over one in three seniors – receive health coverage through MA. In addition, over 31 percent of African American Medicare beneficiaries and more than 44 percent of Latino Medicare beneficiaries are enrolled in MA.

Our own internal actuarial findings align with non-partisan published research showing the annual impact of the HIT results in approximately $240 of additional annual cost to MA members through higher premiums and/or diminution of supplemental health benefits. Given that nearly half of all MA beneficiaries have incomes below $24,000 this undue additional financial burden is substantial, and potentially harmful to health outcomes.

Seniors depend on their health coverage costs to be both affordable and predictable. CMS has pointed to the current calendar year moratorium of the HIT as one of the key contributing factors resulting in a 6 percent average reduction of MA premiums. Without Congressional action, seniors could see higher premiums and a loss of needed supplemental benefits in 2020.

We strongly support S. 172, which continues the current moratorium of the tax through 2020 and 2021, and S. 80, which permanently repeals the tax. We encourage the working group to adopt recommendations supporting these bills and advancing policy recommendations to ensure the current HIT moratorium remains in place in order to provide financial health coverage relief to the nearly one in two Americans impacted by the HIT.

As the working group convenes listening sessions, we would welcome being extended an invitation to participate. If you have any questions or would like additional information, please reach out to Rachel Magnuson, Director of Federal Affairs (RMagnuson1@Humana.com and 202-467-8686).

Thank you.

Sincerely,

Douglas Stoss
Vice President of Federal Affairs
Humana, Inc.

STOP THE HIT

June 17, 2019

The Honorable Patrick Toomey
Co-Lead, Health Taskforce
Senate Finance Committee
United States Senate

The Honorable Robert Casey, Jr.
Co-Lead, Health Taskforce
Senate Finance Committee
United States Senate

Dear Senators Toomey and Casey,

As members of the Stop The HIT Coalition, representing the nation's 29 million small businesses, their employees and the self-employed, we applaud the Senate Finance Committee's commitment to addressing the health care affordability concerns facing millions of Americans. One of the most pressing and urgent cost challenges facing small businesses and entrepreneurs is the Health Insurance Tax (HIT) which adds to the cost of health coverage and undermines our shared goal of affordable health care.

Already, our Coalition members and small businesses across the country are in the process of renewing 2020 health coverage for employees. By advancing legislation that would suspend the tax for two years (2020 and 2021), Congress can provide small businesses with continued stability now and savings of nearly $1,000 on average over the next two years. Families making between $10,000 - $50,000 bear the brunt of this tax so this cost-savings will provide significant financial relief.

Allowing the HIT to return next year would result in higher health insurance premiums for small businesses and their employees – roughly $480 in added premium costs on average for a family purchasing coverage in the small group market. As small business owners throughout the country look to plan ahead for employee benefit programs and future growth, we urge you to take immediate action to once again delay the impact of this regressive tax before it is factored into premiums moving forward.

Since 2013, legislation has been introduced in both the House and Senate on a bipartisan basis to suspend or repeal the tax. HIT relief has been signed into law by both President Obama and President Trump. We are encouraged by the continued bipartisan support from leaders in the U.S. Senate including the work from Sens. Cory Gardner (R-CO), Jeanne Shaheen (D-NH), John Barrasso (R-WY), Tim Scott (R-SC), Doug Jones (D-AL) and Kyrsten Sinema (D-AZ) to introduce bipartisan legislation (S.172) that would extend HIT relief through 2021.

We urge you to take action now before small businesses are once again burdened by this misguided tax.

Sincerely,

American Council of Engineering Companies
American Farm Bureau Federation
American Rental Association
Associated Builders and Contractors
Associated General Contractors
Auto Care Association
Independent Electrical Contractors
National Association of Health Underwriters

National Association of Home Builders
National Association of Wholesaler-Distributors
National Club Association
National Community Pharmacists Association
National Funeral Directors Association
NFIB
National Restaurant Association
National Retail Federation
National Roofing Contractors Association
National Small Business Association
Petroleum Marketers Association of America
Retail Industry Leaders Association
Society of American Florists

ACLI Submission to the Senate Finance Committee Health Task Force

June 14, 2019

Thank you, Chairman Grassley and Ranking Member Wyden, for your leadership in forming several bipartisan task forces to examine temporary tax provisions that have expired or will soon expire. It is a worthwhile exercise to provide as much long-term certainty as possible in the Tax Code. As the Health Task Force undergoes its review, the American Council of Life Insurers (ACLI) urges Congress to make permanent the employer credit for paid family and medical leave (PFML) as found in Section 45S of the Tax Code (Fischer Credit) and which is due to expire at the end of this year. The life insurance industry plays a key role in the private marketplace in providing solutions to address PFML.[1]

ACLI advocates on behalf of approximately 280 member companies dedicated to providing products and services that contribute to consumers' financial and retirement security. Our members represent 95 percent of industry assets in the United States, and proudly protect 90 million American families with financial products that reduce risk and increase financial security through offerings like life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, dental and vision and other supplemental benefits. ACLI represents member companies in state, federal, and international forums for public policy that supports the marketplace for life insurer products that provide peace of mind to families and individuals.

Paid leave is a critical issue facing Americans today. One way to alleviate the financial and administrative challenges that arise from offering a paid leave benefit in the workplace is through private disability income insurance. This product is offered by life insurers and is the most common form of income protection for workers, allowing millions of American workers to maintain their income when a medical condition or the birth of a child keeps them out of the workplace. It's noteworthy that for the 47 percent of full-time civilian workers covered by our short-term disability policies, maternity leave is the number one paid benefit. When Congress discusses policies in support of paid leave, it is important to maintain and expand upon a vibrant private marketplace for solutions. In this debate, there are many approaches to consider, including tax incentives. Legislative proposals, such as the Fischer Credit, is one approach that incentivize employers to voluntarily provide PFML benefits to their employees. While current law only provides this credit for two years, permanency would ensure greater utilization of this benefit.

In addition to making the credit permanent, attached are suggested changes to Section 45S that would improve the Fischer Credit for employers. Collectively, these modifications would provide employers with greater flexibility when offering PFML benefits to employees as well as making it easier for more generous benefits to be paid. It's important to consider and adopt changes that

[1] Please find attached a document which describes the industry's role in helping employers offer paid leave.

would expand paid leave coverage for employees by removing barriers to employers for offering them.

Thank you for this opportunity to offer comment as the Senate Finance Committee evaluates expiring tax provisions. We look forward to working with you on these important issues.

SEC. 45S. EMPLOYER CREDIT FOR PAID FAMILY AND MEDICAL LEAVE.

45S(a) ESTABLISHMENT OF CREDIT.—

45S(a)(1) IN GENERAL.— For purposes of section 38, in the case of an eligible employer, the paid family and medical leave credit is an amount equal to the applicable percentage of the amount of wages paid to qualifying employees ~~during~~ with respect to any period in which such employees are on family and medical leave.

45S(a)(2) APPLICABLE PERCENTAGE.— For purposes of paragraph (1), the term "applicable percentage" means 12.5 percent increased (but not above 25 percent) by 0.25 percentage points for each percentage point by which the rate of payment (as described under subsection (c)(1)(B)) exceeds 50 percent.

45S(b) LIMITATION.—

45S(b)(1) IN GENERAL.— The credit allowed under subsection (a) with respect to any employee for any taxable year shall not exceed an amount equal to the product of the normal hourly wage rate of such employee for each hour (or fraction thereof) of actual services performed for the employer and the number of hours (or fraction thereof) for which family and medical leave is taken.

45S(b)(2) NON-HOURLY WAGE RATE.— For purposes of paragraph (1), in the case of any employee who is not paid on an hourly wage rate, the wages of such employee shall be prorated to an hourly wage rate under regulations established by the Secretary.

45S(b)(3) MAXIMUM AMOUNT OF LEAVE SUBJECT TO CREDIT.— The amount of family and medical leave that may be taken into account with respect to any employee under subsection (a) for any taxable year shall not exceed 12 weeks.

45S(c) ELIGIBLE EMPLOYER.— For purposes of this section—

45S(c)(1) IN GENERAL.— The term "eligible employer" means any employer who has in place a written policy that meets the following requirements:

45S(c)(1)(A) The policy provides—

45S(c)(1)(A)(i) in the case of ~~a~~ substantially all qualifying employees who are~~is~~ not ~~a~~ part-time employees (as defined in section 4980E(d)(4)(B)), not less than 2 weeks of annual paid family and medical leave, and

45S(c)(1)(A)(ii) in the case of a qualifying employee who is a part-time employee, an amount of annual paid family and medical leave that is not less than an amount which bears the same ratio to the amount of annual paid family and medical leave that is provided to a qualifying employee described in clause (i) as—

45S(c)(1)(A)(ii)(I) the number of hours the employee is expected to work during any week, bears to

45S(c)(1)(A)(ii)(II) the number of hours an equivalent qualifying employee described in clause (i) is expected to work during the week.

45S(c)(1)(B) The policy requires that the rate of payment under the program is not less than 50 percent of the wages normally paid to such employee for services performed for the employer.

45S(c)(2) SPECIAL RULE FOR CERTAIN EMPLOYERS.—

45S(c)(2)(A) IN GENERAL.— An added employer shall not be treated as an eligible employer unless such employer provides paid family and medical leave in compliance with a written policy which ensures that the employer—

45S(c)(2)(A)(i) will not interfere with, restrain, or deny the exercise of or the attempt to exercise, any right provided under the policy, and

45S(c)(2)(A)(ii) will not discharge or in any other manner discriminate against any individual for opposing any practice prohibited by the policy.

45S(c)(2)(B) ADDED EMPLOYER; ADDED EMPLOYEE.— For purposes of this paragraph—

45S(c)(2)(B)(i) ADDED EMPLOYEE.— The term "added employee" means a qualifying employee who is not covered by title I of the Family and Medical Leave Act of 1993, as amended.

45S(c)(2)(B)(ii) ADDED EMPLOYER.— The term "added employer" means an eligible employer (determined without regard to this paragraph), whether or not covered by that title I, who offers paid family and medical leave to added employees.

45S(c)(3) AGGREGATION RULE.— All persons which are treated as a single employer under subsections (a) and (b) of section 52 shall be treated as a single taxpayer.

45S(c)(4) TREATMENT OF BENEFITS MANDATED OR PAID FOR BY STATE OR LOCAL GOVERNMENTS.— Solely f~~F~~or purposes of ~~this~~ subsection (a), any leave which is paid by a State or local government or required by State or local law shall not be taken into account in determining the amount of paid family and medical leave provided by the employer.

45S(c)(5) NO INFERENCE.— Nothing in this subsection shall be construed as subjecting an employer to any penalty, liability, or other consequence (other than ineligibility for the credit allowed by reason of subsection (a) or recapturing the benefit of such credit) for failure to comply with the requirements of this subsection.

45S(d) QUALIFYING EMPLOYEES.— For purposes of this section, the term "qualifying employee" means any employee (as defined in section 3(e) of the Fair Labor Standards Act of 1938, as amended) who—

45S(d)(1) is not described in any clause of section 105(h)(3)(B) (applied by substituting "1 year" for "3 years" in clause (i) thereof), unless ~~has been employed by the employer for 1 year or more~~elected by the employer, and

45S(d)(2) for the preceding year, had compensation not in excess of an amount equal to ~~60~~ 80 percent of the amount applicable for such year under clause (i) of section 414(q)(1)(B).

45S(e) FAMILY AND MEDICAL LEAVE.—

45S(e)(1) IN GENERAL.— Except as provided in paragraph (2), for purposes of this section, the term "family and medical leave" means leave for any 1 or more of the purposes described under subparagraph (A),

(B), (C), (D), or (E) of paragraph (1), or paragraph (3), of section 102(a) of the Family and Medical Leave Act of 1993, as amended, whether the leave is provided under that Act or by a policy of the employer.

45S(e)(2) EXCLUSION.— If an employer provides paid leave as vacation leave, personal leave, or medical or sick leave (other than leave specifically for 1 or more of the purposes referred to in paragraph (1)), that paid leave shall not be considered to be family and medical leave under paragraph (1).

45S(e)(3) DEFINITIONS.— In this subsection, the terms "vacation leave", "personal leave", and "medical or sick leave" mean those 3 types of leave, within the meaning of section 102(d)(2) of that Act.

45S(f) DETERMINATIONS MADE BY SECRETARY OF TREASURY.— For purposes of this section, any determination as to whether an employer or an employee satisfies the applicable requirements for an eligible employer (as described in subsection (c)) or qualifying employee (as described in subsection (d)), respectively, shall be made by the Secretary based on such information, to be provided by the employer, as the Secretary determines to be necessary or appropriate.

45S(g) WAGES.— For purposes of this section, the term "wages" has the meaning given such term by subsection (b) of section 3306 (determined without regard to any dollar limitation contained in such section). Such term shall not include any amount taken into account for purposes of determining any other credit allowed under this subpart.

45S(h) ELECTION TO HAVE CREDIT NOT APPLY.—

45S(h)(1) IN GENERAL.— A taxpayer may elect to have this section not apply for any taxable year.

45S(h)(2) OTHER RULES.— Rules similar to the rules of paragraphs (2) and (3) of section 51(j) shall apply for purposes of this subsection.

~~**45S(i) TERMINATION.—** This section shall not apply to wages paid in taxable years beginning after December 31, 2019.~~

Modifications to Section 45S in Connection with Extension of Credit

1. *Clarify timing for payment of wages.*

We suggest this modification:

> Section 45S(a)(1) is amended by striking "during" and inserting "with respect to"

Currently, the statutory language, read literally, requires the wages to be paid during a period of leave. Under normal payroll practices, a wage payment with respect to leave may not occur during that leave. Additionally, normal accrual concepts would be difficult to apply in this context because the wages are being paid for services that are not performed. Accordingly, allowing the credit for wages paid "with respect to" a period of leave provides clarity and is consistent with the purposes of the statute.

2. *Allow the credit when leave is provided to substantially all full-time employees.*

We suggest this modification:

> Section 45S(c)(1)(A)(i) is amended by striking "in the case of a qualifying employee who is a part-time employee" and inserting "in the case of substantially all qualifying employees who are not part-time employees".

Requiring employers to strictly offer the same leave package to all employees sets up an impossible standard. A "substantially all" standard would allow an employer room for error with respect to a de minimis percentage of employees without losing eligibility. Introducing the "substantially all" concept will allow the Treasury Department to interpret the statute in a manner consistent with the purposes of the statute.

3. *Allow employers offering more generous leave in states or localities requiring leave to be eligible for the credit.*

We suggest this modification:

> Section 45S(c)(4) is amended by striking "For purposes of this section" and inserting "Solely for purposes of subsection (a)".

Currently, the statute disregards leave mandated by a state or locality both for purposes of eligibility and in calculating the credit. As a result, an employer offering more generous leave is generally ineligible for the credit. For example, an employer in a state requiring eight weeks of paid family and medical leave that instead provides nine weeks of leave would not be eligible for a credit because only one additional week of leave has been offered, which does not satisfy the statutory minimum of two weeks. We suggest the statute be modified to allow that employer to claim the credit for the additional week of leave, which would incentivize employers to be more generous than state law would require but would not reward employers for simply complying with state law.

4. *Allow employers limited flexibility to identify qualifying employees.*

We suggest this modification:

Section 45S(d)(1) is amended by striking "has been employed by the employer for 1 year or more" and inserting "are not described in any clause of section 105(h)(3)(B) (applied by substituting "1 year" for "3 years" in clause (i) thereof), unless elected by the employer".

Most employers' business needs require differentiating benefit arrangements between certain categories of employees. Limiting an employer's flexibility to make this differentiation has substantially limited the statute's incentivizing impact. Allowing employers to tailor arrangements based on the categories of employees identified in section 105(h) (this includes, as modified, employees with less than one year of service; employees under the age of 25; part-time or seasonal employees; certain employees covered under a collective bargaining agreement; and certain nonresident aliens) will encourage employers to make incremental changes to expand paid family and medical leave without imposing insurmountable hurdles to eligibility.

5. *Increase the compensation cap for qualifying employees.*

We suggest this modification:

Section 45S(d)(2) is amended by striking "60 percent" and inserting "80 percent".

Currently, qualifying employees are limited to those earning $75,000 (60% of section 414(q)(1)(B) threshold of $125,000, as indexed in 2019) or less. At this level, an employer's paid family leave to the caregiver of a family of five earning $80,000 (below 300% of the 2019 Federal Poverty Level) would not be eligible for the credit. Incrementally increasing the compensation cap would incentivize employers to provide leave to such a family.

LIFE INSURERS' ROLE IN PAID FAMILY AND MEDICAL LEAVE

$4.6 BILLION

in short-term disability insurance benefits...

25%

of short-term disability claims are related to pregnancy and maternity.

47%

of full-time civilian workers receive paid leave...

under their employer's short-term disability plan.

■ **Private disability income insurance offered by life insurers is the most common form of income protection for workers—allowing millions of American workers to maintain their income when a medical condition or the birth of a child keeps them out of the workplace.** In 2017, the private employer-based system paid American workers approximately $4.6 billion in benefits as they recovered from conditions that kept them from working, including those associated with pregnancy and the birth of a child. Twenty-five percent of all short-term disability claims are related to pregnancy and maternity. Currently, many state mandated leave programs allow employers to meet the requirements of paid medical leave for an employee's medical condition through a short-term disability plan. Others may also allow employers to meet other requirements of PFML programs via private industry.

■ **The elements of PFML can be confusing.** For example, the "ML" in PFML is fairly straightforward and typically is provided by an employer through short-term disability insurance and/or a self-funded program. It provides income replacement when an employee is unable to work due to a medical condition. The approach to the "FL" in PFML is far less straightforward. There is no uniform definition for paid family leave amongst the states, localities, or the federal government. This includes varying covered caregiving events, durations of covered leave and ranges of income replacement. Paid paternity/parental leave is almost always an employer-funded income replacement for time off to care for and bond with a newborn or adopted child.

■ **In jurisdictions with PFML requirements there are significant variations:**

- Maternity leave can range up to 12 weeks.
- Maximum medical leave can range up to 52 weeks.
- Maximum income replacement can range from $170 week to $1,252/week.
- Plan eligibility and funding formulas differ.

■ **Short-term disability insurers already provide much of the paid family and medical leave that would be required under new PFML proposals.** Approximately 47% of all full-time civilian workers are provided paid leave under their employer's short-term disability plan and approximately 50% of civilian workers in a union have access to short-term disability benefits. Short-term disability plans provide paid leave for employees' inability to work due to a medical condition. The most common benefits under these policies pay for maternity leave - typically for a period of 6 to 8 weeks following the birth of a child, and for additional paid time during pregnancy if medically necessary. The typical short-term disability plans provide income replacement (usually between 60 - 67%) for 26 weeks. Private short-term disability insurance policies do not provide coverage for paternity/parental leave.

"ACLI'S CARRIERS HAVE THE EXPERTISE, SYSTEMS AND STAFF TO PROVIDE AND ASSIST IN ADMINISTRATION OF PAID FAMILY AND MEDICAL LEAVE BENEFITS IN PROGRAMS."

■ **Private disability insurers are able to protect American workers whose short-term absences extend into the longer-term.** Private insurers not only help employers protect their employees who face short-term absences, they also seamlessly transition workers whose absences extend beyond the short term. Most disability carriers administer benefits for both short- and long-term disabilities, and do so with minimum burden on employers and employees and without disruption of income benefits. Information gathered during a short-term absence is used to ensure that those workers who are unable to return to work don't face a second significant financial disruption as their short-term benefits expire. Long-term disability benefits coordinate with short-term paid leave to ensure a continuous income stream for employees. The private industry typically makes benefit decisions very quickly without income disruption to employees.

■ **Private plans benefit employers and employees alike.** Private insurers offer employers the flexibility to provide coverage with equal or more generous benefits than may be required under law, and allow multi-state employers the ability to provide equal benefits to all employees. ACLI's carriers have the expertise, systems and staff to provide and assist administration of PFML benefits in programs.

■ **ACLI supports a role for private insurers to participate in federal and state PFML programs.** A private solution for government required paid leave would enable employers to provide coverage either through self-funding, through private insurance or a combination of the two. This would enable programs to build upon existing paid leave, rather than creating new government-run mandated programs. Private insurers have assisted states in administration of paid and protected family leave for decades and to utilize that expertise will help effectively run any new programs that are established. ACLI also supports a tax credit for employers to provide these benefits and mitigate the financial impact to employers providing these new benefits to their employees.

ACLI
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The American Council of Life Insurers (ACLI) advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers' financial and retirement security. 90 million American families depend on our members for life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, dental and vision and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers' products for peace of mind. ACLI members represent 95 percent of industry assets in the United States. Learn more at acli.com.

VENSANA CAPITAL

8095 Innovation Park Drive
Building D, Suite 703
Fairfax, Virginia 22031

June 18, 2019

Senator Pat Toomey
U.S. Senate
Washington, DC 20510

Senator Bob Casey, Jr.
U.S. Senate
Washington, DC 20510

Dear Senator Toomey and Senator Casey,

I write to you today to share my deep concerns over the present state and the future of a proud and uniquely American success story: innovation in our medical technology industry. I am a physician by training, and for the last thirteen years I have applied my background and experience to support early stage medical device and medical technology companies as a venture capital investor. I have been one of the most consistently active medical technology investors, having funded over twenty start-up companies, including more than a dozen novel medical devices to successful FDA Premarket Approvals and de novo 510k clearances and market introductions. Most recently, I elected to embark on my own entrepreneurial journey to co-found a new medical technology focused venture capital fund called Vensana Capital. During my medical school training, I also earned a law degree from Harvard Law School and have a particularly strong interest in how our laws and public policy impact medical innovation and entrepreneurship.

Medical technologies are a part of virtually every step in the healthcare delivery system in both improving the quality of care and controlling costs. Thanks to innovations by medical device companies in the United States, patients throughout the world have benefited from longer life expectancies and quicker recoveries from injuries and chronic conditions for many years now. Similarly, innovations in medical technology have dramatically reduced healthcare costs by enabling surgical procedures to be performed less invasively, or to be performed in lower cost settings outside of the hospital. These innovations have been accomplished through the collective work of multiple stakeholders who are striving to improve patients' lives and healthcare delivery, and constantly examining new methods and procedures for improvement.

Over the course of my career I have seen numerous hurdles that thwarted patients and their physicians' access to innovative cures and therapies, and there is perhaps no better known example of this than the medical device excise tax. When the medical technology innovation ecosystem has never been more vulnerable, the medical device excise tax is not only a threat to the breakthrough advancements of tomorrow, it is a threat to our nation's ability to lead the world in high-tech manufacturing and innovation over the course of the 21st century. I applaud the Committee's examination of what to do with this

egregious policy, and strongly encourage you to seek a solution for the permanent repeal of the medical device tax.

Many of us take for granted innovations that we see in the hospital setting or our doctor's office. As someone who has dedicated his career to the healthcare field, I often found myself doing so as well. But it is a long, arduous journey for the development of any innovative medical technology before it is accessible in the marketplace, and it often starts with an engineer or a physician-inventor and someone like me, a venture capitalist. And unfortunately, the journey required for that entrepreneur's innovative idea to reach the market where it can actually improve the life of a patient has only gotten longer and more expensive over the course of my career. I have worked on innovations that, while now in the marketplace and transformative to patient care for chronic, costly diseases like diabetes, took more 20 years and well over $250 million dollars before it was able to help one patient as a commercial product.

The venture capital community is shouldering the burden of financing medical technology innovation through these longer and more capital-intensive paths. Pressures on large medical technology companies to manage their own expenses have escalated and public company investors have grown more risk averse and reluctant to invest in early stage medical technology companies. This means that our start-up companies must achieve more than ever with our support. Our most novel medical technologies must finance their entire journey through private capital, including idea and product development, clinical evidence generation, regulatory review and approval, market development including obtaining new reimbursement codes, negotiating payment rates and securing payor coverage policies—just to be able to commercialize broadly in the United States. Take the case of one of my companies—developing a novel treatment for chronic axial low back pain as an alternative to opioid narcotics: from start to finish, this process will take between 15 and 20 years. And when the average life of a venture capital fund is only 10 years, it is easy to see why there is less and less early stage capital available for medical technology companies. At a time where innovators in software and gaming can develop a product in months and achieve valuations in the billions in a few years, the medical technology industry is fighting for access to early stage capital with both hands tied behind its back.

In the case of one company that I have been supporting for the last four years as their largest investor—their novel solution for saving limbs from peripheral arterial disease just received FDA PMA approval this year supported by their product's excellent clinical data. The company, based in Wayne, PA outside of Philadelphia, has now raised over $115 million since inception. And while they are just beginning to generate revenue through sales of their product in the United States, they are projected to continue to lose money as a business for the next few years. And every dollar that they have to raise from venture capitalists is a dollar that should be spent on increasing product distribution, physician training and patient access—and should not be funneled out the door for an excise tax.

As you may know, there are periods of ebbs and flows of investment in every industry over the years. The medical technology sector proves the case in dramatic fashion, especially for early stage investment in novel medical devices. In just one example, according to data from PriceWaterhouseCoopers, in 2007, 116 early stage medical device companies raised approximately $720 million in initial funding. Four years later, investments in this important sector to 55 companies raising just $200 million. Over the ten-year period since 2007, start-up company financings at the Series A stage have been cut in half and are not recovering. While there continues to be a more respectable amount of investment in late stage companies (though a rounding error compared to biotechnology investment or software and consumer start-ups), early stage investment for medical devices remains suppressed, threatening our future pipeline of new innovations that can ever impact patient care and healthcare cost. While there are many reasons for the alarming trend of decreases in early stage investment in medical technology companies, the medical device tax poses a major barrier that my colleagues and I are deeply concerned about.

When the device tax was in place, there were several surveys and analyses that examined its impact on both start-up companies and large commercial stage medical technology companies. In one survey, 72 percent of respondents noted that as a result of the medical device tax, their company cut their R&D investments when the device tax was in place. Conversely, when Congress passed the first two-year suspension of the medical device tax, 70 percent of innovators reported increases to hiring and R&D investments, with an average increase of 19 percent. This is all entirely logical: at a time when large public companies are pressured to maintain consistent quarterly earnings growth but revenues are barely growing, they have cut operating expenses, including R&D investment. Layering in additional taxes to be paid on their revenue only forces them to cut internal expenses further. And similarly, for our early stage medical device companies who must raise ever larger amounts of venture capital and debt to build a commercial business before they could go public or be acquired, that late stage capital requirement devalues early stage capital, directly disincentivizing early stage investors like me.

Where the medical technology industry has distinguished the United States as a global leader, and we depend on innovation in medical technology to address the growing challenges of our healthcare system, the medical device excise tax is simply bad policy. An excise tax is a policy that is designed to limit the use and production of a product because of the perceived negative consequences of it. At a time when there are more pressing demands on our health care system and a greater need to improve outcomes, it seems that the last thing we want is a policy that diverts precious resources from research and development in medical technology innovation. When I meet with my colleagues and explain the importance of investing in medical technology startups as opposed to the newest version of a dating app or online game, it can be challenging. When I have to explain why Congress has added an extra hurdle to the process in the form of a medical device excise tax, it can make it almost impossible.

It is increasingly challenging for the federal and state governments to make investments in long-term economic development and the industries of tomorrow, which makes it even

more important that the private sector seed and support novel ideas and transformative products. The very technologies that my colleagues and I work on every day will benefit tremendously from a full and permanent repeal of the medical device tax, but importantly, so will the countless patients and physicians who rely on the cures and therapies we are working on. I urge you to seek a solution that will fully repeal the medical device tax, which will boost an ecosystem that has a tremendous track record of solving some of the most pressing problems facing patient care. In recent years alone, we have seen medical technology innovation allow the deaf to hear, the blind to see, and the paralyzed to walk. The least we can do is remove misguided policies that would thwart the next generation of medical advancements. I'm humbled and honored to play a small part in this ecosystem, and I am excited for the potential that I see over the coming years and decades in patient care. Please help us to succeed. Please permanently repeal the medical device tax.

Sincerely,

Justin Klein, MD, JD
Managing Partner, Vensana Capital

June 18, 2019

Senator Deb Fischer
United States Senate
454 Russell Senate Office Building
Washington, D.C. 20510

Senator Angus King
United States Senate
133 Hart Senate Office Building
Washington, D.C. 20510

Dear Senators Fischer and King:

On behalf of AARP's 38 million members and America's 40 million family caregivers nationwide, I am writing in support of S. 1628, the Paid Family Leave Pilot Extension Act. The bill would extend the business tax credit for the paid family and medical leave pilot program, which is set to expire on December 31, 2019, for an additional three years. The pilot provides up to a twenty-five percent tax credit for employers that voluntarily offer up to twelve weeks of paid family leave to employees.

Unpaid family caregivers are the backbone of the care system in the United States, helping loved ones -- including older adults, veterans, and people with disabilities – live independently in their homes and communities. About 60 percent of these caregivers work full-time or part-time. In addition to time spent at the office or on the job site, they devote, on average, 24 hours per week to tasks like managing medications, preparing and serving meals, helping their loved ones bathe and dress, and arranging transportation to medical appointments.

Paid family leave is an important benefit that employers can provide to support the family caregivers in their workforce. AARP research also shows that having caregiver-friendly workplace policies is good for business. In a 2017 survey of company benefit managers, 87% of respondents said that supporting family caregivers in the workforce can increase productivity, and 75% said that having a caregiving-friendly workplace would help attract and retain talent.

We appreciate your support of family caregivers and your leadership with this legislation. If you have any questions, feel free to contact me or have your staff contact Cristina Martin-Firvada Vice President for Financial Security and Consumer Affairs at CMfirvida@aarp.org.

Sincerely,

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs

national partnership for women & families
Because actions speak louder than words.

The National Partnership for Women & Families

Comments for Health Tax Task Force
United States Senate

June 19, 2019

Thank you to Co-Chairs Toomey and Casey for the opportunity to provide input on the paid leave tax credit in the Tax Cuts and Jobs Act (TCJA) of 2017. The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy organization based in Washington, D.C. Our mission is to improve the lives of women and families by achieving equality for all women. We promote fairness in the workplace, reproductive health and rights, access to quality, affordable health care, and policies that help women and men meet the dual demands of their jobs and families. We work toward creating a society that is free, fair and just, where nobody has to experience discrimination, all workplaces are family friendly, and every family has access to quality, affordable health care and real economic security.

It is past time for this country to invest in working families by passing an inclusive national paid family and medical leave program. At the National Partnership, we have been working on this issue for decades. Since our founding in 1971 as the Women's Legal Defense Fund, the National Partnership has fought for every major federal policy advance that has helped women and families, including our leadership in passing the nation's unpaid leave law, the Family and Medical Leave Act (FMLA) of 1993. Today, we convene the National Work and Family Coalition, which includes hundreds of organizations nationwide fighting for a national paid family and medical leave plan and other policies to create a more family friendly and equitable economy and country.

A key part of our work to advance paid leave has involved developing policy solutions, and we have been honored to work with advocates and legislators in seven states plus the District of Columbia that have adopted paid family and medical leave laws that now cover approximately 33 million people.[1] Evidence from the state paid family and medical leave programs proves that a national program can cover every working person in the United States and be funded in a responsible, affordable way.

We believe the Family And Medical Insurance Leave (FAMILY) Act would address America's paid family and medical leave crisis and benefit working people, their families, businesses and our nation's economy. It would create a comprehensive national program that helps meet the needs of new mothers and fathers and people with serious personal or family health issues through a shared fund that makes paid leave affordable for employers of all sizes and for workers and their families.

We acknowledge the TCJA attempted to make progress on paid leave, but as we advocated at the time of passage, tax credits do not create enough of a financial to substantially

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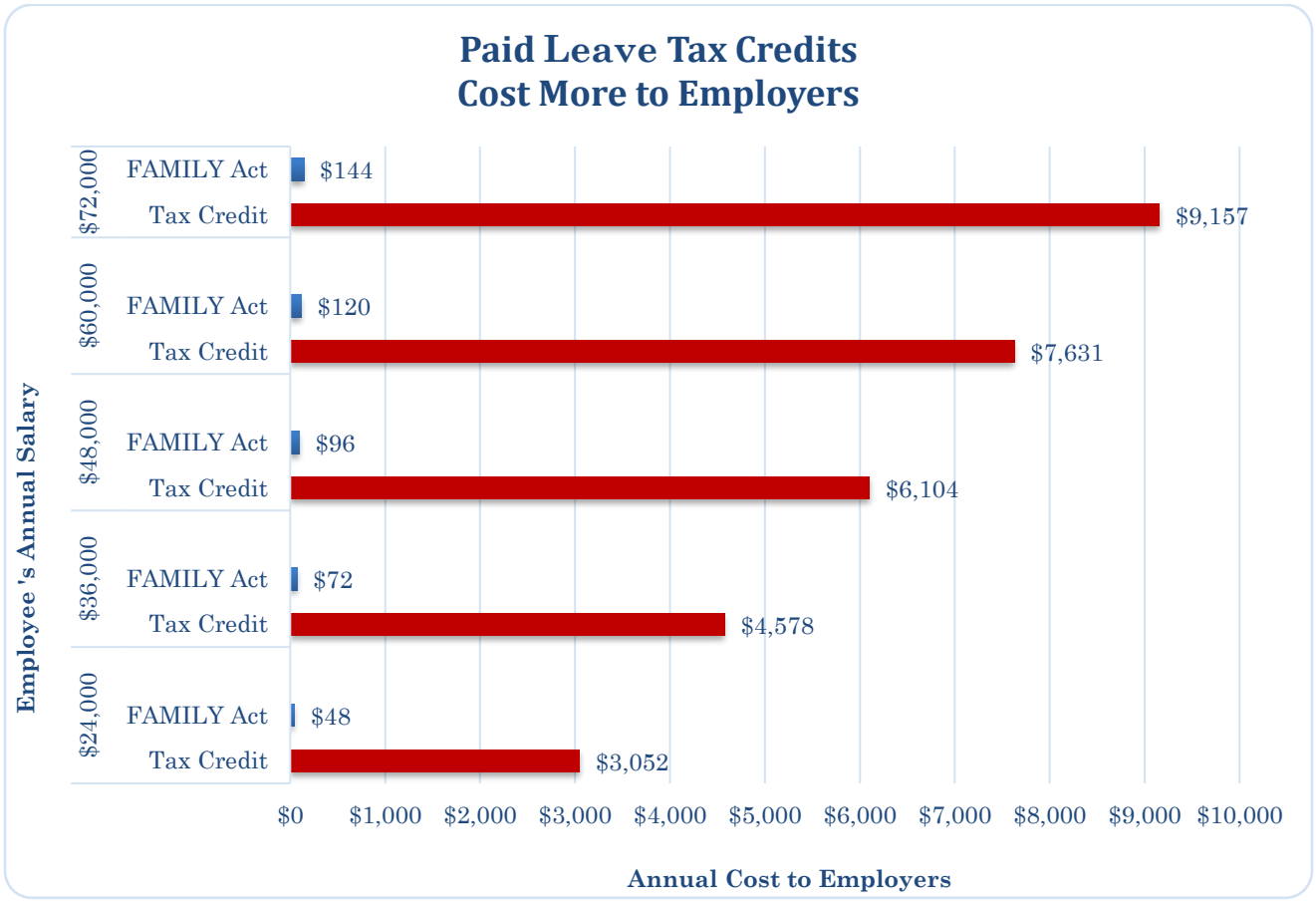
increase access to paid leave in the private sector, particularly for workers in low-wage jobs and in the gig economy.

The TCJA included a provision that offers small tax credits to employers who voluntarily offer paid family and medical leave to certain employees. Under this tax provision, employers can receive a scaled tax credit of between 12.5 and 25 percent of the wages paid to an employee on leave, which means employers could shoulder as much as 87.5 percent of the cost of an employee's paid leave. Employers would only receive credits for wages paid to employees with compensation in the prior year that was at or below 60 percent of the compensation threshold for "highly compensated employees" under the Internal Revenue Code. In 2017, that means employers only receive a credit for the paid leave they provide to employees paid $72,000 or less.

The data in the chart illustrates how tax credits fail to provide a financial incentive for employers to provide paid family leave. The chart shows the annual cost to an employer of providing an employee with 12 weeks of paid leave at 66 percent of the employee's usual wages. For example, if an employee making $60,000 annually took 12 weeks of paid leave at 66 percent of their wages, the upfront cost to an employer receiving tax credits under the TCJA would still be $7,631. Under the FAMILY Act, the annual cost to the employer for this same employee would only be $120.



Any approach that requires businesses to individually fund the full up-front costs of paid leave would unfairly punish small businesses and businesses with low profit margins by requiring large upfront expenditures, and would force working people to continue to rely on the goodwill of their employers. In order to claim the tax credit under TCJA, employers would be required to make substantial and often unpredictable out-of-pocket expenditures to provide paid family and medical leave, in exchange for a small tax credit that would not be available until year-end tax filings. This makes it highly unlikely that tax credits will significantly change workers' access to paid family and medical leave. Instead, the tax credits would likely go to larger businesses that can already offer paid leave and continue to leave the most vulnerable without access to paid leave.

Alternatively, under the FAMILY Act, employers would make small, predictable contributions to a fund to ensure their employees have access to paid family and medical leave. Employees would also contribute a small, predictable portion of their pay to the fund. This model works well in a growing number of states. See Table 1 for a breakdown of the cost to employers of providing leave under each policy.

TABLE 1. COST TO EMPLOYERS OF PROVIDING EMPLOYEES 12 WEEKS OF LEAVE AT 66 PERCENT PAY

Employee's Annual Pay		Out-of-Pocket Cost to Employer	End-of-Year Tax Credit to Employer	Net Annual Cost to Employer (Per Employee)
$24,000	**TCJA**	**$3,655**	**$603**	**$3,052**
	*FAMILY Act**	*$11*		*$48*
$36,000	**TCJA**	**$5,483**	**$905**	**$4,578**
	*FAMILY Act**	*$17*		*$72*
$48,000	**TCJA**	**$7,311**	**$1,206**	**$6,104**
	*FAMILY Act**	*$22*		*$96*
$60,000	**TCJA**	**$9,138**	**$1,508**	**$7,631**
	*FAMILY Act**	*$28*		*$120*
$72,000	**TCJA**	**$10,966**	**$1,809**	**$9,157**
	*FAMILY Act**	*$33*		*$144*
$84,000	**TCJA**	**$12,794**	**None****	**$12,794**
	*FAMILY Act**	*$39*		*$168*

* Amounts shown here indicate the typical quarterly and annual contributions an employer would make to cover an employee under the FAMILY Act. The employer would not pay an employee during the period of leave (the fund would provide the wage replacement). However, employers can choose to "top up" employees' FAMILY Act benefits.

** The TCJA only offers tax credits to employers who provide paid leave to employees paid $72,000 or less per year.

In addition to the shortcomings with the design of the tax credit, research shows that employer tax credits do not lead to widespread changes in business practices and policies. In a 2017 Ernst & Young (EY) survey, fewer than 40 percent of employers, and just 35 percent of companies with fewer than 100 employees, said tax credits would influence their decision about whether to offer paid leave.[2] In a survey conducted by Main Street Alliance, 79 percent of small business owners responded that a social insurance program would help them offer paid leave to their employees, while only eight percent said a tax credit would be the most helpful.[3] The research suggests that tax credits will not offer working families or the nation's economy real, positive change.

At a time when just 17 percent of workers in the United States have access to paid family leave at their jobs and fewer than 40 percent have personal medical leave through employer-provided short-term disability insurance, the country needs to invest in working people, families, businesses and the economy by creating a real national paid family and medical leave standard – one that is inclusive and affordable for all working people and businesses of all sizes. Putting the burden solely on businesses, even with tax incentives, is not working – rather, we know from state evidence that we can affordably create a national program that covers every working person.

---

[1] National Partnership for Women & Families. (2019, March). *Map: Paid Leave and Paid Sick Days Laws Are Helping More Than 45 Million People Better Care and Provide for Their Families*. Retrieved 21 May 2019, from http://www.nationalpartnership.org/our-work/workplace/how-many-million-americans-benefit.html

[2] Ernst & Young. (2017, March). Viewpoints on paid family and medical leave: Findings from a survey of US employers and employees. Retrieved 18 September 2017, from http://www.ey.com/Publication/vwLUAssets/EY-viewpoints-on-paid-family-and-medical-leave/$FILE/EY-viewpoints-on-paid-family-and-medical-leave.pdf

[3] Main Street Alliance. (2018). *The View from Main Street.* Retrieved 21 May 2019, from: https://d3n8a8pro7vhmx.cloudfront.net/mainstreetalliance/pages/716/attachments/original/1518636864/MSA_PFML_Report_-_Phase_1_v3.pdf?1518636864

Thank you for this opportunity to submit comments regarding the restoration of this tax. Please see the comments below and attached testimony UMWA President Cecil Roberts delivered before the Workforce Protections Subcommittee of the House Education and Labor Committee on June 20, 2019.

Phil Smith
Director of Communications and Government Affairs
United Mine Workers of America
703-291-2430 (desk)
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Comments:

The modest benefits paid to Black Lung victims or their widows are small compensation for the constant pain and suffering caused by this disease. These workers contracted this always-fatal occupational disease because they went to work in coal mines whose operators did not take the necessary steps to properly protect them.

Miners get black lung by working in a mine where the operator is not adequately controlling respirable dust. This happens because the company is not complying with laws and regulations regarding proper ventilation of the mine and/or not following other required health and safety laws and regulations.

Coal operators caused this problem, and they are the ones who should be responsible for funding the compensation these workers receive. Letting them off the hook by reducing the amount they are required to pay is not just wrong, it is rewarding bad corporate behavior.

Allowing the contribution rate to drop would cause the Black Lung Benefits Program to go $1.85 billion dollars further into debt over the next ten years. That money funds small but critically needed benefits that these miners and widows need to help provide some of the basic necessities of life.

At a time when Black Lung is on the rise, especially among younger miners, Congress should restore the tax to its original levels. Miners are going to need these benefits for decades to come. This is a problem that has been created by the coal industry, there was a system to help the victims of this disease that the coal industry paid for, and we see no reason why we would put the taxpayers on the hook instead

United States Senate
WASHINGTON, DC 20510

June 20, 2019

The Honorable Patrick Toomey
United States Senate
248 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Robert Casey, Jr.
United States Senate
393 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Michael Enzi
United States Senate
379A Russell Senate Office Building
Washington, D.C. 20510

The Honorable Mark Warner
United States Senate
703 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Toomey, Senator Enzi, Senator Casey and Senator Warner:

We write today to emphasize the urgent need for legislative action to suspend the health insurance tax for 2020. To accomplish this important goal, we have introduced bipartisan legislation, S. 172 the Health Insurance Tax Relief Act, which has been cosponsored by 25 of our colleagues.

Unless Congress takes action quickly, this tax will impose additional costs next year on families, seniors, small business owners, and state governments. Health insurers are already in the process of proposing premium rates for 2020. Without more certainty from Congress about the potential suspension of the health insurance tax, insurers will build the cost of the tax into 2020 premiums, which will raise costs for millions of Americans. To avoid this outcome, we need to pass our bipartisan legislation, in both the Senate and the House. Sending this legislation to the President's desk is one of the most effective steps we can take to provide relief from rising health care costs to the American people.

The uncertainty about whether this tax will return next year is a source of concern and frustration for American consumers and small businesses across the nation—as well as working families, seniors enrolled in Medicare Advantage plans, and state Medicaid programs.

In addition, an August 2018 Oliver Wyman analysis provides a clear picture of the economic burden associated with the health insurance tax. This study estimates that if the health insurance tax is allowed to resume in 2020, it would increase premiums next year on a per enrollee basis by an estimated $196 for individuals in the non-group market, $154 for individuals and $479 for families in the small group market, $158 for individuals and $458 for families in the large group market, $241 for Medicare Advantage enrollees, and $157 for each enrollee covered by Medicaid managed care programs.

There is strong bipartisan support in Congress for suspending the health insurance tax and helping reduce premium costs for millions of Americans. We strongly urge you to ensure that this issue is addressed as soon as possible during the 2019 session.

Sincerely,

Cory Gardner
United States Senator

Jeanne Shaheen
United States Senator

cc:
Chairman Charles E. Grassley, Senate Committee on Finance
Ranking Member Ron Wyden, Senate Committee on Finance

Extending the Tax Credit for Paid Family Leave would Provide Valuable Time to Assess Its Success

Aparna Mathur, Erin Melly
AEIdeas | June 19, 2019

In December 2017, an employer credit for paid family and medical leave (Internal Revenue Code §45S) was enacted as part of the Tax Cuts and Jobs Act (P.L. 115-97). Sponsored by Sen. Deb Fischer, this two-year pilot program gives a tax credit to employers who offer paid family and medical leave to qualifying employees, therefore incentivizing employers to provide leave by reducing the program's cost. There is now a proposal to extend the pilot for another three years. We believe this is worth considering.

The Fischer tax credit is a voluntary program and not a mandate on businesses. The amount of credit received is contingent upon how much leave the business provides. If a business replaces 50% of employees' wages during the period of leave, then the credit rate is 12.5%. If they provide 100% wage replacement, then the credit is 25%. To prevent abuse of the credit and ensure workers receive adequate leave, the minimum standard for eligibility is at least 50% wage replacement for a minimum of two weeks.

An important feature of this credit is that it targets the most vulnerable employees. Low-wage workers are the least likely to receive paid leave. Data show that only 4% percent of workers in the bottom 10% of the wage distribution have access to some amount of paid family leave. Most of these workers are also not eligible for job protected unpaid leave under the Family and Medical Leave Act. Employees are only credit-eligible if their compensation in the preceding year did not exceed 60% of a "highly compensated employee" (defined as $72,000 in 2018). This aims at addressing the concern that this policy merely subsidizes already existing employee-sponsored plans.

Finally, the credit applies to a broader base and not only new parents. Any employee can take leave for any of the three reasons — parental leave, medical leave, and family care leave. This is different from existing Republican proposals that typically only cover parental leave.

Of course, a voluntary tax credit program has its limitations. Will employers respond to this incentive to offer a new benefit to their low wage employees? Will it end up subsidizing existing paid leave programs at companies? Is a two-year pilot program enough incentive to change employer behavior? It is tough to offer a new benefit, but then take it away in case the credit is not extended. These are questions worth exploring.

Unfortunately, the current credit is only in effect in the 2018 and 2019 fiscal years. Between the decision of employers to utilize the credit, the time to design and implement a program and it being widely used by employees, the two-year window is clearly not long enough. Therefore, an extension of the pilot program is worth considering. As proposed, the Paid Family Leave Pilot Extension Act would extend the credit for three years and commission a GAO study in order to get data on how the credit is working. If possible, we would suggest an even longer extension of the credit, and more frequent data gathering on the employer and employee response, to gauge its success.

A pilot program enables the data collection and analysis before implementing a permanent policy. Under a pilot, data on take-up rates (of both employees and employers), productivity outcomes, costs and employee retention and attraction can be consciously monitored.

The debate on paid leave and how best to design policies is spurring innovative solutions. From voluntary tax credits to Social Security to opt-in type programs, as proposed in New Hampshire and Vermont. While there are many approaches, the best policy will be the one that the data show as truly improving access to paid leave for the most vulnerable workers. Therefore, an evaluation of these diverse solutions is key to solving the puzzle of the best evidence-based policy design.

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June 20, 2019

Senator Patrick Toomey, Co-Lead
248 Russell Senate Office Building
Washington, D.C. 20510

Senator Robert Casey, Jr., Co-Lead
393 Russell Senate Office Building
Washington, D.C. 20510

Senator Michael Enzi
379A Senate Russell Office Building
Washington, DC 20510

Senator Mark Warner
703 Hart Senate Office Building
Washington, DC 20510

Dear Senators Toomey, Casey, Enzi, and Warner:

AARP, on behalf of our nearly 38 million members nationwide and all Americans age 50 and older urges you to reinstate and permanently extend the 7.5 percent income threshold for the medical expense deduction, which expired at the end of 2018. Extension of this threshold will provide important financial protection for all taxpayers with high heath care costs.

Individuals seek some measure of financial stability while managing their high medical expenses, and as you examine temporary tax policies, we urge you to make every effort to keep the threshold for the deduction as low as possible to help protect those with high medical costs.

The medical expense deduction provides important tax relief that helps offset the cost of acute and chronic medical conditions for older Americans, children, and individuals with disabilities. An estimated 4.4 million Americans will claim the medical expense deduction at the 7.5 percent income threshold, and 70 percent of taxpayers claiming the deduction have income between $23,100 and $113,000. The medical expense deduction plays an important role in helping to offset high out-of-pocket expenses -- expenses that qualify include money paid for diagnosis, treatment, equipment, long-term care services, and long-term care insurance premiums.

The medical expense deduction makes health care more affordable for people with significant out-of-pocket expenses. Even with Medicare, a significant share of beneficiaries spend a considerable amount on out-of-pocket expenses each year. The average Medicare beneficiary spends about $5,680 out of pocket on medical care.

Furthermore, older Americans often face high costs for long-term services and supports -- which are generally not covered by Medicare -- as well as hospitalizations and prescription drugs. The median cost for a private room in a nursing home is over $97,000 annually, while the median cost for even more cost-effective home-based care is still over $30,000 per year (for 20 hours of care a week). In 2013, roughly 25.8 million beneficiaries in traditional Medicare spent at least 10 percent of their income on out-of-pocket health care expenses. Tax relief in this area can provide needed resources, especially important to middle income seniors with high long-term care and medical costs.

The medical expense deduction is a critical tool in managing health care costs for Americans with high out-of-pocket expenses. The bipartisan Senate Finance leaders recently recognized that it should remain at 7.5 percent and have included it in their tax extenders proposal, S. 617. We urge you to do the same and recommend including the medical expense deduction in any tax extenders package under consideration. Given the uncertainty faced by current taxpayers, we also strongly urge the Taskforce to implement such an extension prior to the end of 2019.

We look forward to working with you and your colleagues to extend the medical expense deduction at the 7.5 percent income threshold. If you have any questions or need additional information, please feel free to contact me or have your staff contact Jasmine Vasquez at JVasquez@aarp.org.

Sincerely,

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs

Testimony of
Cecil E. Roberts
before the
United States House of Representatives
Committee on Education and Labor
Subcommittee on Workforce Protections

June 20, 2019

Good morning Chairwoman Adams; Ranking Member Byrne and the members of the Committee on Education and Labor in attendance today. My name is Cecil E. Roberts, International President of the United Mine Workers of America ("UMWA"). In that capacity I represent the largest unionized group of active and retired coal miners in North America. However, today Madam Chairman, I come before the members of this distinguished Committee as the representative of every coal miner in this nation, whether an active dues-paying member, a retiree of the UMWA or a coal miner who is working in the industry and has not yet joined the ranks of the Union. In short, I am here to be the voice of the miners who have risked their lives and health to energize and build this nation, no matter where they live and no matter their affiliation with organized labor.

The testimony I will present to this Committee today will outline, in great detail, the struggles that coal miners face every day in this country. These struggles exist for miners who are actively employed in the industry and those who have left the mines, whether they retire after years of hard work in dusty and dangerous conditions or they are forced from their jobs by occupational injury or illness. I will focus my testimony on the specific topic of this very important hearing: the effects of Coal Workers' Pneumoconiosis ("CWP" or "Black Lung disease") on the lives of America's coal miners.

The purpose of this hearing is to discuss the resurgence in reported cases of Black Lung across the coalfields of the country. According to data from the Center for Disease Control ("CDC"), the National Institute for Occupational Safety and Health ("NIOSH"), the Mine Safety and Health Administration ("MSHA" or "Agency") and a host of independent studies, the highest concentration of these historic increases in the disease are occurring in the central Appalachian Region of

the United States (attachments 1-4). This area includes all or parts of Kentucky, Ohio, Pennsylvania, Virginia and West Virginia.

I hope that this Committee will forgive me if I repeat myself in my testimony today. I ask at the outset for your indulgence if you hear me say something at this hearing that you have heard me say before. But the truth is, I cannot help but repeat myself. This is not the first time I have climbed the steps of the Capitol to speak on behalf of coal miners regarding the dangers of Black Lung disease. While the Union would agree that recent studies show there has been an alarming resurgence in the number of Black Lung cases, including the most severe form of the disease known as Progressive Massive Fibrosis ("PMF"), I have been here before to discuss that risk. The industry, and the Federal government have known for years of this resurgence. I have testified in the past about the failures of MSHA's dust control rules and policies. I have testified before about the nefarious methods that operators have used to circumvent mandatory dust monitoring. The UMWA has recommended methods and ways of improving the sampling system and that might have helped head off this resurgence. But no action has been taken.

And so, I repeat myself. I repeat myself because I come here today not explain to you a new or unprecedented danger in the nation's coalfields. We know this disease, we know what causes it, and we know how to prevent it. We do not lack information. What we lack today is the same thing we lacked all the other times I came to speak to Congress regarding the dangers of Black Lung: we lack the will to act.

Therefore, I do not apologize. I will never apologize for raising the uncomfortable truth that this government has all the data and the tools necessary to end the Black Lung epidemic in the nation's coalfields, but has consistently failed to act. If you hear me say something that I already raised in May of 2003, the first time I testified before a Congressional Committee on this issue, consider it an indictment of this government's failure to take seriously the known threat of Black Lung disease. Know that I repeat myself today because, since May 2003, over 18,000 miners have died in this country from Black Lung (attachment 5). And if Congress again fails to act, that number is expected to skyrocket in the coming decades. I will not stop repeating these truths until Congress listens. Until Congress passes legislation that requires MSHA to promulgate specific standards that protect

miners, and corrects the shortcomings of the current dust standards, nothing is going to change.

The Union would argue that the seeds of the recent wave of CWP were sown by the actions of Federal agencies and coal operators whose primary job is to protect the health and safety of the nation's miners. This epidemic was further propagated by medical and legal professionals that profited from the misery of those miners unfortunate enough to contract this horrible disease. The fact is Madam Chairman, CWP is a preventable occupational disease (attachment 6) that would have been eradicated from the industry years ago, but for the greed of the industry and the failings of those who are charged to protect the nation's miners.

The History of Black Lung in The United States

It is important to understand the scope of this problem in a historical sense if we are to understand the situation we find ourselves facing today. The problem we are discussing has been plaguing the coal industry and has been a horrific reality for miners since the industry began large scale industrial mining in the mid-1800's. According to the research done by Nash Dunn (attachment 7), a Communications Specialist at North Carolina State University, more than 200,000 miners have died from Black Lung disease since the turn of the last century. A separate report *Undermining Safety: A Report on Coal Mine Safety* by Christopher W. Shaw (attachment 8), a policy analyst at the Center for Study of Responsive Law, claims, that historically "there were at least 365,000 deaths from pneumoconiosis (prior to the passage of the Coal Act of 1969), and a further 120,000 miners succumbed to the disease over the next thirty years." We should all take a moment and allow that number to sink in.

As we think about these numbers, we should not lose sight of what we are really talking about here. No matter what number you choose to accept, these miners were fathers and sons, mothers and daughters, they were grandmothers and grandfathers, aunts and uncles, they were part of a family and members of the community. These lives were cut short in the most gruesome way imaginable. These miners died struggling for their final breath, literally suffocating as a result of a preventable disease. Madam Chairman and members of the Committee, I submit to you that when it comes to protecting miners from exposure to coal mine dust, something has been very wrong for a very long time.

There are credible reports throughout history of doctors and mine operators extolling the benefits of breathing coal dust, noting the coughing experienced by miners would in fact clear their lungs. Much like evidence regarding the dangers of smoking cigarettes, industry and government downplayed the hazard of respirable coal dust. The coal industry was making profits and the victims were simply expendable. Despite evidence to the contrary and the efforts of the United Mine Workers, this type of thinking continued in this country through the 1960's.

It was not until the Farmington #9 Mine Disaster on November 20, 1968, where 78 miners were killed in a series of explosions, of which 19 miners remain entombed in the #9 mine today, that the Federal Government was finally forced to take action. To be honest Madam Chairman, had it not been for the fact that the #9 Disaster was the first mine explosion carried live on television across the nation and around the world, it is doubtful any substantive action would have resulted from even that tragic event. The American people were publicly outraged and called for Congress to take action. It is an unfortunate reality that miners in this country must die in large numbers, and the suffering of miners and their families must be shown on television, before anything is done to protect them from the hazards that this industry allows to exist.

I bring this up, Madam Chairman, because it was not until December of 1969 that President Richard Nixon reluctantly signed the Coal Mine Health and Safety Act ("Coal Act"). Included in the Coal Act was language limiting the amount of respirable coal mine dust permitted in the mine atmosphere. By that time, according to reports, hundreds of thousands of miners had died from Black Lung disease in the United States. These miners died alone, one at a time in the seclusion of their homes or hospital rooms. They were isolated from the world, only their families knew of their suffering. Industry leaders and the federal government turned a blind eye to that suffering. No television cameras chronicled their final, gasping moments.

The Coal Act was a monumental piece of legislation and I do not wish to diminish the protections it afforded miners. However, there were pieces of that legislation that were ripe for fraud and deception. The most obvious problem in that regard deals specifically with the important matter we are here to discuss today, the enforcement and policing of the Respirable Dust Sampling Program. To put it bluntly, the incidence of fraud on the part of the mine operators and lack of adequate

enforcement by MSHA has been a problem from the inception of the program. I understand that this statement may seem inflammatory to many people, however, I intend to demonstrate these facts through my testimony.

The initial problem with the dust sampling program was created when the Mine Safety and Health Administration promulgated a rule allowing the mine operators to run the program (attachment 9, Section 202 of the Coal Act). Despite the Union's objections and the vocal opposition of active miners, the routine sampling of miners was placed in the hands of mine management. In the eyes of the miners and their representatives, allowing the mine operators to administer the program doomed it from the beginning. These are the very same individuals who callously placed miners in excessively dusty areas of the mine with no regard for the long-term damage they were causing to their health.

Even in the earliest days of the sampling program it was common knowledge among miners that dust sampling by the mine operators was not being done in a manner that would reduce exposure to excessive respirable dust or enhance their health. The gravimetric sampling devices were often carried by company personnel in outby[1], meaning less dusty, areas of the mine or hung in cleaner intake air entries.[2] This not only continued to place miners lives at risk, it further eroded the credibility of the program and the miners' faith in MSHA.

All White Center Tampering (AWC) Case

While the Union suspected for many years that mine operators were tampering with the sampling devices and sending fraudulent data to the Agency in order to meet the requirements of the law, the first conclusive evidence of deception was uncovered in the late 1980's (attachment 10). The Agency became aware that more than 500 coal companies had tampered with dust samples at more than 850 operations. MSHA issued 4,710 citations and $6.5 million in fines to coal operators.

[1] Locations in mines are described by their position relative to the cutting face of the coal. If a miner is standing in the middle of the mine, halfway between the portal (entrance) and the face, the face is "inby" and the portal is "outby." If a miner is standing directly at the face, the entire mine behind him/her is "outby." Miners sometimes refer to "outby areas" when referring to areas far from the working face, where there is less dust.

[2]Intake air entries are the passageways in the mine where fresh air is pumped towards the face. Because these entries contain fresh air and are "upstream" from the face, they are less dusty.

In this case, the dust sampling cassettes used by the company to monitor miners' exposure were sent to MSHA as required by regulation for weighing and evaluation. During that testing MSHA technicians discovered the filters inside many of the cassettes all displayed a strange characteristic. The center of the filters were absent of dust, creating a "doughnut hole", almost like this area of the filter was new, despite being underground and operating in the mine atmosphere. It was determined at the time that the only possible way for this to occur would be if someone blew air through the cassette to dislodge and purge the dust from the filter. This phenomenon became known as the "Abnormal White Center" ("AWC") case and the tampering ended any shred of faith miners had in the program.

The Coal Mine Respirable Dust Task Group

In May 1991, in the aftermath of the AWC case, the Honorable Lynn Martin, Secretary of Labor, directed MSHA to conduct a review of the Respirable Dust Sampling Program. In response to the Secretary's directive, the Agency created the *Coal Mine Respirable Dust Task Group* (Task Group) to review all aspects of the sampling program (attachment 11, pertinent excerpts from the Task Group). Notably, the Task Group did not include representatives from Labor, Industry, NIOSH or other interested parties connected to the mining industry. In essence, the Secretary was permitting the Agency that had failed to adequately protect miners from the deceptive actions by coal mine operators to investigate itself.

Despite the fact that they were given no formal role in the Task Group, miners and many mine health and safety experts expressed their concern that mine operators could not be trusted to administer the coal dust sampling program. They contended that, "there is simply too great an incentive to manipulate the program, and a lack of adequate MSHA oversight makes it far too easy for some operators to do so." These critics also, "urged that MSHA assume responsibility for the collection of all samples of the mine environment used for compliance determinations."

While the Task Group offered recommendations, most would prove to be superficial and therefore ineffective. As to the question of MSHA taking responsibility for all compliance sampling, the Task Group failed to even make a recommendation. They instead kicked the can down the road arguing that MSHA took strong action **after** operator abuse and that it would require the Agency to redirect significant resources towards that goal. Perhaps the most disingenuous

reason for the Task Groups refusal to make such a recommendation was that, "the future adoption of a program based on continuous fixed-site monitoring would significantly reduce the need for either the operator or MSHA to conduct periodic sampling."

The Task Group then doubled down on its decision not to wrest control of the sampling program by stating, "The Task Group believes that the existing operator sampling program can provide adequate assurance that miners will not be exposed to unhealthful levels of respirable coal mine dust until continuous monitoring is feasible, if appropriate improvements are made in the program." This was particularly absurd given the fact that the AWC case, among other incidents, proved that "adequate assurances" were not present. Further, the Task Group did not address the fact that the technology for continuous monitoring was still decades away. That meant that in light of the coal industry's demonstrated circumvention of the respirable dust standards, the Task Group's solution was a few more decades of operator-administered dust tests. In short, no change.

The Task Group failed in its primary mission to make practical and necessary recommendations that would protect coal miners from continued exposure to excessive respirable coal mine dust. Instead they made inconsequential recommendations that did not alter the worsening trajectory of the dust control program. Worse, they devalued the life of every miner in the country by not taking bold and decisive action. They determined the financial cost of providing protection for the miner was too high. This was an abdication of responsibility by a group made up of individuals working for the Agency charged by law to protect the health and safety of the nation's miners.

Advisory Committee on the Elimination of Pneumoconiosis Among the Nation's Coal Workers

Five years later, the Advisory Committee on the Elimination of Pneumoconiosis among Coal Mine Workers ("Advisory Committee") was established by the Honorable Robert B. Reich, Secretary of Labor, on January 31, 1995. The Committee was chartered to "make recommendations for improving the program to control respirable coal mine dust in underground and surface mines in the United States." The Committee was to "examine how to eradicate

pneumoconiosis through the control of coal mine respirable dust and the reduction of miners' exposure to achieve the purpose of the Federal Coal Mine Health and Safety Act of 1969 and the 1977 Mine Act amendments" and to "review information and experience in the United States and abroad concerning the prevention of pneumoconiosis among coal miners; the availability of current state-of-the-art engineering controls to prevent overexposure to respirable coal mine dust; and the existing strategies for monitoring of coal mine dust exposures." The Committee was charged to "make recommendations to the Secretary for improved standards, or other appropriate actions, on permissible exposure limits to eliminate black lung disease and silicosis; the means to control respirable coal mine dust levels; improved monitoring of respirable coal mine dust levels and the role of the miner in that monitoring; and the adequacy of the operator's current sampling program to determine the actual levels of dust concentrations to which miners are exposed."

Unlike the Task Group, the Advisory Committee appointees did not include employees of any government agency. Instead, the Committee consisted of five members from academia and the medical profession, two representing the interests of labor and two representing the interests of industry. The Advisory Committee did consult individuals from MSHA, NIOSH, the Pittsburgh Research Center (PRC) and other government agencies as necessary. However, none of those consulted were voting members of the Committee.

In 1996, the Advisory Committee completed its work and submitted a report to the Secretary of Labor (attachment 12, pertinent exerts from the Advisory Committee report). The Union was generally pleased with the work of the Advisory Committee. Its members were able to identify many of the more difficult challenges inherent in the Respirable Dust Sampling Program without the encumbrance of self-examination that hampered the previous internal review. The Advisory Committee researched some of the more controversial issues surrounding the Respirable Dust Sampling Program and offered concrete recommendations to correct them.

It will be helpful to look at some of the Advisory Committee's recommendations, and review how MSHA has acted, or failed to act on them. In the Committee's first area of concern, members made recommendations regarding actual amount of dust present in mine atmosphere. Specifically, they advocated reducing the overall level of respirable dust permitted in the mine atmosphere, creating and enforcing separate Permissible Exposure Limit (PEL) for silica and coal

mine dust, and directing MSHA to seek input from NIOSH for advice on lowering the current silica exposure of miners. The Committee also recommended adjusting the PEL to take into consideration extended work weeks (recommendation 16a).

When the Advisory Committee issued its report in 1996, NIOSH recommended a standard of 1.0 mg/m³ (milligrams per cubic meter of air) of respirable dust. NIOSH also recommended a 50 µg/m³ (micrograms per cubic meter of air), PEL for silica. At the time, MSHA was enforcing a 2.0mg/m³ respirable dust standard. The 2.0mg/m³ was reduced if silica (quartz) was present in the mine atmosphere. There was (and is) no separate silica standard in the mining industry. It was not until 2014, 18 years later, that the Agency promulgated a new regulation that reduced the dust standard from 2.0mg/m³ to 1.5mg/m³ and accounted for extended work days and work weeks (attachment 13, Summary of 2014 Dust Rule). This was still higher by 0.5mg/m³ than NIOSH recommended in 1996. The Agency has still not taken up the Committee recommendation to create a separate PEL for silica, nor has it lowered the exposure limit. MSHA continues to maintain the PEL for silica at 100µg/m³, twice the NIOSH recommended exposure limit. In 2018 OSHA established a reduced silica standard of 50µg/m³.

As noted above, the Advisory Committee recommended adjusting the PEL to consider extended work weeks. The Advisory Committee was concerned that, even at lower levels of exposure, more hours worked would result in dangerous levels of cumulative exposure. Today, there remains some question as to the actual exposure to respirable dust that miners receive at the 1.5mg/m³ over a 12 or 14-hour shift. The Union has expressed its concern that such respirable dust exposure during longer shifts may exceed the standard set by Congress in the Mine Act.

In other recommendations, the Advisory Committee attempted to tackle the overriding issues of fraud and tampering inherent in the Respirable Dust Sampling Program. They also recommended ending operator control of the sampling process.

The Committee determined in recommendation 16c, by a unanimous vote, that they considered it, “a high priority that MSHA take full responsibility for all compliance sampling at a level which assures representative samples of respirable dust exposures under usual conditions of work. In this regard, MSHA should explore all possible means to secure adequate resources to achieve this end without adverse impact on the remainder of the Agency's resources and responsibilities.” Note that both industry representatives voted in favor of this recommendation (attachment 14, Committee votes).

In 16b, the Committee noted that there were methods available to MSHA to obtain necessary resources that would permit the Agency to conduct all compliance sampling and eliminate operator participation in that aspect of the Sampling Program. The Committee stated that it believed, "…that any MSHA resource constraints should be overcome by mine operator support for MSHA compliance sampling. The Committee recommends that to the degree that MSHA's resources cannot alone serve the objective identified, resource constraints should be overcome by mine operator funding for such incremental MSHA compliance sampling. One means for obtaining this support could be a reasonable and fair operator fee, based on hours worked, or other equivalent means designed to cover the costs of compliance sampling." The recommendation passed the Committee 8-0-1, the lone abstention was cast by a representative of industry. Significantly, one of the industry representatives voted in favor of this recommendation.

The Advisory Committee noted several times the importance of having representatives of the miners actively participate in all aspects of the Respirable Dust Sampling Program. In order to facilitate their input, the committee repeatedly recommended that miners be afforded the rights provided in Section 103(f) of the Mine Act (attachment 15). This would allow miners to receive compensation, at their regular rate of pay, while taking an active role in the Respirable Dust Sampling Program.

Unfortunately, these particular Advisory Committee recommendations, recommendations that the Union believes are key to affording miners the protections Congress intended, have never been acted on by MSHA. The Agency continues to argue that the recommendations are too expensive, too burdensome and will not result in substantial improvement in the Respirable Dust Sampling Program. MSHA argues, without support, that the recommendations offer no significant health benefits to miners. The Union vehemently disagrees with the Agency's decision regarding these recommendations and further argues that the Agency's logic for making such a decision is incorrect and detrimental to the health and safety of the nation's miners.

The Union believes that if the Agency imposed a mandatory fee for service on each operator to conduct all compliance sampling, while at the same time relieving the operator of the expense associated with performing this sampling under the current statute, both parties would benefit from the arrangement. MSHA could

then be certain that all the respirable dust sampling was done in accordance with the law and that all the samples were accurate. Mine operators would save valuable assets both in terms of manpower and money. Significantly, operators would no longer be tempted to submit fraudulent samples or tamper with sampling devices in order to comply with the law. One beneficiary of this system would be conscientious operators, who would know that their competitors could not gain a competitive advantage by gaming the system. However, the individuals who will benefit the most by eliminating the mine operator from the sampling equation is the miner. This action would further the initial objective of the Mine Act by better protecting the industry's most precious resource – the miner.

The Union would also encourage MSHA to accept the Advisory Committee's recommendation to afford the Representative of the Miners the right to participate fully in the Respirable Dust Sampling Program. The Agency should modify its interpretation of the Mine Act to allow miners to utilize Section 103(f) "Walk Around Rights" at all times, regardless of the reason a Representative of the Secretary is on mine property. That would include granting walkaround rights for the purpose of compliance sampling. The participation of miners at mining operation is critical to the overall success of Mine Act in general and the health and safety of the workers at the facility in particular.

Finally, Congress and MSHA need to carefully examine a problem the Union has recognized for decades and the Advisory Committee addressed in recommendation 19f. The Committee stated that it recognized, "the problem of miner representation and participation in the dust control programs at mines not represented by a recognized labor organization and recommends that MSHA target such mines for compliance sampling. MSHA targeting should be active in nature and should consider many factors including miner input, compliance history, and medical surveillance data. Given the seriousness of this problem, MSHA should immediately start auditing and appropriately targeting these types of operations." This has been a historic problem in the industry that cuts at the very heart of the Mine Act's ability to be applied equally at all mining operations. The nature of the industry and MSHA's inability to adequately police non-compliant operators creates a bifurcated enforcement system that does not afford equal protection for all miners. The safest mines are Union-represented operations, where workers have a legitimate voice on the job.

Stanford Review

You do not have to simply take my word, or the word of the Advisory Committee, for the proposition that union represented mines are safer and more healthful than nonunion mines. The numbers bear that out, as shown in an article published by Stanford Law Professor Alison D. Morantz, entitled *Coal Mine Safety: Do Unions Make a Difference?* Vol. 66 Industrial and Labor Relations Review, No. 1 (2013) (attachment 16). Professor Morantz conducted a statistical analysis of injury reporting at underground, bituminous coal mines between 1993 and 2010. She researched both union and non-union mines to determine whether unionization reduced mine injuries or fatalities. The results of her inquiry were stark, but not surprising to those of us who work to improve miner health and safety every day.

Specifically, Professor Morantz found that unionization results in a "sizeable (more than 20%) and highly significant decline in traumatic injuries. . ." Similarly, she found "unionization is associated with an even larger (more than 50%) fall in fatal injuries . . ." That is, miners in union mines were far less likely to suffer traumatic or fatal injury. In analyzing this data, Professor Morantz concluded that traumatic and fatal injuries were the least prone to "reporting bias" therefore demonstrating "real" union safety effect in U.S. underground coal mines. While Professor Morantz was studying injuries (rather than occupational disease), I would argue that her findings are highly significant for the topic we are discussing today. First and foremost, the statistics show that union mines are safer than nonunion mines. Miners are less likely to die or suffer traumatic injury when they work in a union represented mine.

And the reason why this is the case is illustrated by the statistics regarding non-traumatic injuries. Specifically, while showing that union represented mines were far less likely to have fatal and traumatic injuries, the statistics also showed that union mines were "associated with a very sizeable (more than 25), robust, and statistically significant *increase* in non-traumatic injuries . . ." (emphasis in original). However, in explaining this counterintuitive result, Professor Morantz concluded that her findings lend "credence to claims that injury reporting practice differ significantly across union and nonunion mines." Put simply – nonunion miners were not less likely to suffer non-traumatic injuries; they were just less likely to report them. They reported higher levels of fatal and traumatic injuries, because those sorts of injuries are harder to hide.

These findings demonstrate what any union miner already knows: union represented mines are safer because union miners feel empowered to actively participate in their own safety. Union miners report lower numbers of fatal and traumatic injury because union miners know they can refuse to perform unsafe acts and can demand that their employer follow the rules. Further, union miners are more likely to report non-traumatic injury because they know that if the company retaliates against them for reporting the injury, that their union brothers and sisters will have their back. Nonunion miners reasonably fear retaliation from operators. They cannot afford to insist that their employers follow the rules and they cannot risk reporting minor injuries.

There is no reason to believe that this dynamic is any different as it relates to respirable dust. Union miners will insist that their employers follow the laws and ventilation plans to control respirable dust. When union miners see a problem, they will speak up. Non-union miners do not have the support systems necessary to take that risk. Instead, they will silently suffer while they breathe in the coal and silica dust that will slowly kill them.

Louisville Courier Journal

Following the issuance of the Task Group and Advisory Committee reports, The problems associated with the Respirable Dust Sampling Program continued. While this is not surprising, considering the fact that no action was taken to improve conditions in the mines, it is nonetheless disheartening. And the nation learned about it from a newspaper. Beginning on April 19, 1998, the *Louisville Courier Journal* ("*Courier Journal*") published the results of a year-long investigative report into the problem. The newspaper printed a 5-part series, *Dust, Deception and Death; Why Black Lung Hasn't Been Wiped Out* (attachment 17, relevant articles). I am sure many of you, especially those from the coalfield areas of northern Appalachia, are familiar with the reporting. But I believe it is important to revisit some of what the newspaper uncovered, to understand the depth of the problem miners have been dealing with for years. It is also critical that we realize the efforts to subvert the Respirable Dust Sampling Program by many operators and the inability of MSHA to adequately address these problems was not isolated to any particular area of the country, that it was not ended by the notoriety and MSHA fines that occurred as a result of the AWC case, and that it still occurs today.

The subheading for the first edition of the Journal story was, "*Cheating on coal-dust test widespread in nation's mines."* While that blaring indictment

naturally makes us think about the abhorrent actions of the coal companies, I would like to ask each member of this Committee to think about the people actually harmed. Think about the miners whose health was permanently ruined by this cheating.

Let me highlight one of those miners, whose experience was chronicled in the *Courier Journal*. After serving in the U.S. Army for 3 years, Leslie Blevins started his mining career in a low seam coal mine (36 inches) in 1972 at the age of 23. Blevins spent a lot of his 21 years in the mine operating a continuous mining machine, one of the dustiest jobs in any mine. It involved operating a massive piece of machinery designed to tear coal from the solid mine walls. For two years he was assigned to cut through solid rock in the mine, a common occurrence in many operations. The rock is much harder than coal and generates huge amounts of silica dust, which in much more toxic and damaging to the lungs. "Sometimes, I would have to shut the miner down and go in the fresh air and puke", stated Blevins. "My boss would tell me to get back in." But Blevins' story gets worse. Blevins was operating a miner, an occupation MSHA requires to be sampled for respirable mine dust. When he was asked about the sampling practices at the mine Blevins stated, "There would be times when I took company samples and the foreman would turn off" the sampling machine. "Or I'd come out of the mine, and they'd say, 'you took a sample today' and I'd say. 'I did? Where was it?' and they'd say, 'in the intake (clean air).'" The situation Mr. Blevins was subjected to is disgraceful. What is truly disgusting is that these same incidents still occur today.

Let me take a moment and explain exactly what, according to the *Courier Journal*, Mr. Blevins' employer and other coal operators were doing to avoid their obligations to provide healthy work environments for their employees. MSHA's dust program requires miners to be sampled on a routine basis while performing their normal duties at the mine. The sampling device was to be worn for 8 hours while the miner was in the mine. However, in an effort to have the company appear to be in compliance with the mine's dust plan, many mine operators devised countless ways to game the system.

Miners were told that the dust samples, that were supposed to be used to give an honest assessment of the amount of dust in the mine's atmosphere, must come out of the mine "clean", or within permissible limits. So instead of wearing the devices and risk disciplinary action by the mine operator, the sampling devices were routinely hung in fresh air intakes, placed in other less dusty areas or placed in the miners' lunch bucket. In one report in the *Courier Journal*, a miner remembers the only time he ever wore a dust sampling device. "I got a bad sample, and they told

me in front of everybody that I would be carrying that thing for the rest of my life if I didn't get a good sample. So, I took it in the next day and set it at the breaker box in clean air and got a good sample." There should be no doubt in anyone's mind that the message from mine management to this individual was not a single incident. These types of actions by coal operators are as old as the Dust Rule and are in fact still occurring today. There is no doubt in my mind, that if that miner had continued to bring out accurate samples that were not in compliance, he would have been fired.

In one particularly incredible scenario, miners at A.T. Massey Coal Company's Crystal Fuels mine took 45 dust samples at the mine face, the area where the solid coal is mined. Thirty-four of those samples, or 76 percent, contained just 0.1 mg of dust per cubic meter of air sampled. This is an outcome that by all accounts, including the opinions of experts with years of experience, is impossible to achieve. I would submit to this Committee that a miner working all day in intake air would not be able to attain such sampling results. And yet, the Union was unable to find any investigation or inquiry by MSHA questioning the validity of these sampling results. Let me put it bluntly: A.T. Massey obviously and transparently cheated on their dust sampling, but MSHA ignored these obvious "red flags."

Despite this evidence of rampant tampering, not to mention the 23-year-old recommendations of the Advisory Committee, coal operators are still charged with administering the Respirable Dust Sampling Program. As a result, MSHA must bear a major share of the blame for the current state of that Program. As I stated earlier, the seeds for the program's failure were apparent from the start, and those seeds have clearly taken root. Little has changed since the *Courier Journal* wrote its scathing report. The words of former Assistant Secretary for Mine Safety and Health Davitt McAteer at the time still ring very true. McAteer stated that, "Expecting operators to police themselves defies human nature…the system is broken." Recognizing that fact, McAteer was seeking to increase testing by federal inspectors and relying less on mine operator sampling. That idea, like so many other proposals, never came to fruition. Despite being able to concretely identify the shortcomings in the system, MSHA has done little to remedy the most blatant problems.

I realize that up to this point much of my testimony has focused on, what many would consider, the distant past. However, as I will point out, those sins of the past have never stopped plaguing the nation's coal miners.

Previous Congressional Hearings

On July 13, 2010 and again on March 27, 2012, I came before the House Committee on Education and Labor and the House Committee on Education and the Workforce, respectively, to discuss the disaster at Massey Energy's Upper Big Branch Mine South ("Upper Big Branch" or "UBB") in Montcoal, Raleigh County, West Virginia (attachments 18-19). While the overriding context of that testimony dealt with the events leading up to the mine explosion and its aftermath, the information I submitted and the testimony I gave predicted, that if action was not taken by Congress and the Agency, we would witness the Black Lung crisis we are discussing today. The Union has been raising the concerns routinely for years. I have enclosed the past several years of the *UMW Journal* (attachments 20-29), the official publication of the Union, that chronicles the Union's continual attempts to bring these problems to the forefront of public debate. However, like so many other efforts to protect workers, the legitimate warnings about Black Lung the Union has raised have been ignored by industry, MSHA and Congress.

The conditions in the Upper Big Branch mine, specifically the amount of coal dust that exploded and killed 29 miners, presents a microcosm of the dust problem that has haunted the industry for almost two centuries. While the UBB disaster could still provide fodder for hundreds of Congressional hearings, what is important to the topic we are here to discuss today is that the thick layers of coal dust that filled the entries of the UBB were not restricted only to the mine surfaces. This respirable and deadly dust also lined the lungs of the workers at that operation, slowly but surely killing the miners. In my 2012 testimony, I specifically referred to the fact that autopsies performed on the miners at UBB showed the majority of those killed had some level of Black Lung Disease. This is true of some of the youngest miners who lost their lives in the disaster.

Further, the report issued by the Union after the disaster, *Industrial Homicide,* (attachment 30, relevant pages) stated, "The fact that miners worked in such a dusty atmosphere offers great insight into the prevalence of black lung disease in many of the miners killed in the disaster. Of the 24 miners, between the ages of 24 and 61 whose lungs could be examined during autopsy, 17 or 71 percent, showed some stage of black lung." With respect to the mining practices at UBB, the report noted that the practice of running the longwall shearer without the required water sprays amounted to, "…reckless disregard for the law…And over the long term, exposure

to uncontrolled coal mine dust greatly increases miners' chances of contracting black lung disease."

Madam Chairman, the UBB disaster occurred on April 5, 2010. It is not ancient history. More importantly based on the information that is available, it is clear that this type of illegal activity on the part of many coal operators are accepted practices in the industry. There is a clear and uninterrupted pattern of behavior on the part of the coal industry that runs back to the earliest days of the Respirable Dust Sampling Program. Tragically, even the spotlight shone on the issue by martyrs of UBB could not put an end to the industry's reckless behavior.

National Public Radio and Center for Public Integrity

In 2012, an investigation by National Public Radio (NPR) and the Center for Public Integrity (CPI) found that the Black Lung disease has spiked in the last decade, especially in portions of Kentucky, West Virginia and Virginia (attachment 31). NPR and CPI documented weak enforcement by federal regulators and cheating by mining companies involving the system that is supposed to limit exposure to coal mine dust. If you have heard this all before, you are not alone.

NPR followed up on the story in December of 2016 when it printed data obtained from Black Lung Clinics in Central Appalachia (attachment 32). The story demonstrates the correlation between the industry's and the government's failure to curb excessive exposure to coal dust and the effects on miners' health.

NPR reported that recent studies showed that the occurrence Black Lung disease among coal miners across the nation had skyrocketed beyond anything ever seen before in the industry. Younger, less experienced miners were contracting the disease at an earlier age, subjecting them to a shortened and debilitating existence until they ultimately succumb to the ravages of the illness.

NPR reported that data from Black Lung Clinics across Appalachia, studies from NIOSH, and information that they uncovered all came to the same conclusion: the occurrence of Black Lung and PMF was being diagnosed in unprecedented numbers across the region. Perhaps even more alarming, many of the individuals contracting the disease were younger miners with less than 20 years of mining experience.

The information obtained from eleven Black Lung Clinics in Pennsylvania, West Virginia, Virginia and Ohio discovered 962 cases of the disease from 2010 to 2015. This is nearly ten times the number of cases reported by NIOSH during those five years. NPR also stressed that the frequency rate could be even higher because some clinics had incomplete records and other clinics refused to provide information.

At long last, on April 23, 2014, MSHA, perhaps responding to public outcry generated by the earlier NPR reports and pressure from the UMWA, published a final rule titled "Lowering Miners' Exposure to Respirable Coal Mine Dust, Including Continuous Personal Dust Monitors." After decades of turning a blind eye, MSHA was finally taking some action on respirable dust. The rule became effective on August 1, 2014, and was phased in over a two-year period. It included a reduction in the concentration of respirable coal mine dust permitted in the mine atmosphere from $2mg/m^3$ to 1.5 mg/m^3, use of the personal dust monitor (PDM), required full shift sampling of specific designated occupations (DOs) and designated areas (DAs) and permitted MSHA to cite a mine operators for violating the law based on a single shift sample. The Rule did not include, nor did it contemplate, including the requirement for a separate, legally enforceable, PEL for silica.

At the time, the UMWA offered "qualified" support for the rule noting, "There are aspects of the rule the Union believes will help lower miners' exposure to mine dust and reduce the chances they will contract black lung. However, there are other issues we believe MSHA should have included in the final rule to better protect miners." The Union went on to state that, "The PDM is cutting edge technology, but MSHA did not require it be used to sample all miners." and that "MSHA enforcement of the new rule will be critical to its ultimate success, which would be more likely had the Agency taken over the sampling procedures." While the Union continues to stand by that assessment, we must face the unfortunate reality that operator fraud and tampering along with inadequate enforcement has once again doomed the respirable dust sampling program.

According to a report published in the September, 2018 edition of the *American Journal of Public Health,* one in every ten coal miners who have worked for at least 25 years in the industry has been identified as suffering from Black Lung disease (attachment 33). The situation in West Virginia, Kentucky and Virginia is much worse. NIOSH data has determined that one in five miners with two and a half decades mining experience in central Appalachia have contracted some level of the disease. NIOSH also noted that the number of miners diagnosed with

progressive massive fibrosis (PMF), the most severe form of the disease, will likely increase at the same rate in the coming years. To put this health crisis in perspective, the number of cases of Black Lung diagnosed through 2016 in West Virginia and Kentucky have increased over 16 percent compared to 1970. In Virginia, the same year comparison shows an increase of over 31 percent. Doctors from the National Institute for Occupational Safety and Health have described the incidence rates as nothing short of an epidemic.

Armstrong Coal Company

Madam Chairman, in the event that any person on this Committee is inclined to think that coal industry changed after the tragedies I have discussed today, I would offer a review of a recent indictment of both the coal industry and MSHA. The case I am referring to came to a head just last year and is currently being prosecuted by the United States Attorney for the western District of Kentucky. A federal grand jury indicted nine officials from the Armstrong Coal Company on charges of conspiring to commit dust fraud. Those nine officials were Glendal "Buddy" Harison, the Manager of all of Armstrong's western Kentucky Mines; Charles Barber, superintendent of the Parkway Mine; Brian Keith Casebier, Parkway Mine safety director; Steven Demoss, Parkway Mine assistant safety director; Billie Harold, Parkway Mine section chief; Ron Ivy, Kronos Mine safety director; John Ellis Scott, worked in the safety department at Parkway Mine; Dwight Fulkerson, Parkway Mine section chief and Jeremy Hackney, Parkway Mine section chief. The grand jury charged that each individual, "…knowingly and willingly altered the company's required dust-sampling procedures, by circumventing the dust-sampling regulations, submitting false samples and making false statements on dust certification cards." The fraud and deception occurred between January 1, 2013 and August 8, 2015, through the time frame when MSHA's new dust rule was being implemented. The indictments were made public in July 2018. New charges related to the alleged fraud were added in February of this year (attachments 34-35).

While the Union is pleased the alleged perpetrators of these crimes were indicted, it is important to note that MSHA enforcement activity did not play a role in initiating this case. Rather, the miners at the operation who contracted Black Lung or were experiencing shortness of breath brought the damning information to the attention of the Huffington Post, resulting in an investigation by the Agency. Miners at the operation reported that the company officials at Armstrong used many of the

same tactics that other coal operators have used since the inception of the Respirable Dust Sampling Program. Dust pumps were hung in intake entries, company officials falsified tests on days the mine was not even operating, workers wearing dust sampling devices were removed from dusty areas or occupations and replaced by miners not wearing the devices. The devices were also wrapped in cloth to restrict dusty airflow into the pumps.

So, Madam Chairman and members of the Committee as we sit in this beautiful hearing room, breathing in clean fresh air, I am disappointed to report that nothing much has changed in the coal industry. There is a new respirable dust rule, there is a new Assistant Secretary at MSHA, there is new continuous dust monitoring devices in the nation's mines and the industry is still willfully, knowingly and with impunity causing the slow and horrific death of thousands of miners every year. The dollar they put into their pocket at the expense of these miners' lives is apparently worth the harm they are causing.

Allow me to repeat myself; after nearly two centuries of mining coal in the United States very little has changed.

Madam Chairman, it has been brought to my attention that at the conclusion of this panel, the Committee intends to hear from a representative of the mining industry and the Assistant Secretary for Mine Safety and Health Administration, Mr. Zatezalo. I cannot be certain about the exact details of the testimony they will be offering the Committee. However, based on my knowledge of this issue and from what I have read and seen in other sources, I can confidently speculate that their views will not align very closely with what I have stated today.

I am certain that industry will attempt to explain the continued occurrence of Black Lung disease among today's miners as a remnant of the past. The leftover casualties of a time before operators became enlightened, followed the letter of the law, and looked out for the health of the miner. There will be attempts to show this Committee that the industry has changed and only a few rogue operators are still placing the lives of miners at risk. I could not disagree more.

The failure of the Respirable Dust Sampling Program is apparent. There is no question that in order to gain a competitive advantage over a competitor or increase their profit margin, today's mine operators will resort to the same tactics the have

used for years to game the system. If left to their own devices and permitted to retain control of the sampling program, coal operators will continue to expose miners to excessive and deadly coal dust with no regard for the lives they are destroying.

The Mine Safety and Health Administration will attempt to demonstrate the success of the Respirable Dust Sampling Program by reciting the number of dust samples that have been taken and the percentage that are in compliance since the inception of the new dust rule. If I am not mistaken, those figures will reflect that between MSHA and mine operators 138,768 samples have been taken and that over 99 percent are below the Permissible Exposure Limit. The data will also show the average concentration of these samples are at a historic low of 0.61mg/m^3. The Agency will attempt to paint the new sampling system as successful, based on this data. Unfortunately, this data has been removed from MSHA's web site.

From the prospective of the UMWA, based of years of experience and the history of the industry, we simply do not accept or trust the data being presented by the Agency. Unfortunately, the overwhelming evidence of tampering and fraud by coal operators and the lack of adequate oversight by MSHA leaves the Union no other choice but to dismiss this information as subjective and not scientifically sound. Given the history of what I have recounted today, what would give this Committee, or any reasonable observer, any confidence that the numbers cited by MSHA are accurate?

In the end, I believe both industry and MSHA will seek to delay any attempts to strengthen the protections afforded to miners though Congress or by rulemaking. They will request more time to establish whether the new rule is working sufficiently. Madam Chairman they may have more time for studies and information gathering, but the nation's miners do not. Additional time for miners under the present conditions is, simply put, additional time to contract Black Lung. Time is something miners do not have when it comes to protecting their health and safety.

It is not my intention to impugn the sincerity of the testimony any individual will present to this Committee, although I would not hesitate to question the factual basis for their remarks. I believe that MSHA honestly wants its Respirable Dust Sampling Program to work. But, the Union's views are clear on this matter. The Program does not work. We know why. We know ways to fix it. It is time to take action.

After the Diagnosis

Madam Chairman, this is not the end of the problems created by the broken Respirable Dust Sampling Program that miners are forced to work under. To the contrary, for most miners who have contracted the disease, the difficult and deadly process is only just beginning. The realty of the situation for miners is that rather than accept the responsibility for their actions and seek to compensate disabled miners and mitigate the effect of the disease, coal operators and others do everything in their power to shirk that responsibility. It is not confined to dust sampling and Black Lung. If the Committee had time, I could fill the congressional record with stories of operators disclaiming responsibility for anything and everything that happens to miners they are charged to protect. But when it comes to Black Lung, it seems that the excuses and evasions never end. Operators will stop at nothing to avoid paying for Black Lung benefits. It's a sad situation that just keeps playing out over and over again.

There are countless stories of miners who have contracted the most severe form of Black Lung disease, PMF, but were unable to receive the benefits they were owed. These miners are examined by medical experts from the U.S. Department of Labor and their own doctor to confirm their worst fears only to see their employer contest their eligibility in administrative proceedings, sometimes for decades. The truth is that, almost without exception and despite overwhelming evidence supporting the miner, coal operators still refuse to recognize the miners' disability. The premise behind the operator's decision to deny benefits is simple: The delaying effort allows them to rely on time and money, two things most miners with the disease don't have. The morality of their actions is also simple: it is reprehensible.

The expense of pursuing the claim can cost the miner tens of thousands of dollars they simply do not have and most lawyers familiar with the Black Lung legal system know the return on their investment in time and research is meager at best. So, after an initial filing and a series of hearings before the administrative law judge, most miners cannot afford to continue the fight. The case is dropped, the company wins and the miner suffers in obscurity until the disease causes their lungs to fill with liquid and they drown.

Perhaps one reason the company wins so many Black Lung claims is a rule employed by the Department of Labor's Administrative Law Judges ("ALJs"), and the Benefits Review Board that oversees those ALJs, that denies benefits when the

evidence supporting and the evidence refuting a claimant's Black Lung diagnosis is equal. Under the adversarial system created to administer of the Black Lung Benefits Act, claimants and their former employers will each submit a certain number of x-ray readings, a certain number of spirometry and blood gas results, and a certain number of medical reports to prove their case. The miners will present evidence showing they have Black Lung and are disabled. Operators will present evidence showing they are not sick or are not disabled. As I will discuss later, the evidence presented by operators is sometimes inaccurate or downright fraudulent. Nonetheless, it is easy for an ALJ to look at the evidence, determine that all the doctors involved have equally impressive credentials, and decide the evidence is equal. And, finding the evidence is "in equipoise" those ALJs then deny the claim. In short, if an ALJ cannot or will not make up his or her mind about the existence of disabling Black Lung, the miner pays the price.

Madam Chairman, in the 115th Congress, H.R. 1912, was introduced by Representative Matt Cartwright and was entitled the "Black Lung Benefits Improvement Act." That bill would have, among other things, changed the Black Lung Benefits Act to state, "[i]n determining the validity of a claim under this title, an adjudicator who finds that the evidence is evenly balanced on an issue shall resolve any resulting doubt in the claimant's favor and find that the claimant has met the burden of persuasion on such issue." That change, and other changes contained in H.R. 1912 would have been significant improvements. I would like to thank Representative Cartwright, and the co-sponsors for their work on that bill. I would also like to thank Senator Robert Casey, Jr. and his co-sponsors, who introduced a similar bill in the Senate. Unfortunately, the bills were not passed and miners continue to suffer under the current system.

Under the current circumstances, should a miner have enough resources and find an attorney willing to accept and stick with their case to continue the fight for benefits, the employer's legal team relies on the passage of time to settle the case. Miners with PMF have a limited time left on this earth. Through court hearings, delays, appeals and any number of stalling tactics, the miners' time is slowly drained away as the case languishes in the system. Ultimately, the miner will suffocate and die. But, for the mine operator and his legal team, the case is over and no benefits are paid. It's a win no matter what the cost in human tragedy!

Unfortunately, the truth about these despicable tactics by mine operators and the law firms they hire with the profits from the miners' labor is that, they work.

A Special Place in Hell

The intervention and deceitful dealings of the operators' lawyers, and in many instances the less than truthful medical personnel they hire to do the companies bidding, must also be taken into account. While miners, their lawyers and the UMWA have always suspected that an unethical and unholy alliance came together that would resort to whatever means necessary to defeat the miners' claims for benefits, the fact is, there is evidence to confirm our suspicions. It all came to light in a report issued by CPI (attachments 36-38).

The most notorious case concerns one of the largest legal firms representing coal companies, Jackson Kelly, PLLC and one of the most prestigious medical institutions in the nation, Johns Hopkins University Medical Center. The two institutions know each other well. They have worked together on Black Lung cases for decades. Their collaboration and interaction with coal operators around the country have been extremely damaging to miners seeking compensation for the illness that is ravaging their bodies and destroying their lives.

Jackson Kelly has spent nearly two centuries catering to the coal industry. This has made them the go-to law firm for the giants in the business. The firm's aggressive and ruthless approach to defending their coal industry clients is apparent, but a report by CPI raised serious ethical questions about the firm's tactics. In a very limited review of cases handled by Jackson Kelly, CPI found at least eleven cases that the firm was "…found to have withheld potentially relevant evidence [of Black Lung] and, in six cases, the firm offered to pay the claim rather than turn over documents as ordered by a judge." In one case in particular, a miner underwent a biopsy to determine if he was suffering from lung cancer. The tissue was examined by a pathologist and was ruled negative for the disease. However, without the knowledge of the miner, Jackson Kelly obtained the medical slides of the biopsy and sent it to two pathologist the firm had previously contracted to consult on Black Lung cases. Both reported that the tissue from the biopsy was likely complicated Black Lung disease. The report that definitively proved the miner had Black Lung, which only Jackson Kelly had, was suppressed, hidden away and never shared with the miner, his doctor or his attorney at trial. The miner's benefits were denied.

The report also discovered that, according to Jackson Kelly's own documents, the firm has a history of withholding evidence unfavorable to its clients and "shaped the opinions of its reviewing doctors by providing only what they wanted them to see." The firm claims that they are not required to disclose such information because

it is "attorney work product." Meanwhile, as miners continued to suffer and die from the incurable effects of the disease, Jackson Kelly continued to defend the practice. In court filings, Counsel for the firm noted, "there is nothing wrong with its approach and that its proper role is to submit evidence most favorable to its clients." In the end, truth be damned, miners are collateral damage in the industry and Jackson Kelly must win no matter what the cost.

Of course, Jackson Kelly, and other company lawyers, could not subvert the process on their own. They are lawyers, not doctors. Unfortunately, coal companies found willing allies in white lab coats. A small unit of radiologists in one of the nation's most prestigious medical schools was willing to do the bidding of coal companies in their attempts to deny miners Black Lung claims for decades. For 40 years, medical professionals at Johns Hopkins Medical Center reviewed x-rays of miners suffering from Black Lung disease. Almost without exception these individuals, whose x-ray interpretations cost up to 10 times the rate typically paid for such services, have never diagnosed the most severe form of the disease, Massive Pulmonary Fibrosis.

To get the full picture of the impact that Johns Hopkin's Black Lung program has had on miners across the country, you need only look at the work of one man who ran the operation for the hospital, Dr. Paul Wheeler. Wheeler, who retired after the story by CPI was printed, was considered by many to be a leading authority on lung disease. With a medical degree from Harvard University, and the prestige associated with Hopkin's Medical Center, judges took his evaluations of patients as gospel. Some sided with the coal company's medical professional because he [Wheeler] is, "…the best qualified radiologist" and stating their decisions were because of Wheeler's testimony noting, "I defer to Dr. Wheeler's interpretation because of his superior credentials."

But, a deeper look into Wheeler's expertise revealed some alarming problems. The Center's reporting found that, "In more than 1,500 cases decided since 2000 in which Wheeler read at least one x-ray, he never found the severe form of the disease, Complicated Coal Workers' Pneumoconiosis." However, in more than 100 of the cases Wheeler determined to be negative, biopsies and autopsies provided indisputable evidence of Black Lung.

The doctor may have many reasons for his findings, beyond the fact that coal companies are the clients. His own words seem to indicate as much. For whatever reason, he believed miners do not have Black Lung and are being wrongfully

compensated. He stated, "They're getting payment for a disease that they're claiming is some other disease." Wheeler generally blamed miners' lung problems on tuberculosis or histoplasmosis (an illness caused by a fungus in bat and bird droppings). His arrogance, however, did not end there. He made it clear that despite what the law says, miners should be required to prove the existence of Black Lung. When confronted with his misinterpretation of the law, Wheeler's contempt reached a new level when he stated, "I don't care about the law." Johns Hopkins was so embarrassed by the report of Dr. Wheeler's actions that it terminated its Black Lung program.

The story by CPI was an enlightening look into the less than honorable and sometimes unethical levels coal operators and their surrogates will go to in order to win. Miners stand little chance of proving their case when the odds are so heavily stacked in favor of big business and bigger money. The tragedy lives on until the miner finally dies, but the "professionals" who oppose them go home to comfort and with another notch in their belt.

Madam Chairman and members of the Committee, there can be no doubt that miners continue to suffer from the inadequacies of a system that, at almost every turn, is stacked against them. They have known for years that the coal operators who employ them have cheated and scammed the system. They have witnessed the blatant fraud and outright lying by the operators whose objective has always been more production at any cost. I would defy anyone from the industry to bring facts to the table that shows otherwise. Industry officials of today may be more sophisticated and speak in nobler terms about the evolution of the industry and the concern that they have for the miners, but they have not moved far from the coal barons who preceded them. Their actions prove that profits continue to trump health and safety at every turn.

Likewise, we must all understand that MSHA's incessant need to demonstrate success, in spite of facts to the contrary, leaves them with little recourse to correct their situation. This persistent need to prove that it is meeting the requirements of the Mine Act or that the rules it has promulgated are effective, even in the face of the fact and the testimony I have presented that proves otherwise, shows the disconnect between the Agency and its true mission. They must know the system, even as it exists today, is horribly broken, yet for whatever institutional reasons that may exist, they cannot and will not admit it. This inability to conduct a thorough and honest evaluation of its own failings and to take the necessary corrective action continues to cost miners their lives.

We must also find a way to curb the abuses miners suffer at the hands of some members of the legal and medical profession. There must be a stringent standard for those who present "expert" testimony and the admission of possible conflicts the presenter may have for arriving at their conclusions. Finally, we must also demand that all the facts be presented in these cases in order to be certain that the ultimate settlement is correct and based on the scientific evidence.

Black Lung Trust Fund

Madam Chairman in January of 2017 the Department of Labor's Office of Workers Compensation Programs proposed major changes in regulations that determine how the Black Lung Benefits Act (BLBA or the Act) is administered . Among other things, the Act, "provides for the payment of benefits to coal miners and certain of their surviving dependents on account of total disability or death due to coal workers' pneumoconiosis. A miner who is entitled to benefits under the BLBA is also entitled to medical benefits." The funding for these benefits is generated by a federal tax assessed on each ton of coal operators produce. That funding stream has been threatened in recent months because of the inaction of Congress to extend that tax.

At the time, the Union strenuously objected to the changes proposed by DOL because of the devastating effects they would have on the overall program and the resulting benefit reductions for disabled miners. The UMWA has carefully reviewed the Proposed Rule and is deeply concerned that in an effort to unilaterally reduce costs, they have lost sight of what is important – the health and wellbeing of the miners and their families. It is unclear when you examine the proposal if the DOL is looking out for the best interest of disabled miners or trying to save money for mine operators who are ultimately responsible for paying the medical bills of these individuals. This is a bad proposal.

The Union is convinced that the Proposed Rule would damage the Black Lung Program so severely that it would eventually become even more ineffective, leaving families in these coalfield communities impoverished, and miners disabled from this deadly disease without adequate medical care. While the DOL discussed how the cuts they are proposing will have little impact on the health care industry as a whole, they ignored the fact that small communities, where these services are offered, are

not reflective of large metropolitan areas of the country. The proposal appears to be aimed at reducing payment schedules to the point it forces providers in these areas to stop offering services that miners are entitled to under the BLBA.

For example, the Agency claims the average cuts to the program amount to approximately 7 percent of total benefits paid, but the decreases for some states are drastic. In Kentucky, for instance, inpatient hospital costs in 2014 were paid at 36 percent of total billing. Under the Proposed Rule those payments would be reduced to 26.5 percent of billing, a cut in benefit payments of almost $1.3 million per year. In Florida, where many UMWA Members reside, the cuts would be even more severe, from 64 percent of total billing to less than 18 percent. The most glaring example of these draconian cuts are the payments made for outpatient hospital services, cuts that would affect every state in the program. The DOL is proposing reimbursement for these services at just 20 percent of current payments; a reduction of 72 percent.

The Union would suggest that instead of trying to determine how to reduce and perhaps eliminate these Black Lung benefits, the DOL could better spend its time correcting the deficiencies in the program. The most glaring defect is placing the burden on the Black Lung Trust Fund to cover the cost of benefits owed to disabled miners by coal operators who are unwilling or unable to pay for such benefits. This is unacceptable Madam Chairman. I submit to this Committee that any operator who cannot pay or refuses to pay these mandatory benefits should not be permitted to continue to mine coal and subject future workers to the hazards that exist in the mines they operate. If they are so financially strapped or callously indifferent to the suffering they have caused, they should be run out of the industry.

Should the actions planned by DOL become effective, miners and their families would be left to suffer and die without the necessary medical treatment and financial assistance they are entitled to receive. They would, once again, bear the brunt of the mine operators' refusal to accept their responsibility for perpetuating this disease, and be subjected to the government's lack of desire to require that the owners meet their obligations. This is an intolerable situation for everyone involved and should not be permitted to occur.

The changes contemplated by the DOL are not the only threat to the benefits miners are owed from the Black Lung Trust Fund (Trust Fund). December 18, 2018,

was a significant day in the lives of disabled coal miners and those who may contract Black Lung disease in the future. That date, established by Congress, as the day the excise tax placed on every ton of coal produced in the United States would be reduced by 55 percent. This tax is used by the federal government to provide the revenue necessary to operate the Trust Fund. Congress set this arbitrary deadline believing that Black Lung would be eradicated before the coal excise tax expired in 2018.

Prior to the expiration of the Coal Excise Tax, operators paid $1.10 on coal produced underground and $.55 on surface coal. According to the Congressional Budget Office (CBO), had the Tax been extended, the Trust Fund's current $6 billion debt would have been reduced to $4.5 billion by 2050. An increase of $.25 per ton of coal would have eliminated the debt altogether. The CBO has determined that allowing the tax to expire, as Congress did in December, will allow the debt to explode and require a multimillion-dollar taxpayer bailout to prop up the Trust Fund (attachment 39).

The sad fact is, no matter how far we seem to come in this country, whether it is advances in science, technology, medicine or a host of other subjects, some things never seem to change. I suppose many industries deny the problems they cause, but the people who own and operate coal mines seem to be the worst. They all argue that they should be allowed to make as much money as possible on their investment without government interference. Then, when their actions cause major economic or health problems, they want the government to force taxpayers to bail them out. That is exactly what happened in the aftermath of the recession of 2008 and that is what coal operators are asking for now. They want to keep their profits private but socialize their losses. It is time Congress told these businesses they are responsible to pay, not the American taxpayer.

When Congress failed to pass appropriations legislation at the end of 2018, it also failed to take the simple and necessary action to sustain the Federal Black Lung Disability Trust Fund by changing an arbitrary date set nearly four decades ago. This is unconscionable.

Madam Chairman, Ranking Member Byrne and the members of the Committee there is much more that I could discuss regarding the ineffectiveness of MSHA's Respirable Dust Sampling Program and the misery that failure has caused

hundreds of thousands of miners and their families. However, I believe that the facts that have been laid out at this hearing and the facts that have been available in the public domain for decades are sufficient to demand action by this Committee and ultimately by the entire United States Congress. There is no longer an alternative and there can no longer be excuses. The carnage in the coalfields from this preventable disease must stop.

With that goal in mind I would like to make the following recommendations, on behalf of the nation's miners, as the starting point to correct this appalling abuse miners have faced for far too long.

1) Congress must take necessary action to require the federal Mine Safety and Health Administration assume the responsibility for conducting all respirable dust sampling used to ensure mine operators are in compliance with all aspects of the Respirable Dust Sampling Program. The standard must require that a Representative of the Secretary be present for all such sampling for the entire duration of the sampling process.

    a) This can be accomplished either through immediate Congressional legislative action or by Congress directing MSHA to issue an emergency temporary standard meeting this requirement.

    b) In an effort to pay for any additional financial burden this new sampling program would impose on MSHA, Congress must require the Agency to issue an emergency temporary standard that permits it to charge a fee for service or any other reasonable method to recover the cost associated with the program.

    c) Congress must direct MSHA to move immediately after the issuance of these emergency standards to codify them into regulation by promulgating a permanent standard that accomplishes these goals.

2) Congress must take necessary action to require the federal Mine Safety and Health Administration promulgate an emergency temporary standard that creates a separate Permissible Exposure Limit for silica. The Standard must set the PEL at the current level recommended by the National Institute for Occupational Safety and Health.

a) This can be accomplished either through immediate Congressional legislative action or by Congress directing MSHA to issue an emergency temporary standard meeting this requirement.

b) The emergency standard must require that the PEL for silica be separate and distinct from the Respirable Dust Standard and enforceable in accordance with all other standards established by the Agency.

c) MSHA must implement a sampling program for silica similar to the current Respirable Dust Sampling Program. MSHA must be responsible for conducting all respirable dust sampling used to ensure mine operators are in compliance with all aspects of the silica standard.

d) In an effort to pay for any additional financial burden this new sampling program would impose on MSHA, Congress must require the Agency to issue an emergency temporary standard that permits it to charge a fee for service or any other reasonable method to recover the cost associated with the program.

e) Congress must direct MSHA to move immediately after the issuance of these emergency standards to codify them into regulation by promulgating a permanent standard that accomplishes these goals.

3) Congress must take necessary action to require the federal Mine Safety and Health Administration promulgate an emergency temporary standard that expands the 103(f) "walk around" rights afforded miners. The standard must permit the Representative of the Miners the right to participate in all activity conducted by a Representative of the Secretary while on mine property or in any activity that directly impacts the health and safety of miners at the operation.

a) This can be accomplished either through immediate Congressional legislative action or by Congress directing MSHA to issue an emergency temporary standard meeting this requirement.

b) This emergency temporary standard must require the mine operator to compensate all Representatives of the Miners who participate in such activity at their regular pay, including applicable overtime, for all such work performed.

c) Congress must direct MSHA to move immediately after the issuance of these emergency standards to codify them into regulation by promulgating a permanent standard that accomplishes these goals.

4) Congress must take necessary action to require the federal Mine Safety and Health Administration to address the problem of miner representation and participation at mines not represented by a recognized labor organization and target such mines for compliance with all aspects of the Mine Act and all rules promulgated by the Agency to advance the safety and health of the miners. MSHA targeting should be active in nature, and include accident reporting, compliance history and patterns of noncompliance with all health and safety laws. Given the seriousness of the problem known to exist at these operations, MSHA should immediately start auditing and appropriately targeting these types of operations.

   a) This can be accomplished either through immediate Congressional legislative action or by Congress directing MSHA to issue an emergency temporary standard meeting this requirement.

   b) Congress must direct MSHA to move immediately after the issuance of these emergency standards to codify them into regulation by promulgating a permanent standard that accomplishes these goals.

5) Congress must take immediate action to restore and increase the funding stream necessary to pay for benefits owed to coal miners from the Black Lung Disability Trust Fund. The increase must be sufficient to pay all disability and medical benefits, as well as retire the debt currently incurred by the Trust Fund. Payment of the debt must be completed in a reasonable and cost-effective time frame, not to exceed 30 years from the date of the legislation.

   This legislation must contain language that does not permit companies who do not have the financial ability to pay for required benefits or refuse to pay required benefits to remain in business.

   In the event current mine operators are in arrears in payments to any beneficiary for required benefits, for any reason, the legislation must

contain language that permits the Trust Fund to recover any assets it has expended to pay these benefits, either by garnishing the revenue of the mine operator or if necessary attaching the mine's assets and selling those assets to cover the debt.

Madam Chairman I would like to take this opportunity to thank you, Ranking Member Byrne and the entire Committee for allowing me the opportunity to testify at this extremely important hearing. The nation's miners are some of the hardest working, dedicated and patriotic people in this country. They have made great sacrifices to protect and energize the nation. They are willing to continue providing whatever is necessary to keep our nation strong and moving forward. They would simply request that their sacrifice be rewarded with a reasonable pension, not cut short because of Black Lung disease. Madam Chairman, the miners have waited for Congressional action far too long. Thank you.

BETTER MEDICARE ALLIANCE

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June 20, 2019

The Honorable Patrick Toomey
United States Senate
Co-Lead, Health Tax Task Force
248 Russell Senate Office Building
Washington, DC 20510

The Honorable Robert Casey, Jr.
United States Senate
Co-Lead, Health Tax Task Force
393 Russell Senate Office Building
Washington, DC 20510

RE: Comments Urging a Long-Term Solution to Health Insurance Tax for Pennsylvania Beneficiaries Under Medicare Advantage

Dear Senator Toomey and Senator Casey:

As Pennsylvania Allies from the leading Medicare Advantage advocacy coalition, Better Medicare Alliance (BMA), which advocates on policies that will further strengthen Medicare Advantage as a high-quality, cost-effective choice for seniors, we write to you to share our deep concerns about the harmful effects of the Health Insurance Tax (HIT) on the 22 million Americans enrolled in a Medicare Advantage plan, including the **1.1 million Medicare Advantage beneficiaries in Pennsylvania**, if Congress fails to act.

Given your leadership on the Health Tax Taskforce announced last month by the Senate Finance Committee Chairman Charles Grassley and Ranking Member Ron Wyden, we strongly urge that as you review health-related tax policies, you seek to permanently repeal or, at a minimum, delay the HIT through 2021.[1]

Our organizations support S. 172, legislation that delays the HIT through 2021, and S. 80, legislation that permanently repeals the HIT. If Congress does not take timely action to suspend the HIT, millions of American seniors, including 1.1 million beneficiaries in Pennsylvania, and others with health insurance coverage could face a major premium increase of more than $20 billion[2] when the HIT returns.

While much of the public's attention has focused on the HIT's harmful effects on individuals and consumers in the employer group markets, there are severe implications for seniors and disabled Americans in Medicare Advantage in relation to this tax. Analysis shows that a return of the HIT in 2020 could impose more than $500 in additional annual premiums for the typical Medicare Advantage couple[3] — a sum that far too many simply cannot afford.

As it is, many current and future retirees are at risk of not being able to afford the costs of health care in retirement. Nearly half of Medicare Advantage enrollees live on less than $24,000 annually.[4] According to a recent analysis, 62% of retirees age 65+ years old, as well as about three out of four non-retired

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[1] *Grassley, Wyden Announce Taskforces to Find Long-Term Solutions to Temporary Tax Policy*, Press Release, U.S. Senate Committee on Finance. May 16, 2019. Web.
[2] *"Analysis of the Impacts of the ACA's Tax on Health Insurance in Year 2020 and Later,"* Oliver Wyman; August 28, 2018. Web.
[3] *Ibid.*
[4] Analysis of 2016 Medicare Current Beneficiary Survey (MCBS) data, provided by Anne Tumlinson Innovations, LLC.

BETTER MEDICARE ALLIANCE

adults age 50 to 64, have less in total retirement savings than what experts recommend saving for health care costs alone.[5]

For these reasons and more, America's seniors are increasingly choosing Medicare Advantage. They appreciate the focus on prevention and disease management and the offering of enhanced benefits and services, such as vision, hearing, fitness and wellness, and dental coverage. These beneficiaries rely on Medicare Advantage for the high-value, integrated care it provides, offering the right care in the most appropriate setting.

We appreciate the decision Congress made to delay the HIT for 2019, but the threat of the HIT remains. According to a recent analysis, without the delay of the HIT for 2019 the nationwide annual premium could have increased from $393.05 in 2018 to $612.09 in 2019, or 55.7%.[6] Had Congress allowed the HIT to take place in 2019, the result could well have been an alarming spike in premiums, causing severe financial hardship for the millions of Medicare beneficiaries who rely on Medicare Advantage.

Delay or permanent repeal of the HIT is one of the most direct ways for Congress to provide financial relief for seniors and individuals who are eligible for Medicare due to disabilities, while maintaining access to the quality, affordable health care they have chosen.

It is our hope that the Health Tax Taskforce will address the HIT swiftly and move to permanently repeal or, at a minimum, delay this harmful tax that most seniors simply cannot afford. Thank you for your consideration of our views on this important issue. Should you have any questions or need further information, please do not hesitate to contact our Director of Government Affairs, Lisa Hunter, at lhunter@bettermedicarealliance.org or (202) 758-3157.

Sincerely,

Better Medicare Alliance
ChenMed
Einstein Healthcare Network
Greater Philadelphia Business Coalition on Health
Health Partners Plans
Philadelphia Corporation for Aging
Pittsburgh Business Group on Health
UPMC

CC: U.S. Senator Michael Enzi, Member of Health Tax Task Force
U.S. Senator Mark Warner, Member of Health Tax Task Force

[5] "*Preparing for Health Care Costs in Retirement: An America's Health Rankings Issue Brief*," United Health Foundation and Alliance for Aging Research; May, 2017. Web.
[6] "*New Analysis: How the 2019 Moratorium on the ACA's HIT Kept Medicare Advantage Premiums Down*," Oliver Wyman; January, 16, 2019. Web.

Senator Deb Fischer
U.S. Senate
454 Russell Senate Office Building
Washington D.C. 20510

June 20, 2019

Dear Senator Fischer:

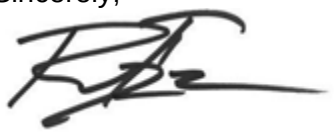
On behalf of the Alzheimer's Association and the Alzheimer's Impact Movement (AIM), including our nationwide network of advocates, thank you for your continued leadership on issues and legislation important to Americans with Alzheimer's and other dementias, and to their caregivers. The Alzheimer's Association and AIM are pleased to support the Paid Family Leave Pilot Extension Act, S. 1628.

More than 5 million Americans are living with Alzheimer's and, without significant action, nearly 14 million Americans will have Alzheimer's by 2050. Today, another person develops the disease every 65 seconds; by 2050, someone in the United States will develop the disease every 33 seconds. This explosive growth will cause Alzheimer's costs to increase from an estimated $290 billion in 2019 to more than $1.1 trillion in 2050 (in 2019 dollars). These mounting costs threaten to bankrupt families, businesses and our health care system. Unfortunately, our work is only growing more urgent.

The Paid Family Leave Pilot Extension Act would add an additional three years to the employer credit for paid family and medical leave. Additionally, it would require the GAO to study the impact of the tax credit on paid family and medical leave. Unfortunately, the burden of caring for individuals living with Alzheimer's and other dementias extends to millions of Americans. In 2017, 16.1 million family members and friends provided 18.4 billion hours of unpaid care to people with Alzheimer's and other dementias, at an economic value of over $232 billion. Approximately one-quarter of dementia caregivers are "sandwich generation" caregivers - meaning that they care not only for an aging parent, but also for children under age 18. For a family caregiver to be able to take paid family and medical leave when a loved one living with dementia is in need would greatly help ease the financial burden placed on family caregivers.

The Alzheimer's Association and AIM deeply appreciate your continued leadership on behalf of all Americans living with Alzheimer's and other dementias. We look forward to continuing to work with you and your colleagues to improve care and support for individuals and families affected by Alzheimer's disease and other dementias. If you have any questions about this or any other legislation, please contact Rachel Conant, Senior Director of Federal Affairs, at rconant@alz-aim.org or at 202.638.7121.

Sincerely,



Robert Egge
Chief Public Policy Officer
Executive Vice President, Government Affairs
Alzheimer's Association

CVS Health

1275 Pennsylvania Ave NW, Suite 700
Washington, DC 20004

Submitted via Health_Tax_Taskforce@finance.senate.gov

June 20, 2019

The Honorable Patrick Toomey
United States Senate
248 Russell Senate Office Building
Washington, DC 20510

The Honorable Robert Casey, Jr.
United States Senate
393 Russell Senate Office Building
Washington, DC 20510

The Honorable Michael Enzi
United States Senate
379A Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
United States Senate
703 Hart Senate Office Building
Washington, DC 20510

Re: Health Tax Taskforce Request for Feedback to Find Long-Term Solutions to Temporary Tax Policy

Dear Senator Toomey, Senator Enzi, Senator Casey, and Senator Warner:

CVS Health, on behalf of its subsidiaries and affiliated entities, appreciates the work of the Senate Finance Committee Health Tax Workforce to find long-term solutions for temporary tax policies and the opportunity to express support for the permanent repeal or suspension of the Health Insurance Tax (HIT).

CVS Health is a healthcare innovation company helping people on their path to better health. Whether in one of our pharmacies or through our health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally-focused, engaging consumers with the care they need, when and where they it.

CVS Health urges the Taskforce to permanently repeal the HIT, or at least suspend it, as it is one of the most direct ways for Congress to provide financial relief to patients, especially seniors, at a time when many struggle to afford healthcare costs. If the HIT is reinstated in 2020, the health insurance premiums of 142 million Americans in small group, large group, Medicare Advantage (MA), and Medicaid plans would increase by a total of $20 billion. In 2020 alone, the HIT will cost fully-insured small businesses and employees over an extra $450 per year, the 22 million seniors in MA will see their premiums or cost-sharing rise by nearly $500 per couple, and State Medicaid programs will incur more than $150 in additional annual costs for every enrollee.[1] We appreciate that Congress suspended the collection of the HIT for 2019 and support S. 172, which delays the HIT through 2021, and S. 80, which permanently repeals the HIT.

CVS Health also urges the Taskforce to consider changes to improve high deductible health plans and health savings accounts (HSAs). We strongly support the Chronic Disease Management Act (S. 2410, 115th Congress), legislation led by Senator John Thune and Senator Tom Carper. This important legislation would give high deductible plans paired with HSAs the

[1] Oliver Wyman. Analysis of the Impacts of the ACA's Tax on Health Insurance in Year 2020 And Later. August 28, 2018.

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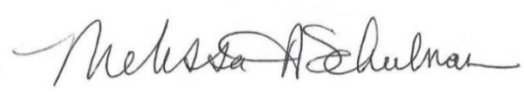
ability to offer first dollar coverage for chronic disease management. Currently, HSA rules allow employers to cover prescription drugs at little or no cost under a preventative drug list – this coverage is allowed outside the patient's deductible. However, once the patient actually gets sick, the patient has to start paying for drugs as part of the deductible in their high deductible plan. If the Chronic Disease Management Act became law, it could immediately help patients in these plans afford their treatments, or get them at no cost. This would have a significant impact on health care costs and on patient outcomes.

CVS Health appreciates the opportunity to work with the Taskforce on the shared objective of providing long-term certainty by repealing or suspending the HIT to ease burdens on consumers. We are happy to answer any questions or provide more information, and look forward to continuing to work with the Taskforce on this important issue.

Sincerely,



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ATR Urges Action on Healthcare Taxes

June 24, 2019

Dear Chairman Grassley, Ranking Member Wyden, and Members of the Senate Finance Committee Healthcare Tax Task Force:

I write to urge Congressional action on healthcare taxes. Lawmakers must act soon to repeal or delay the imposition of a number of taxes that will go into effect in 2020 including the Obamacare health insurance tax and medical device tax. Congress should also extend the 7.5 percent threshold to qualify for the medical expense deduction, extend the tax credit for paid family and medical leave, and repeal the Cadillac tax on employer provided care.

Health Insurance Tax

The Obamacare health insurance tax (HIT) is a tax on insurance premiums that is passed onto the middle class, seniors, and small businesses in the form of higher healthcare costs. **Congress should repeal the health insurance tax.**

The HIT is designed to pass the costs onto the middle class, seniors, and the poor. The HIT is estimated to **negatively impact** the 11 million households that purchase through the individual insurance market and 23 million households covered through their jobs. In 2020 alone, the HIT is projected to add an **estimated $16 billion** to the cost of coverage for families and Medicare Advantage seniors.

If lawmakers fail to act, the HIT **will increase** premiums by 2.2 percent per year and by almost $6,000 over the next decade for a typical family of four with small or large group insurance. This tax is also highly regressive – half of the HIT is **paid** by those earning less than $50,000 a year.

The HIT is also bad for small businesses. Because the tax only applies to fully-insured plans, large corporations and unions (which are universally self-insured) emerge unscathed. According to the American Action Forum, the tax will **directly impact** 1.7 million small businesses. One estimate, conducted by the National Federation for Independent Businesses, **estimates** the tax could cost up to between 146,000 and 262,000 jobs over a decade.

Medical Device Tax

Obamacare imposed a 2.3 percent excise tax on the sale of medical devices by manufacturers and small businesses. This tax covers common hospital equipment like X-Ray machines, MRI machines, and hospital beds. **Congress should fully repeal the medical device tax.**

The medical device tax was in effect from 2013 and 2015 but Congress has suspended the tax since 2016. When it was in effect, research indicates that the tax reduced research and development by $34 million in 2013 and disproportionately harmed companies with lower profit margins. This resulted in a loss of approximately 28,000 jobs.

Medical Expense Deduction

Since 1942, taxpayers with high medical bills have been able to deduct those expenses exceeding a certain percentage of their adjusted gross income (AGI). The medical expense deduction is very popular with the middle class.

Before Obamacare, families facing high medical bills could deduct expenses that exceeded 7.5 percent of their AGI. According to the IRS, approximately 10 million families took advantage of this deduction each year before Obamacare was signed into law. In 2010, the average taxpayer claiming the deduction earned just over $53,000 annually.

Obamacare increased the threshold to claim the medical expense deduction to 10 percent of AGI. This tax hike not only made it more difficult for the middle class to claim this deduction, it widened the net of taxable income. ATR estimated that the tax hike cost families an additional $200-$400 per year.

The Tax Cuts and Jobs Act restored the pre-Obamacare 7.5 percent standard for fiscal years 2017 and 2018. the 10 percent threshold is back in effect effective January 1, 2019. **Congress should make the 7.5 percent threshold permanent.**

Cadillac Tax

The Cadillac tax, a 40 percent excise tax on employer-provided health insurance plans, is scheduled to go into effect in 2022. on plans exceeding $10,200 for individuals and $27,500 for families.

If Congress fails to act, the Cadillac Tax will decrease care and increase costs for millions of American families across the country. It will impact virtually all employer-provided healthcare plans either through direct taxation or by causing employers to increase deductibles and co-pays in an effort to avoid hitting the thresholds.

The Cadillac Tax is also broadly unpopular with the American people – a 2018 poll found that 81 percent of voters oppose taxes on employer-provided healthcare coverage. **Congress should repeal the Cadillac Tax.**

Paid Family and Medical Leave Tax Credit

The Republican-passed Tax Cuts and Jobs Act (TCJA) implemented a paid family and medical leave tax credit for employers for two years (tax years 2018 and 2019). The credit is a good first step toward promoting family and medical leave without creating a new entitlement. **Congress should extend the paid family and medical leave tax credit.**

The credit is a sliding scale contingent upon the percentages of wage the employer pays the employee. If employers pay 50 percent of their employee's wages through the leave, the tax credit is 12.5 percent of the paid wage. The value of the credit increases as the percentage of wages paid increases. If employers pay 100 percent of their employee's wages throughout the leave, the credit is 25 percent. The credit cannot be claimed if the paid leave is less than 50 percent of the employee's wages.

Conclusion

As lawmakers consider reforms to lower healthcare costs and increase access to care, they should be sure to keep in mind the need to repeal damaging healthcare taxes and preserve credits and deductions that improve healthcare flexibility.

Thank you for your consideration. If you have any questions, please feel free to contact me or ATR's Director of Tax Policy Alex Hendrie at 202-785-0266.

Onward,

Grover G. Norquist
President, Americans for Tax Reform

UNITEDHEALTH GROUP®

Daniel J. Schumacher
President & Chief Operating Officer
UnitedHealthcare
9700 Health Care Lane, MN017-E010
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June 21, 2019

The Honorable Pat Toomey
Co-Lead
Health Tax Taskforce
U.S. Senate
248 Russell Senate Office Building
Washington, DC 20510

The Honorable Bob Casey
Co-Lead
Health Tax Taskforce
U.S. Senate
393 Russell Senate Office Building
Washington, DC 20510

The Honorable Mike Enzi
Health Tax Taskforce
U.S. Senate
379A Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
Health Tax Taskforce
U.S. Senate
703 Hart Senate Office Building
Washington, DC 20510

Dear Senators Toomey, Casey, Enzi and Warner:

UnitedHealth Group (UHG) appreciates the opportunity to provide comments on a key tax provision under the scope of the Senate Finance Committee's Health Tax Taskforce, which expires December 31, 2019. Specifically, our comments focus on an extension of the temporary moratorium of the tax on health insurance, commonly referred to as the "Health Insurance Tax," which expires after the 2019 calendar year. **Continuing to extend the moratorium on the Health Insurance Tax for 2020 and beyond would be an immediate step Congress could take now to protect nearly half of all Americans from higher health care costs.**

UHG is a mission-driven organization dedicated to helping people live healthier lives and making our nation's health care system work better for everyone through two distinct business platforms – UnitedHealthcare, our health benefits business, and Optum, our health services business. Our workforce of 310,000 people, including 85,000 clinical professionals, serves the health care needs of 142 million people worldwide, funding and arranging health care on behalf of individuals, employers, and the government. As America's most diversified health care company, we not only serve as one of the nation's most progressive health care delivery organizations, we also serve people within many of the country's most respected employers, in Medicare – serving nearly one in five seniors nationwide – and in one of the largest group of Medicaid health plans, supporting underserved communities in 31 States and the District of Columbia.

Health care affordability continues to be a priority for families, employers and taxpayers across the nation. As the nation's most diversified health care company, we focus everyday on providing our customers with affordable coverage, improving health outcomes and delivering

value for the health care system. UHG is deeply committed to addressing the affordability challenges by advancing care effectiveness, through primary care-led, integrated delivery approaches and innovative payment models; shifting utilization away from costly sites of care and unnecessary and unproven therapies in health care services; expanding coverage options for consumers, resulting in lower-cost alternatives; and leveraging proven pharmacy management tools.

As you consider health-related tax measures, we encourage the Taskforce to include an extension for the moratorium of the Health Insurance Tax for 2020 and beyond as part of its policy recommendations. Absent Congressional action, this harmful Tax will significantly increase the cost of health care and negatively impact employers who provide health benefits to their employees, consumers in the individual market and Government-sponsored programs, including Medicare Advantage, Medicare Part D and Medicaid.

According to an Oliver Wyman analysis, reinstatement of the Health Insurance Tax in 2020 would result in a premium increase of $479 for families with small group coverage and $458 for families with fully insured large group coverage.[1] **Additionally, consumers in the individual market would see premiums increase by $196 and State Medicaid programs are expected to have a premium increase of $157 for each of the 27.7 million insured Medicaid enrollees.**[2]

Congress previously passed bipartisan legislation to suspend the Health Insurance Tax for 2017 and 2019, which was signed into law, respectively by both Presidents Obama and Trump. A moratorium on the Health Insurance Tax was enacted because of a widespread recognition that the Tax increases health care costs for consumers, employers, and Medicare beneficiaries, and raises the costs of State Medicaid programs. **Additionally, an analysis released earlier this year concluded that if Congress had not suspended the Health Insurance Tax for 2019, seniors enrolled in Medicare Advantage could have seen overall annual premiums rise by 55.7 percent.**[3] **This would result in $241 in higher premiums for nearly 22 million seniors in Medicare Advantage plans.**[4]

UHG is committed to supporting policies that lower health care costs for consumers and strongly supports the bipartisan and bicameral legislation that has been introduced in the 116th Congress to delay and permanently repeal the Health Insurance Tax. In the Senate, Senators Cory Gardner (R-CO) and Jeanne Shaheen (D-NH) introduced bipartisan legislation to delay the Health Insurance Tax for two years (S. 172, the "Health Insurance Tax Relief Act of 2019"). The bipartisan legislation is currently supported by over one-quarter of the Senate with 26 bipartisan co-sponsors. A companion bill has been introduced in the U.S. House of Representatives (H.R. 1398), which has garnered 100 bipartisan co-sponsors to date.

Additionally, Senators John Barrasso (R-WY), Gardner and Kyrsten Sinema (D-AZ) introduced bipartisan legislation to repeal the Health Insurance Tax (S. 80, the "Jobs and Premium

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[1] Analysis of the Impacts of the ACA's Tax on Health Insurance in Year 2020 and Later, Oliver Wyman (August 28, 2018), available at https://health.oliverwyman.com/content/dam/oliver-wyman/blog/hls/featured-images/August18/Insurer-Fees-Report-2018.pdf, pg. 3

[2] *Ibid.*

[3] Addendum: 2019 Medicare Advantage Premiums and the 2019 Moratorium on the ACA Health Insurance Tax, Oliver Wyman (January 19, 2019), available at https://www.oliverwyman.com/content/dam/oliver-wyman/blog/hls/featured-images/2019/jan/MA-Addendum-to-HIT-Analysis-FINAL.pdf, pg. 1

[4] Analysis of the Impacts of the ACA's Tax on Health Insurance in Year 2020 and Later, Oliver Wyman (August 28, 2018), available at https://health.oliverwyman.com/content/dam/oliver-wyman/blog/hls/featured-images/August18/Insurer-Fees-Report-2018.pdf, pg. 3

Protection Act"), which Senators Marsha Blackburn (R-TN), Kevin Cramer (R-ND), Martha McSally (R-AZ), and Rob Portman (R-OH) are supporting as co-sponsors. Companion legislation has also been introduced in the U.S. House of Representatives (H.R. 2447).

Delaying the Health Insurance Tax by extending the moratorium on the Tax for 2020 and beyond would be an immediate step Congress could take now to protect nearly half of all Americans from higher health care costs.

We urge you to recommend extending the bipartisan moratorium of the Health Insurance Tax for 2020 and beyond as part of work of the Taskforce, and stand ready to serve as a resource to you and your colleagues as you consider health tax policy. We welcome the opportunity to discuss our comments with you.

Sincerely,

Dan Schumacher
President & Chief Operating Officer
UnitedHealthcare

Cc: The Honorable Chuck Grassley
The Honorable Ron Wyden

United Spinal Association
www.unitedspinal.org

May 20, 2019

The Honorable Chuck Grassley
Chairman
Senate Committee on Finance
135 Hart Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Richard Neal
Chairman
House Committee on Ways & Means
2309 Rayburn House Office Building
Washington, DC 20515

The Honorable Kevin Brady
Ranking Member
House Committee on Ways & Means
1011 Longworth House Office Building
Washington, DC 20515

Dear Chairman Grassley, Ranking Member Wyden, Chairman Neal and Ranking Member Brady:

On behalf of United Spinal Association, we write to voice our support for S.692/H.R. 2207 the Protect Medical Innovation Act of 2019 introduced by Senator Pat Toomey (R-PA) and Representatives Ron Kind (D-WI), Jackie Walorski (R-IN), Scott Peters (D-CA), and Richard Hudson (R-NC). The bill eliminates a tax of 2.3 % on medical devices. This helps spur innovation and increases access to medical devices upon which our membership and community rely.

United Spinal Association is the largest non-profit organization, founded by paralyzed veterans, dedicated to enhancing the quality of life of all people living with spinal cord injuries and disorders (SCI/D), including veterans, and providing support and information to loved ones, care providers and professionals. United Spinal has over 70 years of experience educating and empowering almost 2.5 million individuals with SCI/D to achieve and maintain the highest levels of independence, health and personal fulfillment. United Spinal has over 50,000 members, 54 chapters, close to 200 support groups and more than 100 rehabilitation facilities and hospital partners nationwide including 10 distinguished Spinal Cord Injury Model System Centers that support innovative projects and research in the field of SCI. United Spinal Association is also a VA-accredited veterans service organization (VSO) serving veterans with disabilities of all kinds.

A tax on medical devices has a negative impact on consumer access to critical equipment and treatment and impedes medical innovation. A permanent repeal of the device tax will provide medical technology innovators with the long-term certainty necessary to support advancements in research and development that will lead to innovative therapy and intervention.

Our members rely on technological innovations and advancements in healthcare to improve their lives and independency. With an aging population, people with disabilities living longer and chronic disease rates growing, now is the time for more resources to advance innovative therapies and device development to help people live healthier, longer, more independent lives. United Spinal Association opposes the medical device tax and we urge for robust cosponsorship and swift passage of S.692/H.R. 2207 the Protect Medical Innovation Act of 2019. If you have any questions, please do not hesitate to contact me at the number below or at abennewith@unitedspinal.org.

Sincerely,

Alexandra Bennewith, MPA
Vice President, Government Relationss & Means

June 24, 2019

Senator Pat Toomey
U.S. Senate
Washington, DC 20510

Senator Bob Casey, Jr.
U.S. Senate
Washington, DC 20510

Dear Senator Toomey and Senator Casey,

Thank you for the opportunity to submit comments and recommendations to the Task Force in response to the Finance Committee's efforts to develop long-term solutions to temporary tax policies. On behalf of the medical device members of BioOhio, we appreciate your interest in hearing from stakeholders on such an important issue.

BioOhio represents over 300 members that employ over 100,000 Ohioans – from Ohio's largest employers to emerging start-ups, schools & universities, research institutions, students, and individuals. BioOhio is the lead organization for the bioscience community and the Ohio affiliate for global bioscience associations AdvaMed, BIO, MDMA and PhRMA.

Medical device manufacturers in Ohio are committed to bringing breakthrough innovations to patients, but that commitment is threatened by a number of regulations and policies that have increased costs, lengthened timelines, and deterred companies from investing in the next generation of treatments and cures.

Chief among these policies is the 2.3% excise tax on the sale of certain medical technology that was enacted as part of the Affordable Care Act (ACA). Since its enactment, the medical device tax has been a significant drag on medical innovation and resulted in the loss or deferred creation of jobs, reduced R&D, and slowed capital expansion. What is even more troubling is that this tax was imposed without any real policy justification. The medical device tax is not grounded in any health care policy. It is not connected to individual insurance coverage. It was designed purely as a means of raising revenue from the industry to offset the budgetary impact of the ACA.

Medical devices have revolutionized health care. To cite one example, medical technology has helped add more than five years to U.S. life expectancy since 1980. Advances in treatment mean patients experience less-invasive procedures, shorter hospitalizations, reduced recovery times, and lower overall costs. New technologies diagnose illnesses earlier, lowering the impact of care on a person's daily life. Breakthrough concepts reduce the overall cost of health care for patients and the system. All these gains are at risk if the medical device tax is reinstated.

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The effects of the tax are felt across the industry, as every dollar of revenue (not income or profit) earned by a company is generally subject to the tax. For large, established companies, the device tax equals tens, if not hundreds, of millions of dollars that could be used to expand research and create jobs. For start-up firms, the effect of the tax is two-fold – it deters company growth, since the tax is imposed on the first dollar of revenue earned; and it restricts the ability of established medical technology companies to invest in or acquire start-up companies by limiting the amount of available funds.

Large bipartisan majorities in Congress agree that the medical device tax is bad policy. Thanks in no small part to your leadership and the efforts of the Committee on Finance, Congress has suspended the tax twice for a total of four years. Notably, by the end of this year, Congress will have suspended the tax for longer than it was in effect, with no measurable impact on coverage. Clearly, repeal of the device tax will not have a significant impact on the overall finances of the ACA, despite prior concerns.

Medical technology has improved efficiencies and produced savings to the system through minimally invasive procedures, more precise and accurate diagnostics, and devices that reduce hospitalizations or length of stay. These improvements mean better outcomes and higher-quality care for patients, which lowers cost. Taxing the development and manufacture of medical technology imposes an unnecessary penalty on these savings and erodes the value these technologies provide to the system in the long run.

The current suspension expires on December 31, 2019. Individual companies are already making important planning decisions for the next fiscal year, including how to allocate resources toward research and development as well as employment tied to research and development. As an excise tax, the device tax cannot be addressed retroactively in an effective manner. The longer Congress waits to act, the bigger the impact on the industry's ability to develop the next life-saving, life-enhancing technology.

We strongly encourage the Task Force to recommend full repeal of the medical device excise tax and urge the Committee to move promptly to consider legislation that includes repeal. We stand ready to work with you to advance any legislative vehicle that will address the medical device tax. Permanently repealing the device tax will provide medical technology innovators with the long-term certainty necessary to support future job growth and sustainable, cutting-edge R&D that will ultimately lead to the next generation of breakthroughs in patient care and treatment. With any other policy outcome, effective planning for a sustainable future becomes much more difficult.

Thank you again for this opportunity to share our thoughts on behalf of our medical technology companies. We look forward to working with you and your staff on a solution that will allow our members to retain their position as world leaders in developing and manufacturing technology that will improve the lives of patients in the United States.

Sincerely

John F. Lewis, Jr.
President & CEO, BioOhio

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ERIC
The ERISA Industry Committee
Driven By and For Large Employers
701 8th Street NW, Suite 610, Washington, DC 20001 • (202) 789-1400 • www.eric.org
James Gelfand, Senior Vice President of Health Policy

June 25, 2019

The Honorable Pat Toomey
Health Tax Taskforce
U.S. Senate Committee on Finance

The Honorable Bob Casey
Health Tax Taskforce
U.S. Senate Committee on Finance

Dear Senators Toomey and Casey,

On behalf of The ERISA Industry Committee (ERIC), thank you for taking the lead on finding long-term solutions to challenges in the health tax space. ERIC is the only national association that advocates exclusively for large employers on health, retirement, and compensation policies at the federal, state, and local levels. As you know, more than 181 million Americans receive health insurance through an employer-sponsored plan. It is critical that changes be made to the tax code to enable employers to continue offering affordable, comprehensive coverage – and to allow for innovation in plan design to reduce patients' costs and improve care. Specifically, we request the Taskforce to address the following:

(1) **Eliminate the "Cadillac" excise tax on high-cost employer-sponsored health insurance**. While the Taskforce is focused on other tax provisions in the Affordable Care Act, it is important to note that the Cadillac tax is affecting millions of Americans today, increasing health insurance premiums, deductibles, copays, and coinsurance. This tax must be addressed by Congress years in advance of its implementation date, due to contracting and plan design decisions that employers must make years in advance of a plan year. We urge the Taskforce to include S. 684, the *Middle Class Health Benefits Tax Repeal Act of 2019*, to permanently eliminate this regressive, counterproductive tax.

(2) **Allow HSA-qualified health plans to better meet patients' needs**. The rules established in the tax code governing high-deductible health plans were designed more than 15 years ago, and as a result, have not kept pace with benefit design evolution and innovation. A number of changes are needed to ensure that patients, especially those with chronic conditions, can get the care they need, at affordable prices, without jeopardizing their ability to contribute to a Health Savings Account (HSA). The most important change is to allow plans to offer 1st-dollar coverage of chronic condition management (S. 1948, the *Chronic Disease Management Act*). However, the Taskforce should also consider a number of other changes that would benefit patients, including allowing the coordination of high-deductible health plans with direct primary care arrangements, allowing 1st-dollar coverage of telemedicine and onsite/retail health clinics, fixing glitches associated with adult children and spousal FSA interactions, and more.

ERIC appreciates the opportunity to comment on the Taskforce's agenda, and looks forward to working with you on these and other improvements to the tax code. If you have questions concerning our comments, or if we can be of further assistance, please contact us at (202) 789-1400.

Sincerely,

James P. Gelfand

James Gelfand
Senior Vice President, Health Policy

Reauthorization of the Health Coverage Tax Credit Program (HCTC) is URGENT!
This Program Impacts Trade Adjustment Assistance Workers (TAA) and PBGC Recipients Between the Ages of 55-65 Expiring December 31, 2019

- Reauthorization – CANNOT WAIT UNTIL THE END OF 2019 TO BE REAUTHORIZED, INSURERS WILL NOT PROVIDE INSURANCE QUOTES FOR THIS PROGRAM AT THAT LATE DATE!—Unless it is reauthorized prior to Open Enrollment for 2020 beginning in September and October of 2019 for 2020 Insurance Programs. Insurance providers require the ability to determine eligibility, rates and plans designs as soon as possible, in order to provide HCTC Qualified Plans the ability to select providers and assist in enrolling TAA and PBGC Eligible participants in a timely manner for their 2020 Insurance programs. Please Act Today!

· Eliminate 24 Month Provision for Spouse To Participate in HCTC - after primary participant becomes Medicare eligible (Section 35 (g)(10)(a)), experience indicates it leaves a huge gap for many of the spouses to bridge to Medicare, and continue to be able to afford healthcare on their limited incomes. This usually finds the spouse and any dependents still living at home, without the ability to afford healthcare and often, finds the PBGC recipient is no longer able to work. Elimination of 24-month time limit for HCTC "Spousal Coverage" would be a tremendous help in allowing the spouse and eligible dependents the ability to continue to afford healthcare as the spouse bridges to Medicare. The disparity in age between the PBGC Recipient and Spouse is due in large part to the high number of PBGC Recipients being classified as "Medicare Eligible" at a much earlier age than 65, in many cases, due to the industries they worked in such as the Steel and Auto Industries.

· Expand Access – Allow the IRS to RELAX 501 (c) 9 VEBA rule that today limits access to "HCTC QUALIFIED VEBA'S" in the same "Class and Craft" ONLY– when Deemed an "HCTC Qualified VEBA'S". By allowing "HCTC Qualified VEBA's" to permit both TAA and PBGC participants eligible for the HCTC program the ability to enroll in any available "HCTC Qualified VEBA", regardless of the "Class and Craft", provided the VEBA is an "HCTC Qualified VEBA" and the Board of the "HCTC Qualified VEBA" permits access to different "Classes and Crafts" of any HCTC eligible participants, both TAA and PBGC recipients. Unfortunately, today, the HCTC program severely limits access to many otherwise HCTC eligible participants and their families due to the lack of availability of "HCTC Qualified VEBA'S" in their industries or locations, following the elimination of the "State Qualified Plans", otherwise known as "High Risk Pools" in January 2014. These High Risk Pools were in more than 46 states and allowed both TAA and HCTC eligible plan participants to enroll and pay only the 27.5% subsidy on a monthly basis, instead of today, having to pay 100% of the cost of the premium and receiving the 72.5% subsidy on their income tax the following year. This is an untenable cost for most TAA and HCTC Plan participants.

· The Effort to Provide Access through the "Individual Market" has not provided the needed access to TAA and HCTC Eligible Participants- the introduction of the availability of the "Individual Market" plans was initiated in order to address the lack of access following the termination of the "State Qualified Plans" when the Affordable Care Act began in 2014, and has not proven successful, to date. The program lacks the ability to offer the needed Enrollment Support, Call Centers, and Billing required to make the Individual Market a realistic option for TAA and PBGC recipients across the country, requiring the plan participant to basically fin for themselves when trying to enroll on the individual market. Unlike eligible participants enrolled in the established "HCTC Qualified VEBA'S" offering those support tools available and accessible, to anyone enrolling in their "HCTC Qualified VEBA'S" today, and work closely with the IRS routinely, to manage the enrollment process and hand off to the HCTC Qualified VEBA Call Center that will continue to provide support for the insurance programs throughout the eligibility period of the HCTC eligible participant and their families.

· PLEASE CONSIDER THIS REQUEST TO REAUTHORIZE THE HCTC PROGRAM IMMEDIATELY! This program today provides a vital lifeline to thousands that have been impacted by having their jobs offshored, as well as those that have had their pensions reduced or eliminated, and their healthcare terminated, through no fault of their own, and in most cases, by companies that have filed for bankruptcy and caused these people hardships living with reduced pensions and eliminating their healthcare benefits that were in many cases, unfunded promises to their workers and their families. Thanks very much for your consideration of this request on behalf of HCTC eligible participants and their families across the country that we hear from every day, asking for help in enrolling in these plans as well as asking what they can do to make sure that the leaders in Washington DC know how important this program is to them and their families!

Best regards,
[redacted]
[redacted]

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June 26, 2019

The Honorable Patrick Toomey
Co-Lead, Health Taskforce
Senate Finance Committee
United States Senate

The Honorable Robert Casey, Jr.
Co-Lead, Health Taskforce
Senate Finance Committee
United States Senate

The Honorable Michael Enzi
Health Taskforce
Senate Finance Committee
United States Senate

The Honorable Mark Warner
Health Taskforce
Senate Finance Committee
United States Senate

Dear Sens. Toomey, Casey, Enzi and Warner

The Senate Finance Committee bipartisan Taskforce on Health is charged with finding solutions to provide long-term certainty to temporary tax provisions related to health. Farm Bureau encourages your taskforce to recommend repeal of the Health Insurance Tax (HIT tax).

The HIT tax increases health insurance costs for farmers, ranchers and other small businesses by imposing a levy on health insurance companies that is passed along to consumers. While the 2019 moratorium is temporarily buffering health insurance costs for one year, the HIT tax will again drive up premiums in 2020.

Rural residents already encounter barriers that limit their access to the health care they need. Allowing the HIT Tax to make healthcare insurance more expensive will make it even more difficult for farmers and ranchers to purchase coverage for themselves, their families and their employees.

Farm Bureau urges prompt action to eliminate the HIT tax. Until the HIT tax can be repealed, we recommend a suspension of HIT tax collections including for 2020 and 2021.

Sincerely

Zippy Duvall
President

AFL-CIO

LEGISLATIVE ALERT

June 28, 2019

The Honorable Patrick Toomey
Co-Lead, Health Tax Taskforce
United States Senate Committee on Finance
Washington, DC 20510

The Honorable Bob Casey
Co-Lead, Health Tax Taskforce
United States Senate Committee on Finance
Washington, DC 20510

Dear Senators Toomey and Casey:

We write to urge that a five-year extension of the Health Coverage Tax Credit (HCTC) be included in the tax extenders package that the Finance Committee is drafting.

Congress established the HCTC program as part of the Trade Act of 2002 as a means of ameliorating the impact of job losses resulting from the adoption of free trade agreements. For many workers, the loss of a job due to changes in trade policy also means a loss of comprehensive health insurance.

About 13,000 workers receive HCTC payments, which cover 72.5 percent of their health insurance premiums. These workers are eligible for this assistance either because they receive Trade Adjustment Assistance benefits due to trade-related job or wage loss or because their pension fund has been taken over by the Pension Benefit Guaranty Corporation due to inadequate funding.

It is essential that Congress provide stable funding for this program to ensure that HCTC beneficiaries are not exposed to additional financial strain. Congress must not run away from its responsibility to help those negatively impacted by U.S. trade policy.

Sincerely,

William Samuel
Director, Government Affairs

CC Sen. Pat Roberts, Co-Lead Individual, Excise & Other Expiring Policies Taskforce
Sen. Robert Menendez, Co-Lead Individual, Excise & Other Expiring Policies Taskforce

Main Street Alliance
Comments for Health Tax Task Force
United States Senate

June 28, 2019

Thank you to Co-Chairs Toomey and Casey for the opportunity to provide input on the paid leave tax credit in the Tax Cuts and Jobs Act (TCJA) of 2017. The Main Street Alliance is a national network of 30,000 small business owners working to build a new voice for small businesses on important public policy issues. Alliance small business owners share a vision of public policies that work for business owners, our employees, and the communities we serve.

Comprehensive paid family and medical leave social insurance programs, which spread costs and reduce administration, are the most small-business friendly solution when it comes to leave. This approach helps small businesses retain talent and maintain safe, efficient workplaces with focused employees, supporting the bottom line. Small businesses want a paid leave program and need Congress to take action to make paid leave a reality for our country's 30 million small businesses, our 59 million employees, and the communities they serve from coast to coast.[1] Main Street Alliance supports The Family And Medical Insurance Leave (FAMILY) Act (H. 1185/S. 463), a paid family and medical leave program that works for Main Street.

From a small business perspective, well-structured, comprehensive paid leave programs like the FAMILY Act make leave more affordable and simpler. They spread the cost of leave, reducing the burden on individual employers without creating significant new administrative requirements. When an employee or small business owner needs to take time away from work, they draw income from the fund to get by until they're back on their feet. Small business owners can then use the salary of an on-leave employees as they see fit: to increase hours of current employees, hire a temporary replacement, invest in their businesses, or save it for another use.

Most importantly, workers with paid leave are more likely to return to their jobs. Paid leave then contributes to reduced turnover, which is associated with higher productivity increases and significant

[1] U.S. Small Business Administration. (2018). *2018 Small Business Profile.* Retrieved 1 May 2019, from https://www.sba.gov/sites/default/files/advocacy/2018-Small-Business-Profiles-US.pdf

cost savings for small businesses.[2] In California, where a family leave insurance program has existed for more than a decade, most employers report positive or neutral effects of the program on productivity (89 percent), profitability/performance (91 percent), turnover (96 percent), and employee morale (99 percent), with small businesses reporting even more positive outcomes than large businesses (those with more than 100 employees).[3] Likewise, several New Jersey employers noted that the state's paid leave program helped reduce stress and improve morale among employees who took leave and their co-workers.[4]

Additionally, evaluations of existing state paid family medical leave programs demonstrate that they do not increase costs for small businesses, and are feasible to implement. A survey of California employers revealed that 87 percent confirmed that the state program had not resulted in any increased costs, and 60 percent reported coordinating their benefits with the state's paid family leave insurance system, likely resulting in ongoing cost savings.[5]

A federal paid family and medical leave insurance program is supported by 70 percent of small businesses, by one recent survey.[6] In a Main Street Alliance survey of more than 1,700 small businesses, 78 percent of women business owners and business owners of color supported such a program. Additionally, 76 percent of overall respondents view the funding of such a program as a shared responsibility and support a joint employer and employee contribution model.[7]

In that survey, 79 percent of respondents overall said a social insurance program would help them the most to offer paid leave to their employees while only eight percent said a tax credit would be helpful.

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[2] Glynn, S. J., & Boushey, H. (2012, November 16). *There Are Significant Business Costs to Replacing Employees*. Center for American Progress Publication. Retrieved 1 May 2019, from https://www.americanprogress.org/wp-content/uploads/2012/11/CostofTurnover.pdf

[3] Applebaum, E., & Milkman, R. (2011). *Leaves that Pay* (p. 8). Center for Economic and Policy Research, et al. Publication. Retrieved 1 May 2019, from http://cepr.net/documents/publications/paid-family-leave-1-2011.pdf

[4] Lerner, S., & Applebaum, E. (2014, June). *Business As Usual: New Jersey Employers' Experiences with Family Leave Insurance* (p. 16). Center for Economic and Policy Research Publication. Retrieved 1 May 2019, from http://cepr.net/documents/nj-fli-2014-06.pdf

[5] Applebaum, E., & Milkman, R. (2011). *Leaves that Pay* (p. 10). Center for Economic Research and Policy, et al. Publication. Retrieved 1 May 2019, from http://cepr.net/documents/publications/paid-family-leave-1-2011.pdf

[6] Small Business Majority. (30, March 2017). *Opinion Poll Small Businesses Support Paid Family Leave Programs* (p. 5). Retrieved 1 May 2019, from www.smallbusinessmajority.org/our-research/workforce/small-businesses-support-paid-family-leave-programs

[7] Main Street Alliance. (2018). *The View From Main Street 2018 Paid Family and Medical Report* (p. 4 and 5). Retrieved 1 May 2019, from https://bit.ly/2tCUdFk

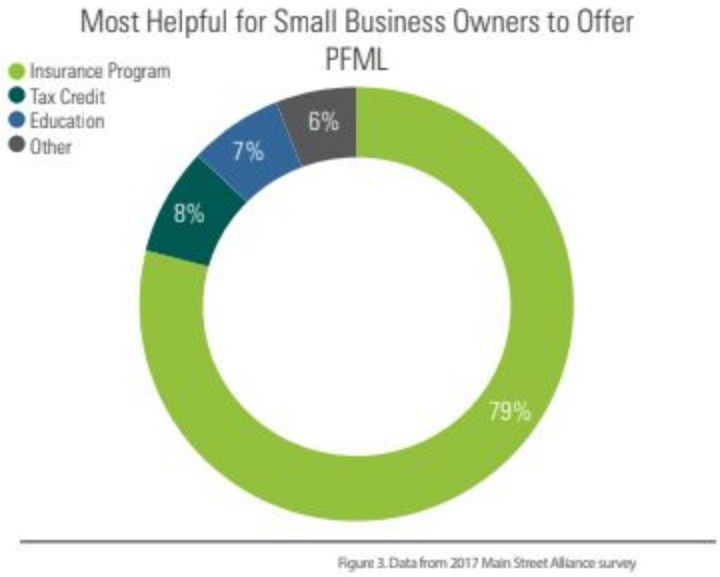

Figure 3. Data from 2017 Main Street Alliance survey

Small businesses can often find tax credits challenging to successfully access for several reasons. With small profit margins, small businesses often lack the up-front capital to make use of tax credits. Understanding and using the programs often require expenditures on accountant services that significantly cut into the benefits. Additionally, without dedicated financial staff, small businesses often do not find about these programs at all.

The TCJA included a provision that offers small tax credits to employers who voluntarily offer paid family and medical leave to certain employees. Under this tax provision, employers can receive a scaled tax credit of between 12.5 and 25 percent of the wages paid to an employee on leave, which means employers could shoulder as much as 87.5 percent of the cost of an employee's paid leave. Employers would only receive credits for wages paid to employees with compensation in the prior year that was at or below 60 percent of the compensation threshold for "highly compensated employees" under the Internal Revenue Code. In 2017, that means employers only receive a credit for the paid leave they provide to employees paid $72,000 or less.

While we appreciate the intent of the TCJA to provide support to business to expand access to Paid Leave, this tax incentive is problematic for small business for each of the reasons we discussed above.

For comparison, if an employee making $60,000 annually took 12 weeks of paid leave at 66 percent of their wages, the upfront cost to an employer receiving tax credits under the TCJA would still be $7,631. Under the FAMILY Act, a social insurance fund, the annual cost to the employer for this same employee would only be $120.

Small firms generally lack the capital and the scale to provide paid family and medical leave even when

business owners want to provide those benefits. The lack of a national paid family and medical leave program hands the advantage to large corporations that can use their size and market power to offer such benefits to top managers but squeeze everyone else with low-wage, uncertain jobs. With modest bottom lines, small businesses often have trouble offering any paid leave, let alone matching more generous paid leave benefits offered by larger employers, resulting in a hiring disadvantage.

Any approach that requires businesses to individually fund the full up-front costs of paid leave would unfairly punish small businesses by requiring large upfront and unpredictable expenditures. The tax credits would likely go to larger businesses that can already offer paid leave and continue to leave small businesses at a competitive disadvantage and the most vulnerable without access to paid leave.

Alternatively, under the FAMILY Act, employers would make small, predictable contributions to a fund to ensure their employees have access to paid family and medical leave. Employees would also contribute a small, predictable portion of their pay to the fund. This model works well in a growing number of states.

Real small businesses want and need Congress to take action. We recognize that this problem can be solved only through good public policy and a well-crafted national social insurance program, not through tax credits that put more up-front burden on small businesses. Any national paid family and medical leave proposal must provide a financially viable way for even the smallest business to offer this leave. Small businesses are eager to contribute to such a program and make it a success. This is a problem we can solve together.

To Whom it may concern,

I am asking you to reinstate the HCTC. This insurance has been a god send for us. My wife had CLL with 17P deletion for 12 years. She passed away in March god rest her soul. If not for HCTC she would not have been able to cross state lines and get proper medical attention. I would not have had the pleasure of her wonderful company for the last 5 years! That is the TRUTH.

On a working standpoint, i was a flight attendant for Usairways for 23 years and loved my occupation. When they closed the Pittsburgh base down it was an easy decision to retire with my with ill. The bad part was the company took half of my pension. So to me HCTC is part of my pension. Please don't take it from me.

Sincerely,

[redacted]

Senators Patrick Toomey and Robert Casey, Jr.,

As you know, every few years Congress engages in a ritual extension of expiring tax provisions. The bills extend targeted temporary tax provisions for a variety of business operations, individual expenses, and industries. There is broad bipartisan support for letting all the tax extenders expire.

Almost every extender currently being considered grants an economic privilege tailored to some particular group or business interest. By picking winners and losers, these corrupt policies distort efficient market outcomes. They thereby hamper economic growth and reduce opportunity for individuals and businesses whom Congress did not shower with special favors.

Specifically, in the category of the health taskforce on temporary tax policy, I believe the tax credit for paid family and medical leave should not be extended.

The TCJA created a new tax credit program for paid family and medical leave. It should be allowed to expire, as it does in current law, in 2020. The employer credit for paid family and medical leave allows a tax credit of up to 25 percent of wages paid to employees on qualifying leave making under $72,000 a year.

The temporary credit is not likely to induce new employers to offer qualifying paid-leave programs. Instead, the benefit accrues to business owners who already offer such programs as a federally subsidized windfall profit. The narrowly tailored credit rules are also likely to derail the impressive expansions of privately provided leave programs that have emerged as a margin of competition for employers to attract talent.

Following in the footsteps of other federal entitlements, the limited credit if extended or made permanent is likely to grow over time. In contrast to the seemingly small $2 billion a year cost of the current credit, a credit to fully subsidize 16 weeks of paid leave (the goal of many advocates) would cost well upwards of $300 billion per year or $3 trillion over 10 years. This will ultimately be the true, long-run cost of the credit, if extended.

The Heritage Foundation recommends allowing the paid family leave credit to expire in our 2020 Blueprint for Balance and in our recommendations for tax reform 2.0. On the topic of avoiding a new national federal entitlement program for paid family leave in general, my colleague Rachel Greszler explains how the federal government can support families' access to PFL by reducing marginal tax rates, encouraging flexible work arrangements, and cuts to costly business regulations.

I would be happy to discuss with you in greater detail the topics included here or any other tax extender. Please feel free to contact me if I can be of assistance in any way.

Sincerely,
Adam N. Michel

Adam Michel
Senior Policy Analyst, Fiscal Policy
Institute for Economic Freedom
The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002

202-608- 6142
heritage.org

TRIPLE-S SALUD
BlueCross BlueShield of Puerto Rico

June 28, 2019

SUBMITTED ELECTRONICALLY VIA
HEALTH_TAX_TASKFORCE@FINANCE.SENATE.GOV

The Honorable Pat Toomey
Chairman, Health Care Subcommittee, Senate Finance Committee
248 Russell Senate Office Building
Washington, DC 20510

The Honorable Bob Casey
393 Russell Senate Office Building
Washington, DC 20510

The Honorable Michael Enzi
379 A Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
703 Hart Senate Office Building
Washington, DC 20510

Re: Senate Finance Health Tax Extenders Task Force Stakeholder Feedback

Dear Senators Toomey, Casey, Enzi and Warner:

As the largest health insurance company in Puerto Rico, Triple-S Management Corporation ("Triple-S") commends the Senate Finance Committee Health Tax Task Force for addressing the health insurance tax as part of its process to provide long-term certainty to expiring tax provisions and urges the Task Force to advance legislation that includes full and immediate repeal of the tax.

Triple-S has been a publicly traded company since 2007, but our experience in providing high-quality health insurance to the people of Puerto Rico extends back for more than 50 years. Triple-S is the leading insurance company in Puerto Rico, chosen by two out of three people to meet their insurance needs. We are an independent licensee of the Blue Cross Blue Shield Association.

As you know, health care in Puerto Rico has faced long-term economic challenges and disparities and continues to be impacted by the devastation associated Hurricane Maria. Not only have we had to address challenges to the physical infrastructure of our health care delivery system, we also confront disruption in terms of human capital as physicians and other health care providers continue to leave the Island to practice on the mainland. Given that we continue every

day to wrestle with recovery, we view relief from this tax as essential because it will directly reduce premiums and make coverage more affordable.

This tax is particularly punitive to plan members in Puerto Rico because ACA subsidies, among other benefits, which this tax was purported to finance, are not available to people living in Puerto Rico, despite also being U.S. citizens.

The health insurance tax rate allocated to each insurer based on their applicable net premiums is close to 2.0-2.7 %.[1] The last annual statement published by Office of the Commissioner of Insurance of Puerto Rico reported a total of 9.861 B in health insurance premiums for 2017.[2] This implies that Puerto Rico health insurance companies will pay approximately $200M in the aggregate annually if the tax delay is not enacted.

As you know, the one-year suspension of the health insurance tax is scheduled to expire on December 31, 2019. If the tax is allowed to restart for any period of time, it will negatively impact Puerto Ricans thought rising premiums and plans through uncertainty, hindering our operations, investments, and financial liquidity at a time when they can least afford it. It is estimated that its enforcement would represent a total increase in premiums to policyholders/beneficiaries in Puerto Rico of anywhere from ($225m-$250m) yearly.

With rate submissions, due to state regulators in the spring and Medicare Advantage rates finalized in June, premiums will be calculated for 2020 early in 2019. The HIT tax will have to be included in some, if not all, of the plan bid calculations across the commercial and government programs when submitting rates if an additional delay is not enacted before September. This means rising premiums at a time when Puerto Ricans can least afford it.

We look forward to working with the Health Tax Task Force and your colleagues in Congress to repeal the health insurance tax. We would welcome the opportunity to serve as a resource as you consider policies affecting health care delivery in Puerto Rico. If we can be of further assistance, please contact Carlos L. Rodriquez-Ramos, Vice President of Legal Affairs and General Counsel at Triple-S. He can be reached at crodrig@ssspr.com or 787-281-2315.

Sincerely,

Madeline Hernández-Urquiza, CPA
President

---

[1] Oliver Wyman, Analysis of the Impacts of the Aca's Tax on Health Insurance in Year 2020 and Later, 2018.
[2] http://ocs.pr.gov/ocspr/files/Informe%20Anual%202017-FINAL%20(Espanol).pdf (page 6 and 33)

The Honorable Patrick Toomey
United States Senate
248 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Michael Enzi
United States Senate
379A Russell Senate Office Building
Washington, D.C. 20510

The Honorable Robert Casey
United States Senate
393 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Mark Warner
United States Senate
703 Hart Senate Office Building
Washington, D.C. 20510

June 30, 2019

Dear Senator Toomey, Senator Casey, Senator Enzi, and Senator Warner:

On behalf of the undersigned organizations, we urge to urge you to extend for ten years the historic excise tax rate that supports the Black Lung Disability Trust Fund.

Rates of black lung disease have doubled nationwide since 2000 and have hit a 25-year high in Appalachian coal mining states. 1 in 5 veteran working coal miners in Central Appalachia now has this preventable and fatal disease, according to the CDC's National Institute of Occupational Safety and Health. This increase is alarming - as is the inaction of Congress, which puts the safety net for those suffering from black lung disease in jeopardy. The modest excise tax on coal sold domestically, which supports the Black Lung Disability Trust Fund, dropped by more than half when Congress allowed the long-standing tax rate, unchanged since 1986, to lapse at the end of 2018. The Government Accountability Office (GAO) estimates that at this lower rate the Trust Fund's debt will balloon to over $15 billion by 2050 and effectively shift the cost of federal black lung benefits from coal companies to federal taxpayers, contrary to the clear intent of Congress when it established the Trust Fund by passing the Black Lung Benefits Revenue Act of 1977.

Congress must protect the solvency of the Black Lung Disability Trust Fund and ensure that coal companies pay their fair share to provide benefits to miners. While we appreciate the inclusion of a one-year extension of the excise tax rate in the Tax Extender and Disaster Relief Act of 2019 (S. 617), such a short extension, if it becomes law, would not correct the solvency crisis facing the Trust Fund and would represent a sharp break from precedent. Previous extensions of the tax rate have been of much longer duration; most recently, in 2008, Congress extended the rate for ten years.

As thousands of disabled coal miners across the country literally struggle for air, this is an immediate way that Congress can allow them to breathe a little easier. Black lung benefits are mandatory under current law, but miners and their families are well aware that rapidly escalating debt in the Trust Fund would serve as a pretext for future legislative efforts to restrict eligibility for benefits.

A 10 year extension of the historic rate is a bare minimum approach. Black lung disease is resurgent among coal miners, and coal companies are manipulating our bankruptcy laws to abandon their

commitments to workers by shedding their liabilities for paying black lung benefits to miners who contracted the disease while working for them.

In 2017 alone, more than 2,500 black lung claims were transferred to the Trust Fund due to coal company bankruptcies. This safety net, which Congress created to ensure benefits to miners permanently disabled by black lung, is too important to be starved of funds. Without an extension of the tax at the rate that has been in place for more than three decades, the GAO estimates that the Trust Fund won't have sufficient revenue to cover its beneficiary payments and administrative costs starting in Fiscal Year 2020.

The many issues facing our coal communities are long term and complicated, but the solvency of the Black Lung Disability Trust Fund is an urgent issue with a straightforward and immediate solution. Coal miners have risked their health and safety to fuel our nation. We urge you to do right by our miners and their families.

Sincerely,

Black Lung Associations and Clinics

Southeast Kentucky Black Lung Association
East Kentucky Coalfield Black Lung Association
Southwest Virginia District II Black Lung Association
Rainelle Medical Center

Supporting National Organizations

BlueGreen Alliance
Center for Biological Diversity
Citizens Coal Council
Friends of the Earth US
Institute for Policy Studies Climate Policy Program
Interfaith Power & Light
National Wildlife Federation
RuralOrganizing.org
Sierra Club
Union of Concerned Scientists
Western Organization of Resource Councils

Supporting Local and Regional Organizations

Appalachian Citizens' Law Center
Appalachian Voices
Appalshop
Center for Coalfield Justice

Coalfield Development Corporation
Eastern PA Coalition for Abandoned Mine Reclamation
Fahe
Kentuckians For The Commonwealth
Mountain Women's Exchange
Ohio Valley Environmental Coalition (OVEC)
Pennsylvania Alliance for Retired Americans
Pennsylvania Interfaith Power & Light
Rise Up West Virginia
The Alliance for Appalachia
Unitarian Universalist Ministry For Earth
West Virginia Healthy Kids and Families Coalition
Western Colorado Alliance
Woodland Community Development Corporation

[redacted]

From: Steve Silver <[redacted]
Sent: Friday, June 21, 2019 1:04 PM
To: taskforce, health_tax (Finance)
Subject: HCTC

Dear Taskforce Committee,

Thank you so much for taking the time to examine this important benefit. I hope you vote to reauthorize it.

As a former pilot for Delta Air Lines, my wife and I depend heavily on this benefit to pay for our health insurance. When Delta went bankrupt, they took down our pensions with it. Right now we are receiving less than 1000 a month from what was supposed to be much more. (NOTE: The executives made sure their pensions were safe).

There is no way we could afford to buy health insurance on the open market. The premiums and deductibles are just way too high.

We have been fortunate that our health has been good so far but you never know. One illness can bankrupt a person pretty quickly. I am sure that we would not have the protections in bankruptcy that major corporations in this country do.

So I urge you renew the HCTC program. It is virtually a life safer.

Best,

Steve Silver
Cincinnati, OH

[redacted]

From: MP <[redacted]>
Sent: Friday, June 21, 2019 1:06 PM
To: taskforce, health_tax (Finance)
Subject: Renew

Please renew the hctc health insurance subsidy Without it I would not be able to afford health insurance as a pbgc recipient.

Thank you
Marc Pearce
Cincinnati Ohio 45244

[redacted]

From: Amusement Park Bear <[redacted]>
Sent: Friday, June 21, 2019 2:53 PM
To: taskforce, health_tax (Finance)
Subject: HCTC

My name is Gary Riley and I worked 38 yrs for USAir, USAIRWAYS, and ended my career after the merger with American Airlines. I was 63 years old when I retired after working outdoors all those years in Pittsburgh and Charlotte as a crew chief. The HCTC program allowed me to do this. I will not be 65 until 4/14 /2020 so I am urging you to please continue the HCTC program. There are many more like my self who put the years in at a labor intense job who would either like to or have to leave the airline industry before the age of 65. Thankyou!

[redacted]

From: VIRGINIA THOMAS <[redacted]>
Sent: Friday, June 21, 2019 2:50 PM
To: taskforce, health_tax (Finance)
Subject: Tax

Please leave the tax credit in place for our healthcare coverage.

Virginia L. Thomas

[redacted]

From: Joel Rohletter <[redacted]>
Sent: Friday, June 21, 2019 1:47 PM
To: taskforce, health_tax (Finance)
Subject: HCTC REAUTHORIZATION

Promises made, now keep the promise to those of us affected by NAFTA. Reauthorize the HCTC health care subsidy for those of us that lost our pensions and have to rely on payments from the PBGC.
Regards,
Joel Rohletter

[redacted]

From: Kim Hansen <[redacted]>
Sent: Friday, June 21, 2019 1:38 PM
To: taskforce, health_tax (Finance)
Subject: HCTC

Hello,

I'm writing today, because of my concerns with the HCTC. My husband and I both are retired airline employees. In 1989 the airline (US Airways) froze our pension and took away our insurance benefit at retirement, yet, telling us through the PPGC, we would be able to acquire affordable insurance. My husband and I both continued to put away as much money as possible into our 401(k) .

We live on a fixed income and would have a Very difficult time paying for more expensive insurance. We worked as customer service and ramp service agents. Middle class workers. We ask that you please continue the HCTC for so many other people like us, In this situation . Thank you so much.

Sincerely,

Marc & Kim Hansen

Sent from my iPhone

[redacted]

From: Theresa DeHaven <[redacted]>
Sent: Friday, June 21, 2019 1:32 PM
To: taskforce, health_tax (Finance)
Subject: Help

PLEASE extend this, I have counted on this since I took the buyout my company offered. I have 3 more years for the need of this. I had happen to me what is called a hemorrhage stroke. So I Need the HCTC. Theresa DeHaven

Sent from Yahoo Mail for iPhone

[redacted]

From: Bernie Freed <[redacted]>
Sent: Friday, June 21, 2019 1:20 PM
To: taskforce, health_tax (Finance)
Subject: Keep the HCTC !!!

Sent from my iPhone

[redacted]

From: ED CARRERA <[redacted]>
Sent: Friday, June 21, 2019 4:20 PM
To: taskforce, health_tax (Finance)
Subject: Extending healthcare credit

Please extend the healthcare tax credit. Thank you

Sent from my iPad

[redacted]

From: mark searcy <[redacted]>
Sent: Friday, June 21, 2019 9:57 PM
To: taskforce, health_tax (Finance)
Subject: HCTC Renewal

Please renew the Health Care Tax Credit that is set to expire in 2019.

[redacted]

From: Sf <[redacted]>
Sent: Friday, June 21, 2019 10:09 PM
To: taskforce, health_tax (Finance)
Subject: Hctc Renewal

Please renew the HCTC. This is critical for my health care as my employer United Airlines went bankrupt and jettisoned my pension plan to the PBGC. I am receiving but a small portion of the pension which I paid into for over 20 years. Thank you for considering this, respectfully, Scott Fuglestad Martinsville Indiana

[redacted]

From: Sandra Hearns <[redacted]>
Sent: Saturday, June 22, 2019 12:50 PM
To: taskforce, health_tax (Finance)
Subject: Health tax

Please continue this program. I dont know how my family would manage without it.
Sent from my iPhone

[redacted]

From: Lynne Bostic <[redacted]>
Sent: Sunday, June 23, 2019 9:25 AM
To: taskforce, health_tax (Finance)
Subject: HCTC Tax Credit

Dear Committee,

PLEASE EXTEND THE HCTC TAX CREDIT!

I am, as many other hard working folks, are dependent on this credit. Piedmont Airlines was a cornerstone of our community in Winston Salem, NC and many locals worked and loved that company. It was purchased by USAir and subsequently, many of us with pension plans lost value that we had worked so diligently for. To compensate somewhat for this, the tax credit helps us immensely. Without it, I do not know what I can do at this point being in my early 60's. Please let me know if there is anything I can personally do to assist and I trust that you will understand the importance and security it provides for many hard working folks. Please, extend this credit!

Lynne Bostic
[redacted]

[redacted]

From: [redacted]
Sent: Sunday, June 23, 2019 11:25 AM
To: taskforce, health_tax (Finance)
Subject: HCTC reauthorization

In 2004, after 25 years working for Delta Airlines as a pilot, I retired. The following year Delta entered bankruptcy and the Delta Pilots' Pension Plan was terminated by the company. When the PBGC assumed the administration of the assets of our retirement plan, DPPP retirees' pension benefits -- my pension benefit included -- were drastically reduced.

We depend on the HCTC program's participation in helping us pay insurance premiums. Unfortunately its participation is essential for us to continue to afford health care.

Please see that the HCTC gets reauthorized without interruption.

Thank you.

Robert J. Patrucco
Reno, Nevada

[redacted]

From: Paul Hotakainen <[redacted]>
Sent: Sunday, June 23, 2019 12:33 PM
To: taskforce, health_tax (Finance)
Subject: Renewing the HCTC

To Whom it may concern,

Please be aware that many retiree's with PBGC pension benefits are taking advantage of this great medical insurance discount. For many the pension they are now receiving through the PBGC is smaller than they would have received if their company had not declared bankruptcy in court. The Health Insurance discount through the HCTC helps to offset that loss.... As you well know, medical insurance and its related costs are often one of, if not the biggest expense we retiree's face in our retirement years.

I would greatly appreciate your Task-force Board consider these facts in your ongoing discussions over the renewing of the HCTC. My wife and I thank you in advance.

Sincerely, Paul and Ruth Hotakainen

B' Yom Hashlishi,

Paul Hotakainen
Pioneer Christian Fellowship

http://pioneerchristianfellowship.us/

[redacted]

From: Anthony Piacentino <[redacted]
Sent: Sunday, June 23, 2019 12:40 PM
To: taskforce, health_tax (Finance)
Subject: HCTC

Having worked with an HCTC program for several years (although not a recipient of funds from it), I can attest to the need of many families for the help provided by this program, to make their health premiums affordable. Unless you have personally experienced the extreme burden that occurs after the loss of both job and benefits due to bankruptcy, you cannot understand the relief this program gives to those who need it. I urge you to please consider extending this worthwhile program. Sincerely, A.Piacentino

[redacted]

From: Nan Flock <[redacted]>
Sent: Sunday, June 23, 2019 6:26 PM
To: taskforce, health_tax (Finance)
Subject: HCTC HEALTH CARE TAX BENEFIT

Hello,
My name is Nanette Flock. I am a retired USAirways Flight Attendant 23 years of service who during the company's bankruptsy stage lost all/most of my 401k . To save what was left of the employees retirement plan ... we were lucky enough to have PBGC.. Pension Benefit Guaranty Corp take over thus helping to ensure the promise of receiving our financial retirement benefit.
We, the retirees, faced financial challenges during the 1990,s, 2000,s ..
1. Unlike todays younger work force, 401k's did not come along until many work years later, not allowing us the same jump start as of todays employees.
2. When we were finally able to contribute to a 401k, companies went through a major restructuring, downsizing , bankruptsy time period.
3. Economy .. real estate market crash also happened a later on.

Our age group will be struggling to find a way to afford retirement.

As you are aware, The HCTC program which is set up for the 55 to 65 age group is helping us save on health care costs which in turn is allowing us time to catch up on those lost retirement savings years.
The money we can save now in health insurance will go a long way toward securing our financial future.

Please keep the HCTC Program running for those of us who are in need of this service.
We are the inbetween souls- struggling to remain independent in our Golden years.
Helping us now... in turn ...will eventually help the Government.

Please SAVE THE HCTC PROGRAM.

Thank you.
Nan Flock.

Get Outlook for Android

[redacted]

From: Debbie Hooton <[redacted]>
Sent: Sunday, June 23, 2019 6:44 PM
To: taskforce, health_tax (Finance)
Subject: HCTC

Please extend the HCTC. I could not afford insurance without it.
Thank you.

[redacted]

From: [redacted]
Sent: Sunday, June 23, 2019 7:35 PM
To: taskforce, health_tax (Finance)
Subject: HCTC

Dear Congressman,

Please reauthorize the Health Coverage Tax Credit. For all of us who had our retirement programs terminated by our employers, this program has been a tremendous help to allow us to make it through the month financially. My wife and I worked for the airlines and both of our companies went bankrupt and terminated our retirement plans. It was unfair and a devastating blow to our finances, especially in the light of how unbelievably profitable those airlines are now. So, please help all of us out and continue the HCTC. Thank you very much.

Bryan & Patricia Clark

[redacted]

From: Gail Bartlett <[redacted]>
Sent: Monday, June 24, 2019 7:15 AM
To: taskforce, health_tax (Finance)
Cc: cathy@coneretireebenefits.com; Cathy Cone
Subject: Please renew!

Hello!
Please renew HCTC! My very small airline pension barely covers the cost of HCTC. If this program isn't renewed, I will have to search for an insurance program that would cover me until I turn 65. Even if I stayed on the same program with out the benefit of HCTC, it would take my whole social security benefit to cover the premium. I kept the airlines I worked for afloat for 35 years with all my paycuts, now please help
me to know I have affordable health care coverage. I am willing to share my plea with anyone who will listen.
Thank you!
Gail Bartlett
Employed by Eastern, USAirways and finally American.

Sent from my iPhone

[redacted]

From: Margaret Eaves <[redacted]>
Sent: Monday, June 24, 2019 2:32 PM
To: taskforce, health_tax (Finance)
Subject: HCTC

Dear Sirs,

I am writing to you in hopes that you will consider & approve the renewal of the Health Coverage Tax Credit Insurance subsidy for the year 2020. I am a former Flight Attendant with US Airways and when I retired in 2003 US Airways promised me & my family Insurance for a lifetime. However, when Obama care came into play our Insurance was dropped. I am now a middle aged single Female who is unable to afford Insurance thru the Marketplace. Fortunately, HCTC has come to my rescue!! Please reauthorize this vital program. I appreciate your Support.

Margaret Eaves
[redacted]

Sent from my iPhone

[redacted]

From: jody blake <[redacted]
Sent: Monday, June 24, 2019 3:32 PM
To: taskforce, health_tax (Finance)
Subject: Reauthorization of the HCTC

Hello to you all from Northern Minnesota. My name is Kenneth Blake and I had worked for over 26 years at the LTV Steel and iron ore mine, hoping to be able to retire from there; when we found ourselves permanently laid off due to bankruptcy. My pension was then cut in half also. No health insurance available so found other jobs but was unable to even think about retiring until I heard about this life-saving HCTC program!! I am asking you to please reauthorize the Health Coverage Tax Credit so that those of us that are not yet there or nearing 65 can continue this for a few more years! Thank you, thank you, thank you!!

[redacted]

From: Robin Omelusik Carley <[redacted]>
Sent: Tuesday, June 25, 2019 8:50 AM
To: taskforce, health_tax (Finance)
Subject: Reauthorization of HCTC Program

Health Tax Taskforce,

I would appreciate your support of the HCTC program which needs to be reauthorized soon.

Being retired, and with my husband's pension cancellation, this program is essential to our financial well-being.

I appreciate your hard work and support of this program.

Sincerely,

Robin Carley
Dayton KY

--
"Though the vision tarry, wait for it, it will surely come." (Habakkuk 2:3)

[redacted]

From: Barry H Steiner <[redacted]>
Sent: Tuesday, June 25, 2019 1:58 PM
To: taskforce, health_tax (Finance)
Subject: Health Coverage Tax Credit Program that is set to expire December 31, 2019

Dear Senators,

We need your Help and support of our efforts to get an extension for the Health Coverage Tax credit program that is set to expire December 31, 2019. This program has been a lifeline for me and my family and other families around the country that have lost our healthcare due to our former employers filing for bankruptcy and having our "unfunded promise" of free or at least affordable healthcare during our retirement years now facing a reduced pension and no longer any healthcare. This HCTC program has been a critical part of being able to afford healthcare for my family over the last few years and continues to be vital for our family today. It is also a tremendous benefit for those workers that have had their jobs offshored to other countries, receiving help to pay for their healthcare through the TAA Program.

Specifically, I request that you work to make sure that there is a Bill in the Senate that will partner with the Bill already proposed in the House "Bill 1939", reauthorizing the Health Coverage Tax Credit Program as soon as possible.

With the HCTC set to expire December 31, 2019 without action taken by Congress to extend the program, action is necessary now to avoid a last-minute decision that would not allow insurance providers the ability to have a plan in place for us to continue to have the healthcare options through this program in 2020 and beyond

As you can see, this is a critical issue for me and for my fellow retirees. I am looking to your leadership as my elected representative to find a way to extend HCTC. I ask that you support the extension of the HCTC program as outlined in the Bill put forth by Congressman Turner in the House and hope you will join with other elected representatives and Sponsor a Bill in the Senate to address our concern today!

Thank you, in advance, for favorably considering my request. As always, I appreciate your hard work on Capitol Hill to best represent those of us back home.

Sincerely,

Barry Steiner

[redacted]

760-902-4747

[redacted]

From: Cathy Cone <Cathy@mymedplans.com>
Sent: Tuesday, June 25, 2019 5:12 PM
To: taskforce, health_tax (Finance)
Cc: John Cone; Cathy Cone; Cusmano, Robert (Portman)
Subject: Urgent HCTC Program Reauthorization for TAA and PBGC Eligible
Attachments: 2019 HCTC 2019 Reauthorization Request 06 24 19.rtf

Dear Members of the Finance Committee,
It is my understanding you will be considering Bills needing to be passed hopefully before the end of August of 2019. This request is regarding the importance of the Reauthorization of the Health Coverage Tax Credit Program as soon as possible. I have attached a letter outlining the importance of the reauthorization and possible improvements to the request providing eligible people with the necessary access to participant in the program. If you have any questions or would like to speak to me regarding this matter, please feel free to contact me at cathy@mymedplans.com or by phone at 832-541-8842

Thanks very much for your consideration of this request,
Cathy Cone

Reauthorization of the Health Coverage Tax Credit Program (HCTC) is URGENT!

This Program Impacts Trade Adjustment Assistance Workers (TAA) and PBGC Recipients Between the Ages of 55-65 Expiring December 31, 2019

- Reauthorization – CANNOT WAIT UNTIL THE END OF 2019 TO BE REAUTHORIZED, INSURERS WILL NOT PROVIDE INSURANCE QUOTES FOR THIS PROGRAM AT THAT LATE DATE!—Unless it is reauthorized prior to Open Enrollment for 2020 beginning in September and October of 2019 for 2020 Insurance Programs. Insurance providers require the ability to determine eligibility, rates and plans designs as soon as possible, in order to provide HCTC Qualified Plans the ability to select providers and assist in enrolling TAA and PBGC Eligible participants in a timely manner for their 2020 Insurance programs. **Please Act Today!**

- Eliminate 24 Month Provision for Spouse To Participate in HCTC - after primary participant becomes Medicare eligible (Section 35 (g)(10)(a)), experience indicates it leaves a huge gap for many of the spouses to bridge to Medicare, and continue to be able to afford healthcare on their limited incomes. This usually finds the spouse and any dependents still living at home, without the ability to afford healthcare and often, finds the PBGC recipient is no longer able to work. Elimination of 24-month time limit for HCTC "Spousal Coverage" would be a tremendous help in allowing the

spouse and eligible dependents the ability to continue to afford healthcare as the spouse bridges to Medicare. The disparity in age between the PBGC Recipient and Spouse is due in large part to the high number of PBGC Recipients being classified as "Medicare Eligible" at a much earlier age than 65, in many cases, due to the industries they worked in such as the Steel and Auto Industries.

- Expand Access – Allow the IRS to RELAX 501 (c) 9 VEBA rule that today limits access to "HCTC QUALIFIED VEBA'S" in the same "Class and Craft" ONLY– when Deemed an "HCTC Qualified VEBA'S". By allowing "HCTC Qualified VEBA's" to permit both TAA and PBGC participants eligible for the HCTC program the ability to enroll in any available "HCTC Qualified VEBA", regardless of the "Class and Craft", provided the VEBA is an "HCTC Qualified VEBA" and the Board of the "HCTC Qualified VEBA" permits access to different "Classes and Crafts" of any HCTC eligible participants, both TAA and PBGC recipients. Unfortunately, today, the HCTC program severely limits access to many otherwise HCTC eligible participants and their families due to the lack of availability of "HCTC Qualified VEBA'S" in their industries or locations, following the elimination of the "State Qualified Plans", otherwise known as "High Risk Pools" in January 2014. These High Risk Pools were in more than 46 states and allowed both TAA and HCTC eligible plan participants to enroll and pay only the 27.5% subsidy on a monthly basis, instead of today, having to pay 100% of the cost of the premium and receiving the 72.5% subsidy on their income tax the following year. This is an untenable cost for most TAA and HCTC Plan participants.

- The Effort to Provide Access through the "Individual Market" has not provided the needed access to TAA and HCTC Eligible Participants- the introduction of the availability of the "Individual Market" plans was initiated in order to address the lack of access following the termination of the "State Qualified Plans" when the Affordable Care Act began in 2014, and has not proven successful, to date. The program lacks the ability to offer the needed Enrollment Support, Call Centers, and Billing required to make the Individual Market a realistic option for TAA and PBGC recipients across the country, requiring the plan participant to basically fin for themselves when trying to enroll on the individual market. Unlike eligible participants enrolled in the established "HCTC Qualified VEBA'S" offering those support tools available and accessible, to anyone enrolling in their "HCTC Qualified VEBA'S" today, and work closely with the IRS routinely, to manage the enrollment process and hand off to the HCTC Qualified VEBA Call Center that will continue to provide support for the insurance programs throughout the eligibility period of the HCTC eligible participant and their families.
- PLEASE CONSIDER THIS REQUEST TO REAUTHORIZE THE HCTC PROGRAM IMMEDIATELY! This program today provides a vital lifeline to thousands that have

been impacted by having their jobs offshored, as well as those that have had their pensions reduced or eliminated, and their healthcare terminated, through no fault of their own, and in most cases, by companies that have filed for bankruptcy and caused these people hardships living with reduced pensions and eliminating their healthcare benefits that were in many cases, unfunded promises to their workers and their families.

Thanks very much for your consideration of this request on behalf of HCTC eligible participants and their families across the country that we hear from every day, asking for help in enrolling in these plans as well as asking what they can do to make sure that the leaders in Washington DC know how important this program is to them and their families!

If there is anything we can do, or any questions you may have regarding the HCTC program, we will be happy at your request to come to Washington, have a conference call or through email, address your questions and concerns.
You can also view one of the websites currently offering the healthcare options for HCTC Eligible Participant today through "Qualified VEBA'S" . www.mymedplans.com

Cathy Cone
John Cone
Cone Retiree Healthcare Group
[redacted]

June 25, 2019

The Honorable Pat Toomey
U.S. Senate
Washington DC, 20510

The Honorable Bob Casey Jr.
U.S. Senate
Washington DC, 20510

Dear Senator Toomey and Senator Casey,

Thank you for the opportunity to submit comments and recommendations to the Task Force in response to the Finance Committee's efforts to develop long-term solutions to temporary tax policies. On behalf of the members of our collective organizations I appreciate your interest in hearing from stakeholders on such an important issue.

As dentists, we are deeply concerned about the possible adverse impact the 2.3 percent medical device excise tax (26 USC § 4191) paid by manufacturers, importers, and producers of certain dental devices will have on patient care and cost. Those subject to the tax will likely offset these new costs by increasing the prices of the materials, supplies, and equipment sold to dental practices. In addition to the excise tax itself, manufacturers will offset the costs of administering and paying the tax, which would likely result in higher fees for our patients. The dental device manufacturing industry has estimated that the medical device excise tax could increase the cost of dental care by more than $160 million annually.

An increase in the cost of oral health care as a result of the excise tax on medical devices, including dental and orthodontic devices, will of course negatively impact access to oral health care services.

In addition, dental professionals who operate solo or small group practices are economic engines for their communities as small businesses. The majority of practicing dentists work in practices comprising five or fewer dentists. Operating costs for dental practices, particularly specialties, are significant, and the ability to sustain or grow small businesses like dental practices will be further strained with the implementation of the medical device tax.

Our respective organizations understand that the rationale justifying the imposition of the tax is, at least in part, that under the Affordable Care Act there will be more patients and, therefore, more revenue for the medical segment of healthcare. Under this reasoning, additional revenue would in part offset the added expense of the excise tax. However, there are no elements within the Act that would result in additional revenue related to the adult dental patient segment. Consequently, the tax places an inequitable burden on the dental community and dental patients.

Large bipartisan majorities in Congress agree that the medical device tax is bad policy. Thanks in no small part to your leadership and the efforts of the Committee on Finance,

Congress has suspended the tax twice for a total of four years. Notably, by the end of this year, Congress will have suspended the tax for longer than it was in effect, with no measurable impact on coverage. Repeal of the device tax will not have a significant impact on the overall finances of the ACA, despite prior concerns.

The current suspension expires on December 31, 2019. Dental practices today are already in the process of making important planning decisions for 2020, with a possible reinstatement of the tax looming before them.

We strongly encourage the Task Force to recommend the full repeal of the medical device excise tax and urge the Committee to move promptly to consider legislation that includes repeal. We stand ready to work with you to advance any legislative vehicle that will address the medical device tax.

Thank you again for this opportunity to share our thoughts on behalf of dentistry and the oral health needs of our patients. We look forward to working with you and your staff on a permanent solution. Please contact Pat O'Connor at (703) 351-6222 or patoconnor@kentoconnor.com with any questions.

Sincerely,

Academy of General Dentistry
American Academy of Oral and Maxillofacial Pathology
American Academy of Pediatric Dentistry
American Academy of Periodontology
American Association of Endodontists
American Association of Oral and Maxillofacial Surgeons
American Association of Orthodontists
American Association for Women Dentists
American College of Prosthodontists
American Dental Association
American Student Dental Association
National Dental Association

[redacted]

From: William Pantesco <[redacted]>
Sent: Wednesday, June 26, 2019 7:14 AM
To: taskforce, health_tax (Finance)
Subject: HCTC

To whom it may concern,

Please re authorize the HCTC program. It has been a God send and vital to our family's financial health and well being.

Failure to extend this program would be a severe financial burden on us.

Thank you for your action.

William J Pantesco
Fernandina Beach, Fl

[redacted]

From: Jeffrey Richards <[redacted]>
Sent: Wednesday, June 26, 2019 7:23 AM
To: taskforce, health_tax (Finance)
Subject: Please Support the HCTC Re-Authorization

I lost my Pension due to Delphi's Bankruptcy. I currently get a fraction of what my pension would have been from the PBGC. As I am also responsible for my own health care; the HCTC is essential.

Please push through the re-authorization.

Please let me know if there are roadblocks or anything I can do to help get support.

Jeffrey Richards
Retired, Delphi

[redacted]

[redacted]

From: mark searcy <[redacted]>
Sent: Wednesday, June 26, 2019 8:21 AM
To: taskforce, health_tax (Finance)
Subject: HCTC

The reauthorization of the HCTC is vital for many Americans for healthcare. I urge you to support and pass the reauthorization.

[redacted]

From: Theresa DeHaven <[redacted]>
Sent: Wednesday, June 26, 2019 8:31 AM
To: taskforce, health_tax (Finance)
Subject: HCTC

I need this. Please reinstate this.

Sent from Yahoo Mail for iPhone

[redacted]

From: fg940701 <[redacted]>
Sent: Wednesday, June 26, 2019 8:48 AM
To: taskforce, health_tax (Finance)
Subject: HCTC

Please extend this valuable plan for its what allows people to have health care coverage for those that have already lost large percentages of thier pensions due to corporate bankruptcies, while corporate America walks away with thier millions.

Thank you for your time and considerstion.

T.D.

Happy Connecting. Sent from my Sprint Samsung Galaxy S® 5

[redacted]

From: thuan nguyen <[redacted]>
Sent: Wednesday, June 26, 2019 9:32 AM
To: taskforce, health_tax (Finance)
Subject: Hctc

Sent from my iPhone

[redacted]

From: Gary <[redacted]>
Sent: Wednesday, June 26, 2019 9:36 AM
To: taskforce, health_tax (Finance)
Subject: HCTC Reauthorization

Health Tax Task Force Team,
Please recommend re-authorization of the HCTC to Congress.
As a past participant in the program I can say it made it possible to afford healthcare coverage.
My experience was due to my employer declaring 'Bankruptcy' and transferring pensions to the PBGC.
It also eliminated 'Retiree Healthcare Benefits' requiring I find insurance in the open healthcare market.
The HCTC made it possible to afford the healthcare which was quite expensive for seniors.
Affected people under the 'TAA Act' and 'Reduced Pensions' through the PBGC need the HCTC assistance.
Appreciate your efforts in this matter.
Have a great day! Thank you.
Gary Conley
[redacted]

[redacted]

From: Kim Hansen <[redacted]>
Sent: Wednesday, June 26, 2019 10:45 AM
To: taskforce, health_tax (Finance)
Subject: HCTC

Dear Law makers,

My husband and I both retired from an airline, that froze our pension in 1989 and no longer providing health insurance coverage , once we retire. The only thing offered through the PPGC, was the HCTC. We continued, while working, putting back as much money as we could afford into our 401 k.

We are praying you will continue the HCTC, so that we are able to enjoy our retirement and afford health insurance. We are middle class folks, living on a fixed income. Please help us, so that insurance is affordable for us all.

Thank you for you time on such an important matter.

Sincerely,

Kim & Marc Hansen
Sent from my iPhone

[redacted]

From: [redacted]
Sent: Wednesday, June 26, 2019 12:25 PM
To: taskforce, health_tax (Finance)
Subject: HCTC extension

I am a former Eastern Airlines employee whose pension was taken over by the PBGC. I currently have health insurance and am able to afford the insurance due to the HCTC. Even with the subsidy, my insurance is over $1,000 per month.

If I, and my fellow retirees, were to lose this tax credit, it would be catastrophic. I would not be able to afford medical insurance without the health care tax credit, nor would most people who are beneficiaries of this credit. Taking the credit away would further add to the millions of Americans, caught up in the healthcare crisis, not being able to afford health insurance, and letting their health suffer without health insurance. For many middle Americans, including myself, the Affordable Care Act, put us in a situation where we make too much money to have lower premiums, but don't make enough money to pay for health insurance. I have had surgery this year, and my access to health care is very important, as it is for most. Again, please extend the HCTC so more people will be able to afford health insurance. (Again, please note, I pay over $1,000 per month, and that is with the subsidy). I worked hard for Eastern Airlines, and would still be working there if the company did not go out of business. My pension was not a lot, however, the HCTC tax credit, helps make up for the earnings/pension monies I did not get due to deregulation of the airline industry.

There are many Americans, from all different types of industry, who are in the same position as me. Please help us keep our benefits.

If you wish to contact me, my contact information is listed below.

Thank you for listening.

Maureen L McNamara
Social Security Disability Advocate~EDPNA
[redacted]

[redacted]

From: Ron McElrath <[redacted]>
Sent: Wednesday, June 26, 2019 12:42 PM
To: taskforce, health_tax (Finance)
Subject: Please Accept

To Whom it Concerns, Please vote for the HCTC. I'm a reception of this program. If it were no for this program I would not be able to meet my monthly bills. Once again please vote to accept HCTC . Thank You In Advance, Ronnie McElrath

[redacted]

From: Sam Farner <[redacted]>
Sent: Wednesday, June 26, 2019 6:38 PM
To: taskforce, health_tax (Finance)
Subject: After 30 years at a steel mill one of the few things that I have left is the hctc. I ask that this continues for my family.

[redacted]

From: Kenneth Phelps <[redacted]
Sent: Wednesday, June 26, 2019 10:27 PM
To: taskforce, health_tax (Finance)
Subject: HCTC

Reauthorization of the Health Coverage Tax Credit Program (HCTC) is URGENT!
This Program Impacts Trade Adjustment Assistance Workers (TAA) and PBGC Recipients Between the Ages of 55-65 Expiring December 31, 2019

- Reauthorization – CANNOT WAIT UNTIL THE END OF 2019 TO BE REAUTHORIZED, INSURERS WILL NOT PROVIDE INSURANCE QUOTES FOR THIS PROGRAM AT THAT LATE DATE!—Unless it is reauthorized prior to Open Enrollment for 2020 beginning in September and October of 2019 for 2020 Insurance Programs. Insurance providers require the ability to determine eligibility, rates and plans designs as soon as possible, in order to provide HCTC Qualified Plans the ability to select providers and assist in enrolling TAA and PBGC Eligible participants in a timely manner for their 2020 Insurance programs. Please Act Today!

- Eliminate 24 Month Provision for Spouse To Participate in HCTC - after primary participant becomes Medicare eligible (Section 35 (g)(10)(a)), experience indicates it leaves a huge gap for many of the spouses to bridge to Medicare, and continue to be able to afford healthcare on their limited incomes. This usually finds the spouse and any dependents still living at home, without the ability to afford healthcare and often, finds the PBGC recipient is no longer able to work. Elimination of 24-month time limit for HCTC "Spousal Coverage" would be a tremendous help in allowing the spouse and eligible dependents the ability to continue to afford healthcare as the spouse bridges to Medicare. The disparity in age between the PBGC Recipient and Spouse is due in large part to the high number of PBGC Recipients being classified as "Medicare Eligible" at a much earlier age than 65, in many cases, due to the industries they worked in such as the Steel and Auto Industries.
- Expand Access – Allow the IRS to RELAX 501 (c) 9 VEBA rule that today limits access to "HCTC QUALIFIED VEBA'S" in the same "Class and Craft" ONLY– when Deemed an "HCTC Qualified VEBA'S". By allowing "HCTC Qualified VEBA's" to permit both TAA and PBGC participants eligible for the HCTC program the ability to enroll in any available "HCTC Qualified VEBA", regardless of the "Class and Craft", provided the VEBA is an "HCTC Qualified VEBA" and the Board of the "HCTC Qualified VEBA" permits access to different "Classes and Crafts" of any HCTC eligible participants, both TAA and PBGC recipients. Unfortunately, today, the HCTC program severely limits access to many otherwise HCTC eligible participants and their families due to the lack of availability of "HCTC Qualified VEBA'S" in their industries or locations, following the elimination of the "State Qualified Plans", otherwise known as "High Risk Pools" in January 2014. These High Risk Pools were in more than 46 states and allowed both TAA and HCTC eligible plan participants to enroll and pay only the 27.5% subsidy on a monthly basis, instead of today, having to pay 100% of the cost of the premium and receiving the 72.5% subsidy on their income tax the following year. This is an untenable cost for most TAA and HCTC Plan participants.
- The Effort to Provide Access through the "Individual Market" has not provided the needed access to TAA and HCTC Eligible Participants- the introduction of the availability of the "Individual Market" plans was initiated in order to address the lack of access following the termination of the "State Qualified Plans" when the Affordable Care Act began in 2014, and has not proven successful, to date. The program lacks the ability to offer the needed Enrollment Support, Call Centers, and Billing required to make the Individual Market a realistic option for TAA and PBGC recipients across the country, requiring the plan participant to basically fin for themselves when trying to enroll on the individual market. Unlike eligible participants enrolled in the established "HCTC Qualified VEBA'S" offering those support tools available and accessible, to anyone enrolling in their "HCTC Qualified VEBA'S" today, and work closely with the IRS routinely, to manage the enrollment process and hand off to the HCTC Qualified VEBA Call Center that will continue to provide support for the insurance programs throughout the eligibility period of the HCTC eligible participant and their families.
- PLEASE CONSIDER THIS REQUEST TO REAUTHORIZE THE HCTC PROGRAM IMMEDIATELY! This program today provides a vital lifeline to thousands that have been impacted by having their jobs offshored, as well as those that have had their pensions reduced or eliminated, and their healthcare terminated, through no fault of their own, and in most cases, by companies that have filed for bankruptcy and caused these people hardships living with reduced pensions and eliminating their healthcare benefits that were in many cases, unfunded promises to their workers and their families. Thanks very much for your consideration of this request on behalf of HCTC eligible participants and their families across the country that we hear from every day, asking for help in enrolling in these plans as well as asking what they can do to make sure that the leaders in Washington DC know how important this program is to them and their families!

Best regards,
Captain Ken Phelps
[redacted]

[redacted]

From: Michel, Adam <Adam.Michel@heritage.org>
Sent: Friday, June 28, 2019 10:16 AM
To: taskforce, health_tax (Finance)
Subject: Temporary tax policy input

Senators Patrick Toomey and Robert Casey, Jr.,

As you know, every few years Congress engages in a ritual extension of expiring tax provisions. The bills extend targeted temporary tax provisions for a variety of business operations, individual expenses, and industries. There is broad bipartisan support for letting all the tax extenders expire.

Almost every extender currently being considered grants an economic privilege tailored to some particular group or business interest. By picking winners and losers, these corrupt policies distort efficient market outcomes. They thereby hamper economic growth and reduce opportunity for individuals and businesses whom Congress did not shower with special favors.

Specifically, in the category of the health taskforce on temporary tax policy, I believe the tax credit for paid family and medical leave should not be extended.

The TCJA created a new tax credit program for paid family and medical leave. It should be allowed to expire, as it does in current law, in 2020. The employer credit for paid family and medical leave allows a tax credit of up to 25 percent of wages paid to employees on qualifying leave making under $72,000 a year.

The temporary credit is not likely to induce new employers to offer qualifying paid-leave programs. Instead, the benefit accrues to business owners who already offer such programs as a federally subsidized windfall profit. The narrowly tailored credit rules are also likely to derail the impressive expansions of privately provided leave programs that have emerged as a margin of competition for employers to attract talent.

Following in the footsteps of other federal entitlements, the limited credit if extended or made permanent is likely to grow over time. In contrast to the seemingly small $2 billion a year cost of the current credit, a credit to fully subsidize 16 weeks of paid leave (the goal of many advocates) would cost well upwards of $300 billion per year or $3 trillion over 10 years. This will ultimately be the true, long-run cost of the credit, if extended.

The Heritage Foundation recommends allowing the paid family leave credit to expire in our 2020 Blueprint for Balance and in our recommendations for tax reform 2.0. On the topic of avoiding a new national federal entitlement program for paid family leave in general, my colleague Rachel Greszler explains how the federal government can support families' access to PFL by reducing marginal tax rates, encouraging flexible work arrangements, and cuts to costly business regulations.

I would be happy to discuss with you in greater detail the topics included here or any other tax extender. Please feel free to contact me if I can be of assistance in any way.

Sincerely,
Adam N. Michel

Adam Michel
Senior Policy Analyst, Fiscal Policy
Institute for Economic Freedom
The Heritage Foundation

214 Massachusetts Avenue, NE
Washington, DC 20002
202-608- 6142
heritage.org

[redacted]

From: Cynthia Ward Wikstrom <[redacted]>
Sent: Friday, June 28, 2019 8:11 AM
To: taskforce, health_tax (Finance)
Subject: Comments re Paid Leave Tax Credit
Attachments: Main Street Alliance Statement re Paid Leave Tax Credit 6 28 19.pdf

Dear Health Tax Task Force,

Thanks for the opportunity to provide input from Main Street Alliance, a national network of small business owners, on the tax credit for Paid Leave in the TJCA. Our statement is attached below, and we are available if you have additional questions.

Sincerely,
Cynthia Ward Wikstrom, Main Street Alliance Campaign's Director
--
Cynthia Ward Wikstrom (she/her/hers) | Campaigns Director
Main Street Alliance | Main Street Alliance Action Fund
Cynthia@MainStreetAlliance.org | 617.549.0678 mobile
mainstreetalliance.org | Facebook | @mainstreetweets

[redacted]

From: Scott & Karen Peterman <[redacted]
Sent: Friday, June 28, 2019 2:14 PM
To: taskforce, health_tax (Finance)
Subject: h c t c

To Whom it may concern,

I am asking you to reinstate the HCTC. This insurance has been a god send for us. My wife had CLL with 17P deletion for 12 years. She passed away in March god rest her soul. If not for HCTC she would not have been able to cross state lines and get proper medical attention. I would not have had the pleasure of her wonderful company for the last 5 years! That is the TRUTH.

On a working standpoint, i was a flight attendant for Usairways for 23 years and loved my occupation. When they closed the Pittsburgh base down it was an easy decision to retire with my with ill. The bad part was the company took half of my pension. So to me HCTC is part of my pension. Please don't take it from me.

Sincerely,

Scott Peterman

United States Senate

WASHINGTON, DC 20510

July 9, 2019

The Honorable Pat Toomey
248 Russell Senate Office Building
Washington, DC 20510

The Honorable Robert Casey
393 Russell Senate Office Building
Washington, DC 20510

Dear Senator Toomey and Senator Casey:

We appreciate your leadership in reviewing expiring tax provisions. As you consider which provisions ought to be extended, we strongly encourage you to extend the Paid Family Leave Tax Credit ("45S" in the Internal Revenue Code).

The Tax Cuts and Jobs Act established a two-year, non-refundable tax credit for employers that offer up to 12 weeks of paid family and medical leave to employees. Employers can receive a credit for up to 25 percent of wages paid to employees who utilize such leave. The credit uses the widely-accepted reasons for leave established by the 1993 Family and Medical Leave Act, such as parental leave for birth or adoption, or taking care of a very ill family member. The leave is distinct from vacation or personal leave, and workers can take it on an hourly basis. Compensation paid to both full and part-time employees is creditable.

To qualify for the credit, employers must have a written policy that allows employees to receive at least 50 percent of their normal wages during a period of paid family or medical leave. The credit scales based on the percentage of wages replaced by employers. Employers who pay employees 50 percent of their normal wages during the leave period receive a 12.5 percent credit. Employers can increase their credit by ¼ of a percent for each additional 1 percent they pay employees, with a maximum tax credit of up to 25 percent if they pay employees 100 percent of their normal wages.

Research shows most individuals with salaries above $75,000 per year have access to paid family and medical leave. The tax credit encourages employers to expand paid family and medical leave by limiting it to employees making $72,000 per year[1] or less, an amount that a recent Pew Study says is the point at which people are less likely to receive paid family and medical leave.[2] This ensures the credit is targeted to those least likely to have this benefit. This also would allow part-time workers to be eligible for a pro-rata portion of paid family leave benefits.

Enacting the country's first national paid family leave policy was a major victory for the American people. Congress cannot allow it to expire a mere two years after its enactment.

Maintaining this incentive for employers to offer paid family and medical leave is bipartisan, effective, and the right thing to do. We have heard from dozens of employers who have interest in the credit, and we have been impressed by the private insurance market's eagerness to help them manage their paid family leave policies. However, these businesses need certainty in order to build effective and long-term policies.

Paid family and medical leave is an issue that has gained significant interest amongst our colleagues, as emphasized by legislation offered by members on both sides of the aisle. Over the next few years, we know the debate over various paid family leave plans will intensify. We

[1] I.e. 60 percent of the current definition of a highly compensated employee.

[2] Stepler, Renee, *Key Takeaways on Americans' views and experiences with family and medical leave.* Pew Research Center: March 23, 2017 https://www.pewresearch.org/fact-tank/2017/03/23/key-takeaways-on-americans-views-of-and-experiences-with-family-and-medical-leave/

understand that any long-term solution is likely be multi-faceted. We believe this tax credit will be act as a "bridge" for Congress to refine and debate how we should provide paid family leave.

Thank you for your consideration of this important issue.

Sincerely,

Deb Fischer
United States Senator

Angus King
United States Senator

Cc: The Honorable Chuck Grassley, the Honorable Ron Wyden, the Honorable Michael Enzi, the Honorable Mark Warner

Office of Senator Deb Fischer
Office of Senator Angus King
United States Senate
Washington, D.C. 20510

Re: Support of the Paid Family Leave Pilot Extension Act

Dear Senators Fischer and King,

The Coalition of Franchisee Associations (CFA) is writing to thank you for introducing the Paid Family Leave Pilot Extension Act and express our support for this important piece of legislation.

By way of background, CFA is the largest franchisee-only trade association in the country. The CFA represents 17 franchisee associations whose members own brands including Subway, Burger King, 7-Eleven, Planet Fitness, Buffalo Wild Wings, Dunkin' Donuts, Meineke, Kumon Learning Centers, Domino's and Edible Arrangements, among others. Together, CFA represents more than 35,000 franchisees who own over 85,000 businesses, which employ over 1.4 million individuals.

CFA fully supports the Paid Family Leave Pilot Extension Act, as it provides additional benefit options for employers while allowing employees to care for their family members. Specifically, the bill extends a pilot program which allows employers to voluntarily offer up to 12 weeks of paid family leave in exchange for as much as a 25 percent tax credit for the amount of wages replaced.

While this program was created as part of the Tax Cuts and Jobs Act which passed in 2017, guidance on this provision was not issued until September 24, 2018. Because of this, employers have had little time to implement the plan and insufficient data will be received before the December 31, 2019 expiration date. The Paid Family Leave Pilot Extension Act extends the program through 2022, giving business owners more time to implement the program, expand paid family leave for employees, and allow lawmakers to access sufficient data to assess the effectiveness of the program.

Today's small business owners are faced with numerous federal, state and local mandates which detrimentally impact their businesses. Providing voluntary options and corresponding tax incentives for use of those options gives them the flexibility to determine whether those costs can be absorbed in such a way that they can continue to successfully run their business. Rather than forcing employers to comply with inflexible directives which often result in fewer benefits, less jobs and increased prices, programs like the Paid Family Leave Pilot Extension Act provide more reasonable alternatives which benefit both employers and employees.

Thank you again for you introducing this bill.

Sincerely,

Executive Director, Coalition of Franchisee Associations