BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

January 21, 2014

The Honorable John Koskinen
Commissioner of Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Submitted via e-mail

RE: Draft Form 8963 (and Instructions): Reporting for the Health Insurance Tax

Dear Commissioner Koskinen:

The Blue Cross and Blue Shield Association ("BCBSA") appreciates the opportunity to provide comments on Draft Form 8963, Report of Health Insurance Provider Information and the Instructions for Form 8963.

BCBSA is a national federation of 37 independent, community-based, and locally-operated Blue Cross and Blue Shield Plans ("Plans") that collectively provide health care coverage for more than 100 million – one in three – Americans. Blue Cross and Blue Shield Plans offer coverage in every market and every ZIP Code in America. Plans also partner with the government in Medicare, Medicaid, the Children's Health Insurance Program, and the Federal Employees Health Benefits Program.

BCBSA appreciates the opportunity to provide comments regarding the draft form and instructions. The fee imposed by section 9010 of the Affordable Care Act ("ACA") (referred to as the "health insurance tax" or "HIT") is unique among taxes imposed by the Federal government. Unlike all the other taxes of which we are aware, the fee is imposed not as a percentage of the taxpayer's revenue, sales, income or some other measure, nor is it imposed as a flat dollar amount multiplied by the number of covered lives, property sold, or policies issued. Instead, an aggregate amount of tax is imposed upon the industry as a whole, with each taxpayer within the industry being allocated a portion of the total fee to be collected based on the ratio of the premiums underwritten by the taxpayer to total premiums underwritten by all taxpayers required to pay a portion of the fee.

Because of this, entities that pay the HIT are very interested in the process being transparent and ensuring that other entities that potentially are required to pay HIT accurately report their premiums on which the HIT is based. Additionally, these entities also want a transparent process on what entities are claiming an exemption from the HIT. The majority of our comments are focused on these issues.

Our key recommendations are as follows:

1. **Medicare and Medicaid Companies Claiming Exemption from Paying HIT –** Currently it does not appear that Medicare and Medicaid companies that are claiming to be exempt from paying the HIT are required to file Form 8963 or any other type of form or filing. BCBSA recommends these entities file Form 8963 so that the IRS and other entities subject to the fee are aware of whom these entities are and that they are claiming to be exempt from paying the HIT.

2. **Standardize Requirements for Reporting "Direct Premiums Written" –** The methodology for reporting "direct premiums written" should be standardized as much as possible to prevent entities from using the amount from the source document that results in them having the lowest "direct premiums written," thus requiring other issuers to pay more.

3. **Add a Column Where Entities Can Show any Adjustments to the "Direct Premiums Written" Amount –** In some cases the amount reported in the "Direct premiums written" column of the SHCE, MLR Form or other equivalent forms will include, or possibly exclude, premium that is subject to the HIT and there needs to be a transparent way for an entity to make adjustments to this number.

Attached are our detailed comments and recommendations. We appreciate your consideration and look forward to continuing to work with the Treasury Department and the IRS on implementation issues related to the ACA. If you have any questions, please contact Richard White at (202) 626-8613.

Sincerely,

Justine Handelman
Vice President, Legislative and Regulatory Policy
Blue Cross and Blue Shield Association

cc: Yvette Lawrence, R. Joseph Durbula, Charles J. Langley, Jr.

BCBSA Detailed Comments and Recommendations on the Reporting Form for the Health Insurance Tax

1. Medicare and Medicaid Companies that are Claiming to be Exempt from the HIT Should File a Report

Issue:

The form and instructions do not appear to require any reporting by entities claiming to have 80% or more of their business in Medicare, Medicaid, and SCHIP who, if that is the case, are exempt from paying the fee. If these entities do not file some type of form or filing, the IRS and other entities that are subject to the fee may be unaware of the existence of these entities and whether they are claiming to be exempt from the HIT or elected not to file to avoid the fee.

Recommendation:

BCBSA recommends that all entities that potentially are subject to the HIT be required to file Form 8963. Column J of Form 8963 and the instructions could be modified to allow these entities to claim to be exempt from the fee similar to how 501(c)(3), (4), (26) or (29) entities report the reduced amount of their premium that is subject to the fee.

Rationale:

The fee imposed by section 9010 of the Affordable Care Act ("ACA") is unique among taxes imposed by the Federal government. Unlike all the other taxes of which we are aware, the fee is imposed not as a percentage of the taxpayer's revenue, sales, income or some other measure, nor is it imposed as a flat dollar amount multiplied by the number of covered lives, property sold, or policies issued. Instead, an aggregate amount of tax is imposed upon the industry as a whole, with each taxpayer within the industry being allocated a portion of the total fee to be collected based on the ratio of the premiums underwritten by the taxpayer to total premiums underwritten by all taxpayers required to pay a portion of the fee.

The unusual means by which this fee is imposed presents a unique concern for those subject to it, because the taxpayer is unable to calculate the amount of fee they owe without information provided to the IRS by other taxpayers. Although taxpayers often rely on information returns to prepare their tax returns, the information returns merely summarize information already available to the taxpayers via their own business records, paystubs, or other means. In contrast, taxpayers subject to the HIT are unable to determine their allocable portion of the total tax imposed without information reported by other taxpayers subject to the tax. Indeed, the drafters of section 9010 recognized the unusual nature of this tax by specifically exempting information reported to the IRS for purposes of calculating each taxpayer's allocable portion of the HIT from the confidentiality provisions of Code section 6103. ACA § 9010(g)(4).

The preamble to the final Treasury Regulations governing the HIT also recognize the due process concerns presented by the manner in which the HIT is calculated and assessed. To provide taxpayers subject to the HIT with a means to verify the correct allocation of the tax, the IRS has agreed to make the information reported on Form 8963 available for public inspection. 78 Fed. Reg. 71476, 71485 (Nov. 29, 2013). Although BCBSA supports the

decision to make the information reported on Form 8963 available to taxpayers that wish to verify the calculation of their portion of the HIT, the final Treasury regulations and draft From 8963 leave a critical gap that will make it impossible for a taxpayer that disclosed its market participation to ensure that all other covered entities under the statute have been allocated a portion of the HIT.

Section 9010(c)(2)(C) provides an exclusion from the definition of covered entities that applies to certain types of health insurance providers that derive 80% or more of their gross revenue from Medicare and Medicaid. Unlike the exclusions in sections 9010(c)(2)(A), (B), and (D), this exclusion is determined under a "cliff" type of testing approach that may apply in some years and not in other years. To ensure that health insurance providers that are excluded from the definition of covered entity under section 9010(c)(2)(C) have properly considered whether they qualify for the exclusion in a given year, the final regulations and draft Form 8963 should be amended to require the entity to certify that it satisfies the 80% requirement for the current year.

If these entities that are potentially subject to the HIT do not certify their status, the IRS and health insurance providers that are subject to the fee mayl not know that these entities exist and will have no means of knowing whether they are exempt from paying the HIT or just merely failed to file. Because of the way in which the HIT is imposed, health insurance providers that are subject to the fee have a legitimate interest in knowing the identity of all entities potentially subject to the fee, including those claiming to be exempt under section 9010(c)(2)(C). Requiring entities that claim to be exempt from the HIT because 80% or more of their business is in Medicare, Medicaid, and SCHIP to affirmatively attest to this fact provides transparency and facilitates a process of more effective enforcement.

Although entities not subject to the HIT under section 9010(c)(2)(C) are not covered entities required to report net premiums under section 9010(g)(1), the IRS is nonetheless authorized by statute to require, by regulation, such entities to file a report certifying their exempt status. Section 9010(i) includes a broad grant of authority that directs the Secretary to promulgate "such regulations as are necessary or appropriate to prevent avoidance of this section, including inappropriate actions taken to qualify as an exempt entity under subsection (c)(2)." Recognizing that entities that are exempt from the HIT will have a competitive advantage in the market, Congress sought to prevent potential abuses by authorizing Treasury and the IRS to prescribe regulations that ensure all health insurance providers competing in the market comply with the requirements of law and do so in the light of day. The language of section 9010(i) is sufficiently broad to compel reporting by all health insurance providers potentially subject to the HIT to verify the proper reporting of their net premiums or actual qualification for the exception.

The preamble to the final regulations recognizes the authority granted to Treasury and the IRS to issue regulations designed to curb efforts to avoid the HIT by claiming exemption under section 9010(c)(2). Specifically, the final regulations revised the proposed regulations to include instrumentalities of the government as excepted under section 9010(c)(2)(B) in recognition that the statute provides an exception for "*any* governmental entity." 78 Fed. Reg. 71479–80 (emphasis added). However, the preamble also provides that if the IRS determines that government instrumentalities are entering the commercial market and competing with commercial insurers, it may exercise the authority granted under section 9010(i) to address that concern, presumably by requiring such entities to report and pay an allocable portion of the HIT. 78 Fed. Reg. 71480.

The IRS's mission is to "[p]rovide America's taxpayers top quality service by helping them understand and meet their tax responsibilities and enforce the law with integrity and fairness to all."[1] By permitting potential market participants to go unchecked, those participants that voluntarily report under the HIT rules are unfairly prejudiced, and the IRS fails to adhere to its statement mission.

Requiring an annual certification of exempt status for entities claiming to satisfy the 80% requirement would ensure that health insurance providers that determine they are near the required threshold do not decide to avoid filing by assuming that it is satisfied in each year. Such an action would be precisely the type of avoidance that concerned Congress when it enacted section 9010(i). An annual certification would require such entities to self-identify to the IRS so that the IRS could select them for examination to verify they are truly exempt from the fee. In addition, the certification would serve as a powerful deterrent against efforts to avoid the fee by simply not filing. Further, each covered entity has a right to know which entities are claiming the exemption because the failure to accurately report by those entities would directly result in an increase in the amount of the HIT owed by every other health insurance provider. Moreover, perhaps the most effective check on compliance is the knowledge that other market participants will know reporting details and which entities have claimed exemption. If the final regulations are not amended to require such certification, the due process rights of covered entities may be violated because they will have no means of verifying the accuracy of the IRS calculation of their allocable portions of the HIT.

Given the legitimate interest of all health insurance providers required to pay a portion of the fee and the due process concerns presented by the unusual process by which each entity's portion of the fee is determined, BCBSA recommends that the IRS amend the final regulations and Form 8963 to provide that an entity claiming to be exempt under section 9010(c)(2)(C) certify their exempt status each year under penalties of perjury.

2. Standardize Requirements for Reporting "Direct premiums written" in Column (f) as Much as Possible

Issue:

The methodology for reporting "Direct premiums written" should be standardized as much as possible to prevent entities from using the amount from the source document that results in them having the lowest "direct premiums written". This standardization results in a more equitable distribution of the amount each entity pays and reduces the ability of entities to game the system, thus paying a lower share of the HIT, which in turn results in other entities paying a higher share of the HIT.

[1] Internal Revenue Service, Mission Statement, *available at* http://www.irs.gov/uac/The-Agency,-its-Mission-and-Statutory-Authority (last visited Jan. 17, 2014). The prior mission statement was amended following the 1998 IRS Restructuring and Reform Act to, among other things, include the words "fairness *for all.*" (Emphasis add).

Recommendation:

BCBSA recommends that the language for "Direct premiums written" on page 3 be modified as follows:

(f) Direct premiums written.

Related acronyms:

- Supplemental Health Care Exhibit (SHCE)
- Center for Consumer Information and Insurance Oversight (CCIIO), and
- Medical Loss Ratio (MLR) Annual Reporting Form (MLR Form).

For each single-person covered entity or member of a controlled group, the source data for determining direct premiums written is the SHCE~~,~~ or CCIIO MLR form~~.~~ ~~or~~ If the entity does not file either of these forms they may use the amount from any equivalent form required by the state of domicile of the entity (or member) or by federal law.

References to the NAIC SHCE and the CCIIO MLR Form in these instructions are ~~solely~~ for ~~your convenience in~~ identifying the premium information required for this report.

~~Generally, i~~ If the entity files…

If the entity does not file a~~n~~ SHCE with the NAIC or an MLR Form with the CCIIO, ~~or those forms do not contain the relevant data for determining all of the direct premiums written for health insurance for United States health risks of an entity (or member),~~ enter comparable direct premiums written information …

Rationale:

Standardization for determining what to report in Column (F), "Direct premiums written", results in a more equitable distribution of the amount each entity pays and reduces the ability of entities to game the system by choosing an amount from a form with the lowest direct premiums written, thus paying a lower share of the HIT which in turn results in other entities paying a higher share of the HIT. If entities file a SHCE or MLR Form they should use the amounts from those forms and make any adjustments in a new, separate column as recommended below.

3. Add a Column Where Entities Can Show any Adjustments to the "Direct premiums written" Amount

Issue:

In some cases the amount reported in the "Direct premiums written" column of the SHCE, MLR Form or other equivalent forms will include, or possibly exclude, premium that is subject to the HIT. For example, in some cases the "Direct premiums written" column for some of our Plans includes premiums associated with Medicaid long-term care coverage.

Recommendation:

BCBSA recommends that an additional "Adjustments to direct premiums written" Column be added after Column (f) and the formula in Column (i) be adjusted accordingly. Entities should be required to include an explanation of any adjustments included in this column and these should also be publicly available.

Rationale:

In some cases the amount reported in the "Direct premiums written" column of the SHCE, MLR Form or other equivalent forms will include or possibly exclude premium that is subject to the HIT. For example, in some cases the "Direct premiums written" include premiums for Medicaid long-term care coverage for some of our Plans. Entities need a way to make these adjustments and it should be done in a transparent manner so that the IRS and other entities understand what adjustments an entity is making to "Direct premiums written". As stated above, the reporting for the HIT is unique from reporting for the vast majority of other taxes as it is a fixed dollar amount that is allocated between various entities based on their reported premium. Because of this, entities that pay the HIT are very interested in the process being transparent and ensuring that all entities that are subject to the HIT report their premiums accurately. Showing the adjustment, along with the accompanying explanation, provides the necessary transparency both the IRS and other entities need to ensure that the correct "Direct premiums written" amount is being reported.

4. Eliminate the Requirement to Obtain Consent from all Control Group Members that are Required to be Listed

Issue:

In the middle of the first column of Page 2 of the instructions it indicates that the designated entity is responsible for:

- Obtaining consent from all control group members that are required to be listed on schedule A of this form, and
- Providing (to the IRS upon request) the consent obtained…

This requirement is unnecessary.

Recommendation:

BCBSA recommends that the requirement to obtain consent from all control group members that are required to be reported be eliminated.

Rationale:

The requirement to obtain consent from all control group members that are required to be reported appears unnecessary and is not required by statute. Additionally, it raises the

question of what the designated entity would do if they could not obtain consent as they are required to report the "Direct premiums written" for all control groups that are required to be listed. Since obtaining consent is not required by statute, the language referencing this requirement in the instructions should be eliminated.

5. Add Instructions on How an Entity would Correct a Mistake in their Filing after the HIT Payments have been Finalized

Issue:

Unlike most other tax forms there does not appear to be a way for an entity to file a corrected form after the Error Correction Report is filed if they later find a mistake in their initial filing.

Recommendation:

BCBSA recommends that the instructions be modified to allow an issuer to file a corrected Form 8963 if they later find a mistake. If this Form is filed after the HIT payments for entities have been finalized the entity would include the difference in the next years Form 8963 in the "adjustments" column recommended above.

Rationale:

It is inevitable that entities will find mistakes in their Form 8963 after submission. Entities need a way to voluntarily correct these mistakes as opposed to them later being found potentially subjecting the entity to punitive action. Allowing entities to correct the Form 8963 and include the difference in the next years Form 8963 appears to be a way to allow entities to comply with the requirements of the law and allow for an equitable division of the HIT among all entities.