STATEMENT OF THE ALLIANCE TO FIGHT THE 40

ON

EMPLOYER-SPONSORED HEALTH COVERAGE

SUBMITTED FOR THE RECORD OF THE HEARING

ON

"THE TAX TREATMENT OF HEALTH CARE"

BEFORE

THE COMMITTEE ON WAYS AND MEANS

ON

APRIL 14, 2016

Introduction

I. Introduction

The Alliance to Fight the 40 welcomes the opportunity to provide comments for the record of the April 14, 2016 Committee on Ways and Means ("Committee") hearing on the "Tax Treatment of Health Care."[1]

The Alliance to Fight the 40 ("the Alliance") is a broad based coalition comprised of private sector and public sector employer organizations, consumer groups, patient advocates, unions, businesses and other stakeholders that support employer-sponsored health coverage. This coverage is the backbone of our health coverage system and protects over 175 million[2] Americans across the United States. The Alliance seeks to repeal the 40% tax on employee health benefits to ensure that employer-sponsored coverage remains an effective and affordable option for working Americans and their families.

Discussion

II. Background on Employer Sponsored Insurance

[1]Committee on Ways & Means Hearing Advisory: http://waysandmeans.house.gov/wp-content/uploads/2016/04/20160414HL-Advisory.pdf

[2]U.S. Census: https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf Table 1

Over 175 million Americans depend on their employers for health coverage, including retirees, low- and moderate-income families, public sector employees, non-profit organizations and small-business owners. 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 Affordable Care Act's looming 40% tax on employer-provided health coverage, which treats such programs only as expenditures that help to trigger the tax.

Employers also provide valuable assistance to employees regarding their health coverage, including assistance selecting the best health plans, navigating complex claims questions, choosing higher quality providers and other assistance. Changes that undermine or weaken the employer-sponsored insurance market, like the "Cadillac Tax," will force more people to the individual market for insurance, a market that is not as efficient, not as innovative, and that does not provide assistance for individuals to deal with complex claims questions.

Employer-sponsored insurance is more cost-effective than government health insurance programs. 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.[3] "Employers pay significantly lower health costs per covered life than government programs," partly because of "the significant amount of improper payments that are still made," the study concluded. "Large employers spend considerable time and resources studying trends within their health plans and taking actions to address the underlying causes of what is driving their cost increases," and "have adopted a consumer-oriented approach that more actively engages their employees to seek out high-quality, low-cost health care.… If government policies move people from programs that cost less per individual to ones that cost more per individual, that could mean that we will be spending more on health care than currently anticipated over the next decade.[4]" Similarly, the collective purchasing power associated with employer-sponsored coverage, brings economies of scale that cannot be replicated in the individual market.

As the Committee continues to examine the tax treatment of employer-sponsored insurance, the Alliance hopes that some of the key "lessons learned" from the 40% tax on benefits (the so-called "Cadillac Tax") will inform its policy development. As discussed below, because the employer and employee share of premiums represents a significant portion of the costs that result in triggering the "Cadillac Tax," if the Committee explores options that rely on premium caps or premium thresholds, these proposals may unintentionally cause similar market disruption and harm to working Americans and their families.

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[3] American Health Policy Institute: http://www.americanhealthpolicy.org/Content/documents/resources/AHPI_STUDY_Cost_Per_Covered_Life.pdf.

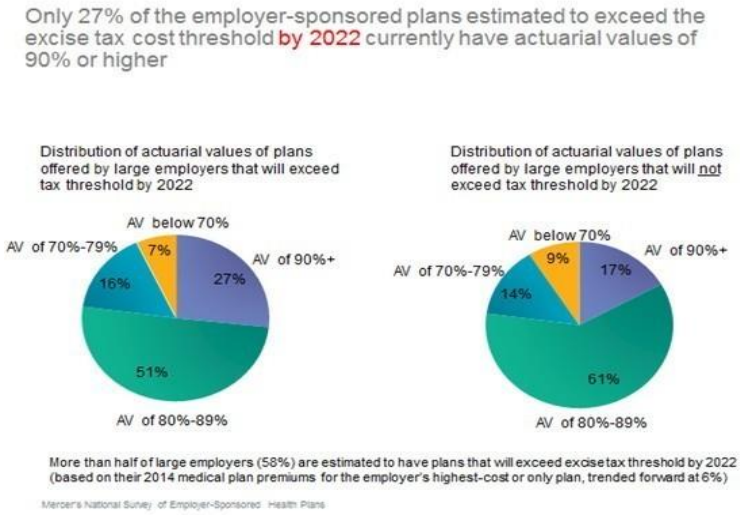
[4] American Health Policy Institute: http://www.americanhealthpolicy.org/Content/documents/resources/AHPI_STUDY_Cost_Per_Covered_Life.pdf

Employer-sponsored benefit plans are the primary source of health coverage for Americans. Even those who hope to increase the portability of health coverage must recognize the efficiency and quality in the existing employer-based health market. We hope that as the Committee explores new policy ideas that those ideas will avoid disrupting the elements of the current system that most agree work well.

III. Repeal the 40% "Cadillac Tax" on health benefits

Impact Far Beyond 'High-Priced' Plans. The ACA's 40% excise tax on employer-provided coverage – whose effective date was delayed from 2018 to 2020 by last year's omnibus spending agreement – would disrupt the health care marketplace by shifting costs to workers and impact all employer plans, contrary to the notion that only "gold-plated" high-value plans would be affected. The tax will apply to plans sponsored by both private- and public sector employers and nonprofit organizations. It penalizes employers that have employees with greater health care needs, workforces with higher numbers of older workers, and employers based in higher-cost areas. The tax will also affect families 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, the clergy, and retirees.

The chart graphic displayed here makes clear that it is the population coverage of a plan -- not the relative richness of the benefits -- that determines whether a particular plan hits the tax. A plan in a higher cost area or with older or sicker workers will hit the tax earlier than a much more generous plan in a lower cost area or with a younger work force.



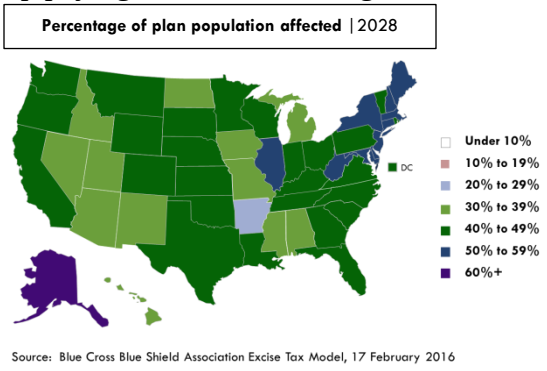
Greater Cost-Sharing. Recent studies by the American Health Policy Institute[5] and Aon Hewitt[6] indicate that significant numbers of employers are modifying their plan designs to avoid paying the 40% tax. Employee deductibles, cost-sharing and co-pays are increasing as employers modify their health plans to avoid triggering the 40% tax. Increasing the amount an employee pays is the main way to decrease the A/V of the plan.

[5] 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

[6] Aon Hewitt, "New Aon Hewitt Survey Shows Majority of Companies Taking Immediate Steps to Minimize Exposure to Excise Tax," October 16, 2014, http://www.prnewswire.com/news-releases/new-aon-hewitt-survey-shows-majority-of-companies-taking-immediate-steps-to-minimize-exposure-to-excise-tax-279402582.html

Increased cost-sharing will force workers to pay more for their health care without a corresponding enhancement of the value of the coverage for which they are paying. In addition, higher cost-sharing leads to lower and middle class insureds unable to actually 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. The workers of those employers that contemplate paying the tax can expect their already high share of the premiums to rise even higher. And under the punitive structure of the tax's thresholds, plan features that are designed to promote better health and reduce costs – such as employee assistance plans, on-site health clinics, flexible spending accounts, health reimbursement arrangements, and both employer and employee pre-tax contributions to health savings accounts – are 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.

Penalizes Employers for Factors Beyond Their Control. The 40% excise tax also unfairly 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 premiums, 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].



Source: Blue Cross Blue Shield Association Excise Tax Model, 17 February 2016

Geographic Disparities. Notably, people who live in higher-cost areas would pay more of the 40% 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% variation in premium. For example, a plan that would cost $9,189 in one area would cost $15,556 elsewhere[8]. The report also demonstrated that the 40% tax's age and gender adjustment features fail to compensate for the impact those factors have on premiums when combined with a high-cost geographic area and/or lower provider discounts.

President Obama's 2017 budget proposal identified the unfair geographic disparity caused by the tax and suggested a modest geographic adjustment. However, geographic disparities are just one of many flaws in the application of this tax. Since, as noted above, many features of employer-sponsored coverage (e.g. on-site clinics, flexible spending arrangements, etc) are included in the tax, tying an adjustment solely to the geographic differences in premiums, alone, does not address the numerous factors that are considered in determining whether the tax is triggered. And the proposal adds enormously to the complexity of

[7] Economic Policy Institute, "Increased Health Care Cost Sharing Works as Intended. It burdens patients who need care the most," May 8, 3013, 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

calculating the tax. The administration has also requested a study of the impact of the 40% tax on sick workers, but a study will not address the inequitable impact of the tax on plans that are expensive simply because they cover a large number of women, older or disabled employees.

Additionally, because the tax is indexed to the 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, 82% of employers already expect their plans will be affected by the tax within the first five years of implementation.[9]

IV. Measures to Reduce Health Care Costs

Instead of trying to raise revenue for the ACA with the blunt instrument of the 40% tax on employer coverage, Congress should focus on strategies to reduce the true cost of health care, such as delivery system reforms. These reforms will require improving meaningful price transparency and enhanced consumer tools and communication. Employers have been driving innovative delivery system reforms, experimenting with accountable care organizations (ACOs) and patient-centered medical homes (PCMH); innovative payment reforms like bundled payments, referenced based pricing and value based purchasing. Efforts related to systematically measuring and reporting quality; reducing health care fraud and abuse; simplifying administrative burdens at providers and insurers; adopting more health information technology; and programs that improve population health through a focus on at-risk populations and those with high needs and high costs offer more hope than tacking a new tax on top of an already costly product.

Administrative costs make up over a third of U.S. health care spending.[10] According to the Institute of Medicine, the United States spends $361 billion annually on health care administration — more than twice our total spending on heart disease and three times our spending on cancer.[11] Implementing the convoluted "Cadillac Tax" will only add complexity, cost and administrative burden to the system.

V. Capping the Tax Exclusion suffers many of the same defects as the "Cadillac Tax"

Capping or eliminating the current employee exclusion of employer-sponsored health benefits from income and payroll taxes, as some have proposed, would amount to a significant new tax on workers. This change would require workers to pay income and payroll taxes on employer-provided applicable coverage above the cap. This is not an effective tool to reduce health care costs in a way that still protects the health care needs of working Americans and their families.

As the Committee examines the tax treatment of employer-sponsored health coverage, the Alliance recommends that it consider key concerns related to lessons learned from the "Cadillac Tax." Because the employer and employee share of premiums represents a significant portion of the costs

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[9] Towers Watson: https://www.towerswatson.com/en/Press/2014/09/nearly-half-us-employers-to-hit-health-care-cadillac-tax-in-2018-with-82-percent-by-2023

[10] New England Journal of Medicine: http://www.nejm.org/doi/full/10.1056/NEJMsa022033.

[11] National Center for Biotechnology Information: http://www.ncbi.nlm.nih.gov/books/NBK53942/.

that result in triggering the "Cadillac Tax," if the Committee explores options that rely on premium caps or premium thresholds, these proposals may unintentionally cause similar market disruption and harm to working Americans and their families. Any new policy proposals should not disrupt elements of the current system that most agree work well.

- **The "Cadillac Tax" increases taxes on middle income families and retirees.** Middle income families and retirees will bear the brunt of the "Cadillac Tax," which increases costs to employees and employers without lowering the actual cost of health care. In order to avoid paying the tax, companies are already being compelled to shift the burden to employees in the form of higher deductibles, increased co-pays and thinner benefits. Proposals that directly tax employees could mistakenly recreate this problem. Joseph Antos, Ph.D., Wilson H. Taylor Scholar in Health Care and Retirement Policy for the American Enterprise Institute, in his testimony before the 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."

- **Reducing incentives to participate in employer coverage could increase government spending.** Employers contribute on average about 70% of the cost of employer-sponsored health care coverage. This is a significant benefit to the 175 million individuals receiving employer-sponsored coverage and it reduces the need for government subsidies to help individuals afford health care. 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.

- **Taxing health care premiums has a negative impact on women, individuals with high cost health conditions, older workers, families, early retirees and small businesses**. The cost of plans varies greatly based on utilization and the insured population. Consequently the tax is expected to have a punitive impact on employers that cover greater numbers of higher cost populations like women (who actuarially have higher costs), individuals with expensive chronic health conditions or who suffer catastrophic health events, older workers, families, early retirees and small businesses.

- **Taxing health care premiums does not directly affect the unit cost of health care**. While taxing health benefits may decrease plan utilization 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.

- **Taxing health care premiums targets families**. The Economic Policy Institute[12] has estimated that a number of proposals to cap or eliminate the exclusion and replace it with tax credits would be "more favorable towards (disproportionately advantages or disadvantages to a lesser degree) single plans over family plans. And, those with family plans will see a higher share of their premiums taxed than their single counterparts."

- **Taxing health care premiums leads to geographic disparities.** As noted above, health care costs vary across the country and within states. This means individuals living in higher cost areas would pay more tax for the same level of health coverage as individuals living in lower cost areas. So curtailing the value of the employee exclusion for health coverage would have the same geographic disparities as the "Cadillac Tax" displays.

Finally, the Congressional Budget Office (CBO) estimated that one alternative, a cap on the exclusion of $7,000 for individual coverage and $17,000 for family coverage, would cause 6 million fewer people to have employment-based coverage than current law.[13]

VI. Conclusion

As the Committee considers different proposals for the tax treatment of health care, we urge lawmakers to seek repeal of the forthcoming 40% excise tax on employer-sponsored health coverage. The tax endangers an employer-based health system that is demonstrably more efficient and cost-effective than other alternatives. The tax will force employees to bear more of the costs of their policies regardless of their ability to do so, a trend that is already emerging as employers prepare for the tax by increasing co-pays and other out-of-pocket expenses. Simply substituting other taxes on employer-sponsored insurance could produce some of the same damaging results, disproportionately affecting retirees, women, older workers, small businesses, and families that have employer-sponsored health coverage. Policymakers should focus on reforms to the health care delivery system as a way to achieve true savings and eliminate waste.

Thank you for the opportunity to share our concerns. We look forward to working with the Committee throughout your policy development.

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

[12] Economic Policy Institute : http://www.epi.org/files/2013/increased-health-care-cost-sharing-works.pdf

[13] CBO, "Health-Related Options for Reducing the Deficit: 2014 to 2023," December 2013,page 63, https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44906-HealthOptions.pdf