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Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

RE: Health Insurance Premium Tax Credit, Notice of proposed rulemaking and notice of public hearing

To Whom It May Concern:

The U.S. Chamber of Commerce (the "Chamber") submits these comments in response to the Notice of proposed rulemaking and notice of public hearing regarding the Health Insurance Premium Tax Credit enacted by the Patient Protection and Affordable Care Act ("NPRM"), which was published in the Federal Register on August 17, 2011.[1] The NPRM provides guidance to the individuals who enroll in qualified health plans through "American Health Benefit Exchanges" ("Exchanges") required by Title I, Subtitle D of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act ("PPACA"). This NPRM was published by the Department of Treasury's Internal Revenue Service ("IRS").

The Chamber is the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector and region, with substantial membership in all 50 states. More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. Therefore, we are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large. Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business -- manufacturing, retailing, services, construction, wholesaling, and finance – is represented. Also, the Chamber

[1] Health Insurance Premium Tax Credit: Notice of proposed rulemaking and notice of public hearing, 76 Fed. Reg. 50,931-50,949 (Auggust 17, 2011) (to be codified at 26 C.F.R. pt. 1) [hereinafter referred to as "NPRM"].

has substantial membership in all 50 states. These comments have been developed with the input of member companies with an interest in improving the health care system.

OVERVIEW

The Chamber and our member companies want quality health care to be readily available at an affordable price, a central goal of PPACA. The Chamber has long advocated for transparency of price, quality and information. We remain hopeful that state-based Exchanges will give Americans more access to affordable coverage options and make price and quality information readily available to them so that they can make optimal choices. Our comments include general thematic recommendations, comments on the economic impact analysis and specific responses to particular sections of the NPRM.

GENERAL RECOMMENDATIONS

As in other comments filed in response to Proposed Rules regarding the statutorily defined Exchanges, we urge the IRS to be apolitical and factually precise.

"SPIN"

With the current politically charged environment and the very partisan views and opinions of the law, implementation of PPACA continues to be controversial. Despite what those that oppose the health law purport, state-based Exchanges are not inherently bad merely because they are included as a part of PPACA. Similarly, although Exchanges hold great potential, they will not function in a vacuum - insurance and economic principles and dynamics will continue to affect these marketplaces. We urge the IRS, as well as others charged with promulgating regulations to implement the law, to leave the spin to the politicians and issue guidance that is factual, correct, neutral and unbiased. The NPRM's preamble begins with Backround section that is far too political.

Exchanges Are Not Inherently Bad

While many who oppose PPACA equate state-based Exchanges with the enactment of what they view to be a flawed and problematic law, the truth is that two states created similar Exchange marketplaces *prior* to the law's enactment. While the Chamber opposed the passage of PPACA because significant elements will fundamentally harm businesses, we do continue to be cautiously optimistic that state-based Exchanges may create new coverage options and strengthen the individual and small group markets. Therefore, as we have in the past, we continue to advocate in favor of the potential these new insurance marketplaces may have to improve choice, facilitate transparency and ideally strengthen the individual and small group insurance markets. However, much remains to be determined with regard to how these Exchanges will function and whether these marketplaces will even succeed. We are mindful that whether these Exchanges augment the current marketplace or become "inherently bad" will depend on how regulations to implement the statute are promulgated.

Exchanges Are Not a Panacea

Similarly, it is important not to oversell the possible success of the state-based Exchanges established under PPACA. Frequently, Administration Officials assert that in purchasing a plan through the Exchange, the enrollee will become part of one, vastly large risk pool. This is not true. In fact, the statute itself contradicts this assertion in two ways:

1. An enrollee is not required to purchase coverage through the Exchange to become part of this larger risk pool;[2] and

2. There is not one risk pool. The pools are bifurcated by market (individual vs. small group)[3] and by issuer (Aetna vs. Cigna).[4]

Specifically, section 1312(c)(1) of PPACA provides that all individuals in the individual market are treated as a single risk pool, regardless of whether coverage is offered inside *or* outside the Exchange. Similarly, section 1312(c)(2) provides that all employees of small employers are also treated as a single risk pool regardless of where coverage is obtained. In addition, the statute clearly indicates that the risk pools in each market will be segmented by the issuer offering plans in which individuals or employees are enrolled. In other words, individuals that purchase plans offered by Aetna in the individual market – whether inside or outside the Exchange and regardless of the type of plan purchased (bronze, silver, gold or platinum) – will be pooled together. The same is true is the small group market.

We urge our partners in the IRS and the Administration to be precise and factually accurate when describing the Exchanges. In order to avoid alienating potential partners with a variety of political opinions, it is important to avoid slanting the facts with "spin" and inaccurate assertions.

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[2] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1312(c), 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1003(b) and (d), 124 Stat. 1029 (2010).
§1312(c)(1)"Individual Market - A health insurance issuer shall consider all enrolless in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, *including those enrollees who do not enroll in such plans through the Exchange*, to be members of a single risk pool."
§1312(c)(2) "Small Group Market – A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, *including those enrollees who do not enroll in such plans through the Exchange,* to be members of a single risk pool."

[3] P.L. No. 111-148, § 1312(c)(1) and (2), 124 Stat. 119 (2010).
§1312(c)(1)"Individual Market - A health insurance issuer shall consider all enrolless in all health plans (other than grandfathered health plans) offered by such issuer *in the individual market*, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool."
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[4] P L. No. 111-148, § 1312(c)(1) and (2).
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Spin in the NPRM

To our dismay, the NPRM's opening paragraph repeats the sales pitch included in previous Proposed Rules issued by the Department of Health and Human Services (HHS) on Exchanges.[5] The NPRM begins by using the new regulatorily created name – "Affordable Insurance Exchanges" – when referring to the statutorily defined Health Care Benefit Exchanges. Typically, regulations begin with a summary that is intended to explain the purpose for promulgating the regulatory material. Often times, this summary includes quotes from statutory provisions, including definitions contained in the law. We find it curious that in the second sentence of this NPRM the IRS repeats a fabricated term and states: "These proposed regulations provide guidance to individuals who enroll in qualified health plans through ***Affordable Insurance Exchanges***."[6] As the IRS must know, the term, "Affordable Insurance Exchanges" is not used in the statute. The law instead refers to "American Health Benefit Exchanges."[7]

Perhaps because HHS created this new name in previous Proposed Rules, all Agencies and Departments must now use this marketing gimmick when referencing the statutorily created American Health Benefits Exchanges. Whatever the rationale for continuing to use this new name, we find the continued use of this new phrase in the regulatory context unusual and inappropriate. While the Chamber certainly hopes that – as the statute states – there will be "affordable choices of health benefit plans"[8] offered in the Exchanges, and that in implementing Exchanges insurance will be more affordable, we urge the IRS to set-aside political rhetoric when promulgating regulations.

The NPRM continues in the Background of the preamble by phrasing goals as facts, in sentences coined in previous HHS Proposed Rules on Exchanges, beginning with the sentence: "Beginning in 2014,… individuals and small businesses will be able to purchase private health insurance through State-based competitive marketplaces called Affordable Insurance Exchanges."[9] The preamble goes on to state *as fact* that, "Exchanges will offer Americans competition and choice;" that "consumers will have a choice of health plans to fit their needs; " and that "Exchanges will give individuals and small businesses the same purchasing power as big businesses."[10] These may be the goal of PPACA's Exchange requirements, but it is by no means clear that those goals will be achieved.

While the Chamber hopes that Exchanges will offer competition and choice, whether they do or not will depend on how successful the state-based Exchanges are and how many plans are offered through these new marketplaces. Whether consumers will have a choice of plans to "fit

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[5] Establishment of Exchanges and Qualified Health Plans; Proposed Rule, 76 Fed. Reg. 41,866-41,927 (July 15, 2011) (to be codified at 45 C.F.R. pts. 155 and 156). Exchange Functions in the Individual Market: Eligibility Determinations: Exchange Standards for Employers, Proposed Rule, 76 Fed. Reg. 51,202-51,237 (August 17, 2011) (to be codified at 45 C.F.R. pts. 155 and 157). [hereinafter referred to as "HHS's Proposed Rules on Exchanges"].

[6] NPRM, 76 Fed. Reg. at 50,931.

[7] P.L. No. 111-148, § 1311(a), (b).

[8] P.L. No. 111-148, § 1311.

[9] NPRM, 76 Fed. Reg. at 50,932.

[10] NPRM, 76 Fed. Reg. at 50,932.

their needs" will depend on how a QHP – which must cover the "essential health benefits" – is structured. In fact, we remain exceedingly concerned that a comprehensive and elaborate "essential health benefit package" will leave consumers with *no* plans that "fit their needs." In trying to protect consumers by mandating that all small group and individual plans cover excessive benefit packages, our fear is that the law and its implementing regulations will offer consumers no-choices, but instead, an array of fully loaded plans that they cannot afford. Finally, it seems a stretch to assert with any credibility at this point that, for example, the Exchanges will in-fact "give small businesses the same purchasing power as large businesses."[11]

To successfully inform and solicit constructive and appropriate feedback from health insurance issuers, states, employers and individuals (all of whom will have varying opinions of the law), we urge the IRS to remain factual in drafting regulations.

ECONOMIC ANALYSIS

The IRS has not provided any assessment of the costs or benefits of the regulatory approach proposed, nor has it presented discussion of any alternative approaches. Instead, the IRS states: "It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required." [12] This is simply incorrect.

Executive Order 12866 states unequivocally that:

> In deciding whether and how to regulate, agencies should assess all costs and benefits of available regulatory alternatives, including the alternative of not regulating. Costs and benefits shall be understood to include both quantifiable measures (to the fullest extent that these can be usefully estimated) and qualitative measures of costs and benefits that are difficult to quantify, but nevertheless essential to consider. Further, in choosing among alternative regulatory approaches, agencies should select those approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity), unless a statute requires another regulatory approach.

The requirement that agencies assess costs and benefits of proposed regulations is not limited to economically significant regulations. The determination regarding the significance (including economic significance) or a regulatory action applies in Section 6 of Executive Order 12688 ("EO 12688") regarding the responsibility of the agency to submit the proposal and economic impact assessment to the Office of Management and Budget, Office of Information and Regulatory Affairs ("OIRA") for review. If an agency's assessment of the costs of a proposed regulation reasonably shows that the annual cost will not exceed the $100 million per year

[11] NPRM, 76 Fed. Reg. at 50,932.
[12] NPRM, 76. Fed. Reg. at 50,938.

threshold that defines economically significant rules under Executive Order 12866 ("EO 12866"), then the agency may be exempt from the requirement to submit the proposal to OIRA for review. OIRA may, however, still exercise its right to review the agency determination on non-economic significance or to review on other grounds.

Regardless of the applicability of OIRA review, under E.O. 12866, the agency is obligated to assess the costs and benefits of the proposed regulations. The assessment should at least show a reasoned basis for the determination that the cost of the NPRM does not rise to the economically significant threshold. In this instance, IRS has provided no data, no discussion and no rationale to justify its determination that the NPRM is not economically significant. The failure of the IRS to provide any assessment of costs and benefits of the NRPM constrains the ability of the public to exercise its right to comment on the NPRM because it omits an important context on which such comments are typically based: the agency's own assessment of the numbers of individuals who will bear costs of compliance with the regulation and the amounts of time and other costs that the typical subject of the regulation will bear.

The NPRM imposes cost burdens on three categories of persons or organizations: The state-based health Exchanges; (2) individuals who apply for the tax credit; and (3) employers whose employees choose to apply for subsidized insurance through the Exchanges rather than enroll in employer-sponsored alternative plans.

1. **State-sponsored health insurance Exchanges.** Under the NPRM, Exchanges must serve as the front-line entity to receive and process individual applications for the insurance premium tax credit. Exchanges will bear the costs of additional staff to handle the inquiries and applications. Exchanges will bear the cost of setting up work flow and information systems to process applications. They will bear substantial costs to train their staff to correctly determine: applicant eligibility for the tax credit, alternative Medicare eligibility, and the affordability and minimum value of employer-sponsored plans. Exchanges will bear the cost of serving as the nexus for communications regarding insurance premium tax credit eligibility with the insured taxpayers who apply for the credit, with the Department of Health and Human Services (and other federal agencies that verify eligibility determinations) and with employers who may be liable for penalties if their employees qualify for the tax credit because employer-offered plans are determined to be unaffordable or to offer inadequate value. The Exchanges will also be responsible for administering an appeals process for taxpayer applicants whose eligibility for the tax credit was denied and for employers whose health insurance plans are found to be unaffordable or to not provide minimum value.

   The IRS website provides a link to a press release that quotes the Congressional Budget Office estimate that 20 million taxpayers annually will benefit from the tax credit.[13] By this estimate, Exchanges will bear the cost of processing and administering more than 20 million tax credit applications annually. Even if the cost

[13] http://www.treasury.gov/press-center/Documents/36BFactSheet.PDF

of processing a tax credit application were a de minimus $5 per case (6 minutes of professional labor), the annual cost of the rule would exceed the $100 million threshold of an economically significant regulatory action. In reality, the cost will likely be many times more. The average case could reasonably require over an hour for a state government professional worker (trained to handle financial information and computations) at $48.09 per hour compensation (according to the latest BLS data for 2011, quarter II). To process 20 million applications on that basis would cost over $961.8 million per year. Since applications will exceed in number the 20 million that CBO estimated would be eligible for the tax credit (because some applicants will be found ineligible), the cost to the Exchanges of processing tax credit applications could reasonably exceed a billion dollars per year. Since workers will need training, equipment, and facilities in which to work, the cost burden that the IRS proposes to impose on the Exchanges could reasonably reach or exceed $2 billion per year. Information technology, such as internet-based information and application portals are not likely to generate significant savings from the likely cost burden, and such systems, even if they ultimately reduce costs in future years, are very costly to develop, test and deploy. The IRS proposal constitutes an enormous unfunded mandate being imposed on state health insurance Exchanges to serve as IRS's de facto agents for administration of the tax credit program. Because all Exchange operating costs must ultimately be recouped through tax levies on the insurance issuers, the enormous cost of the NPRM on the Exchanges will ultimately be reflected in health insurance premiums and be borne by the insured public.

2. **Individuals who apply for the tax credit.** People who seek to participate in the insurance premium tax credit program will be required to expend time compiling required household income and other information and to complete various applications forms, including those needed to determine whether or not they are alternatively eligible for Medicaid. These individuals will also be required to obtain and provide information about any employer-sponsored health insurance plan for which they may be eligible so that affordability and minimum value determinations can be made. Those who are granted eligibility will have further obligations at the end of the tax year to complete and submit to IRS documentation and forms reconciling any advances of premium tax credits received against the aggregate amount for which they are entitled based on final household income results for the year. The process of compiling required information and of completing the necessary applications and tax returns may reasonably total several hours of time. Assuming, minimally, an average of two hours per person, at the $29.98 per hour average compensation per worker rate reported by BLS for the second quarter of 2011, and using CBO's estimate of 20 million eligible, the burden imposed by the proposed regulation on the applicant public would exceed $1.2 billion per year. The amount would be greater in proportion to the excess of applicants over the number found eligible.

3. **Employers.** Employers who offer health coverage to their full time employees are still liable for substantial penalties[14] under the PPACA, if any of their full time employees purchase alternative coverage in the Exchanges and qualify for the insurance premium tax credit because it is determined that the employer's plan is either not affordable in comparison to the employee's household income or because the employer's plan does not meet the minimum value requirements. Under the statutory provisions for tax credit eligibility, an employer-sponsored plan is deemed to be unaffordable if the employee's share of the premium for self only coverage exceeds 9.5% of the employee's household modified adjusted gross income.

   As the IRS appreciates, this provision is challenging for employers. While we appreciate and generally support the safe harbor proposed in Notice 2011—73 and will be filing future comments on this issue, there will still be burdens on employers as they interact with the Exchanges. Affected employers will still have the costs associated with the time and expense it will take for them to avail themselves of the safe harbor's protection. Information to substantiate the safe-harbor exception will need to be provided to the cognizant health insurance Exchange for each applicable case. Further expenses of legal representation and appeals would also be likely and substantial.

   Beyond the safe harbor, employers will also have the burden of interfacing with the Exchanges. Because of the penalties that employers will have to pay if a full time employee receives a tax credit, the employers will have a vested interest in making surre the Exchange's determinations regarding credit eligibility are correct. Employers will also, undoubtedly, have instances where they will need to appeal the Exchange's determination of eligibility. This cost and burden should be quantified by the IRS.

Across the three categories of potentially burdened entities, the IRS's NPRM can be reasonably expected to impose annual costs of at least $3.5 billion per year. This is far in excess of the threshold for OMB review of the proposal under E.O. 12688; it is also in excess of the applicable thresholds for triggering major rulemaking requirements under the Congressional Review Act and under the Unfunded Mandates Act.

Furthermore, IRS has failed to comply with the requirements under E.O. 12866 that it consider and assess costs and benefits for alternative regulatory approaches. The approach proposed by IRS, which imposes on Exchanges the onerous burden of acting as IRS's agent for processing premium tax credit applications, is not the only feasible alternative within the context of the enabling statute. Alternatively, IRS could propose that applicants for the premium tax credit apply directly to IRS using forms, online tools and taxpayer assistance personnel trained and paid directly by IRS. This would shift the administrative burden from the state insurance Exchange entities to the federal government directly. E.O. 12866 does not require agencies to

[14] P.L. No. 111-148, § 1513(b)(1) and (2). Penalties on employers offering coverage which is determined to be unaffordable or does not constitute minimum essential coverage will be $3,000 per full time employee receiving a tax credit not to exceed the product of $2,000 times the total number of full time employees.

account for cost burdens that the federal government imposes on itself. This approach would also avoid the impact of the cost being passed forward to increase overall health insurance premiums. Given IRS's existing infrastructure, the experience of its staff in taxpayer assistance and its greater experience in automation of the tax compliance system, this alternative approach may result in a lower overall cost to society for application processing and would reduce the likelihood of eligibility determination errors.

We appreciate the need for stakeholders to consider this NPRM. Therefore, requesting that the IRS withdraw this NPRM and issue a more complete and appropriate proposal would harm states, issuers and employers even further. Because of the time constraints and the importance of cost analysis information which is heretofore missing, we ask the IRS to publish a separate regulatory document outlining the appropriate regulatory cost analysis and alternative approaches as required under the E.O. 12866 and other applicable regulatory impact assessment requirements.

RECOMMENDATIONS

IRS Verification, Appeals, Penalty Assessment

The agencies should consolidate the information reporting, the appeals processes, and the assessment of employer tax penalties within a single federal entity, preferably the Department of Treasury and the IRS. The Department of Treasury should use its regulatory authority generally to interpret the statute in ways that allow for practical and workable administration of employer benefits and provide predictability of potential penalties for employers, including how and when an employer will be notified of its total liability for federal tax penalties for a given year.

The determination of individual eligibility for premium insurance tax credits or cost-sharing subsidies by state insurance Exchanges should be a separate and distinct process from the subsequent verification of individual household income data and determination of employer penalty assessments by Treasury and the IRS. This is necessary because the Exchanges will make eligibility determinations in real-time based in part on self-reporting by the individual of their household income and employment status. Reporting of household income may often be incomplete. Even if an attempt is made to verify household income with the IRS during the coverage year, it likely will be based on prior year tax returns and might not accurately capture current household income. Treasury and IRS will not be able to verify accurately individuals' household income until their annual individual taxes are filed, which may occur after the coverage year.

It is critical that the IRS verify individual eligibility for a premium tax credit based on household income once the individual's tax return has been filed for the previous year. Verification by the IRS is necessary because this is the standard by which employers will be held liable for penalties under the law and is information that cannot be known to an employer and often may not be truly verifiable in real time by Exchanges**.**

Furthermore, it is also imperative that employers are able to utilize the look-back methodology to determine and report full-time employee status for employees receiving premium tax credits.

End-of-year reporting by employers on their full-time employees, combined with IRS verification of household income based on individual tax filings, will allow for more accurate assessment of employer penalties.

A potential reporting process for Treasury and the IRS could include the information required to make an accurate assessment of employer penalties for those employees receiving tax credits for Exchange coverage as well as:

1. Prospective reporting on general plan information regarding minimum essential coverage provided by an employer;
2. Retrospective or end-of-year reporting on specific employee full-time status and coverage; and
3. IRS verification of household income based on individual annual tax filings.

Finally, given the need to have complete and accurate information to appropriately assess any employer penalty, employers should be assessed penalties on an annual basis, after all employer and employee verifications are complete. Additionally, Treasury should coordinate any penalty assessment that captures total liability for an employer on a given year with an employer‘s annual corporate tax filing and make clear that IRS traditional appeals processes are available to employers to engage with the IRS to ensure the accuracy and appropriateness of any assessments.

Precise Examples

While the multiple example calculations in the NPRM were helpful in clarifying the formula and rules for computing the premium assistance credit amount under various circumstances, there were some inconsistencies and errors in the way the formulas were followed.

In some instances, decimal points were carried over when annual amounts were divided by 12 to arrive at the monthly amount and then multipled by the number of months covered, other times the monthly figure was rounded before it is multipled by the number of months covered. While not of tremendous import, it does make walking through these complicated calculations even more difficult.

In example 6 (iii) on page 50947, the household income of $75,000 is multiplied by the applicable 9.5 percent to equal $7,125 as the contribution amount. This contribution amount is subtracted from the benchmark plan premium of $14,000 and should equal $6,875 for the total advance credit. Instead, the NPRM incorrectly states that the total advance credit is $6,975. This errors make it even more confusing when trying to follow the formulas.

CONCLUSION

The U.S. Chamber of Commerce is optimistic about the development of state-based Exchanges as a mechanism for expanding access to affordable coverage. We urge the IRS to continue to work carefully, pragmatically and cooperatively with the numerous stakeholders and we look forward to continuing to work together in the future.

Sincerely,

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