TAX TREATMENT OF HEALTH CARE

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

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TAX TREATMENT OF HEALTH CARE

THURSDAY, APRIL 14, 2016

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to notice, at 10:00 a.m., in Room 1100, Longworth House Office Building, the Honorable Kevin Brady, [Chairman of the Committee] presiding.

[The advisory announcing the hearing follows:]

WAYS AND MEANS
CHAIRMAN KEVIN BRADY

Chairman Brady Announces Committee Hearing on the Tax Treatment of Health Care

House Ways and Means Committee Chairman Kevin Brady (R-TX) today announced that the Committee will hold a hearing on "The Tax Treatment of Health Care." **The hearing will take place Thursday, April 14, in Room 1100 of the Longworth House Office Building, beginning at 10 AM.**

Oral testimony at this hearing will be from the invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

Details for Submission of Written Comments:
Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, http://waysandmeans.house.gov, select "Hearings." Select the hearing for which you would like to make a submission, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Thursday, April 28**. For questions, or if you encounter technical problems, please call (202) 225-3943 or (202) 225-3625.

Formatting Requirements:
The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and

submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available at http://www.waysandmeans.house.gov/.

Chairman BRADY. The Committee will come to order.

Welcome to the Ways and Means Committee hearing on the tax treatment of health care.

It is only fitting that this important discussion falls during Tax Week, a time when Americans are reminded how unfair and overly complex tax policies are hurting workers, job creators and families.

We can all agree Americans deserve better, which is why we are working toward solutions to make our Tax Code simpler, fairer, and flatter for everyone. Today we will examine proposals to reform the Tax Code to help all Americans access more affordable health care, including proposals to create a new fair tax credit and encourage greater use of consumer driven health care models to spur innovation and lower costs.

The Tax Code is full of provisions affecting the quality and the cost and the accessibility of health care for millions of Americans. Currently the Tax Code contains over a dozen health related tax expenditures, all intended to help more Americans access health care by subsidizing many of the costs.

Unfortunately, using the Tax Code in this way also can have the opposite effect, increasing premiums and costing taxpayers trillions of dollars in the process. Let us consider the largest health tax expenditure for employer-sponsored health insurance plans, commonly referred to as the employer exclusion.

Congress incorporated this high popular tax break in the Tax Code decades ago so that employers could attract and keep workers during a time of wage freezes. At the time this provision was created, the labor market and the health insurance market both looked very different.

Today, more than 150 million Americans under the age of 65 get their health insurance through their employer. Our conversation today is about how we can preserve and modernize this important

tax incentive at work while also expanding tax benefits to Americans who seek additional health care choices.

And perhaps the crux of this hearing specifically is how can we make this nearly 100 year old tax break more flexible so Americans can have a new, modern option to choose a health plan that fits their needs and can travel with them to a new job, to start their own business, or to raise their family at home.

Some consumers today feel confined by their employer-sponsored arrangement because they are required to choose a plan from options determined by their employer rather than getting to shop around for the plan that best meets their needs.

Others who select health insurance through their employer feel trapped in their current job because they do not want to lose the coverage they like. The Tax Code compounds those concerns because this pre-tax benefit is tied to the job, not to the person. This approach limits options, is unfair to those who do not get their health insurance through their job, and creates what many economists call job lock.

Additionally, the employer exclusion is a contributing factor to our country's stagnant wage growth. That is because the Tax Code incentivizes putting a greater share of compensation toward nontaxable health plans and less to taxable paychecks. So as health care costs rise, employers divert increases in salaries to health care at the expense of take-home pay.

Evidence also suggests that the employer exclusion leads to higher health care costs for all Americans. Oftentimes someone who participates in an employer-sponsored health plan does not face the act and increasingly expensive cost of care. This encourages beneficiaries to consume more health services, including services they may not even need, driving up overall costs.

I cannot emphasize enough the employer-sponsored health insureds' market is a vital one. The question we must wrestle with is how we can sustain this option while advancing reforms that make the Tax Code fair and health care more affordable and flexible for all Americans.

We need bold solutions to tackle this challenge, not in my view, Obamacare's punitive tax on high cost health insurance plans that the law itself has made even more expensive.

We also need to consider expanding consumer-driven health care, the model that empowers consumers, not the government, to unleash the forces of choice and competition to lower costs and increase quality. Yet for many people Obamacare has limited the consumer-driven plans they liked, including health savings accounts and flexible spending accounts.

This Committee will continue to protect and expand opportunities for Americans who want to take control of their health care dollars.

I want to thank our expert panel of witnesses for being here today. I look forward to a robust discussion about how we can help all Americans, regardless of employment status, access the affordable, portable, quality health care choices they deserve.

Chairman BRADY. With that I will yield to the distinguished ranking member of the Committee, Mr. Levin, for his opening remarks.

Mr. LEVIN. Thank you, Mr. Chairman.

And welcome to the panel.

Since the Affordable Care Act was signed into law six years ago, the progress we have seen in health care in this country is undeniable. Twenty million Americans who were previously uninsured now have quality coverage they can afford.

Health care costs are growing at the slowest rate in more than 50 years. Millions of young adults have been able to stay on their parents' plans until age 26, and nearly 130 million Americans no longer have to worry about being denied coverage or charged higher premiums because of preexisting conditions.

Yet despite these gains, Republicans continue to try to cook up ways to destroy the law. There have been 63 votes in the House to repeal or undermine ACA. That is a dangerous prospect on its own. But when it is paired with the fact that Republicans have come forth with no viable comprehensive alternative with which to replace the ACA, that is a recipe doomed to fail.

Take, for instance, the Republican proposal to eliminate or limit the tax exclusion that employers receive when they offer health insurance to employees as part of a compensation package. This would disrupt the employer-based health insurance system that the 155 million working Americans and their families rely on for coverage and likely would result in many employers no longer offering health care at all to employees, and it would leave many, including employees who are older or in poor health, without the ability to find affordable coverage.

Republicans have also proposed expanding the use of health savings accounts, which are associated with health plans that have high deductibles and most often used by wealthier households. HSAs are not an adequate replacement for comprehensive health care coverage as they can actually lead low and middle income Americans to put off medical care because they simply cannot afford to pay high deductibles or copays.

Repealing the ACA as Republicans want to do would have devastating effects for millions of Americans who use the tax credits that the law offers. The advanced premium tax credit and premium tax credit are integral in making health insurance plans in the marketplace affordable for Americans. Unlike a once a year tax credit, we chose real time tax credits to help hard-working American families afford coverage throughout the year.

Earlier this year, I met a woman who came down with breast cancer. She lost her job and health care coverage. Because of the ACA, she was able to become covered again with health insurance. Her breast cancer reoccurred, and she made clear to us that this new health coverage, as she said to us looking at us straight in the eye, saved her life, saved her live.

Stories like these remind us of just how vital this law is, and for that woman and for millions and millions of people in this country, the Republican alternative has simply been 63 votes to destroy or undermine the coverage that people have received.

Now is the time to keep building on this success, not to start over and risk losing all that we have achieved for millions and millions and millions of Americans.

I yield back.

Chairman BRADY. Without objection, other members' opening statements will be made a part of the record.

Today's witnesses in the panel includes three experts. First we welcome Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute.

Next we will hear from Avik Roy, a Senior Fellow at the Manhattan Institute.

Finally, we will hear from Steven Kreisberg, the Director of Research and Collective Bargaining Services with the American Federal of State, County and Municipal Employees, AFL–CIO.

The Committee has received your written statements. They will all be made part of the formal hearing record. We reserve five minutes to deliver your oral remarks.

We will begin today with Mr. Antos. Welcome, and you may begin when you are ready.

STATEMENT OF JOSEPH R. ANTOS, PH.D., WILSON H. TAYLOR SCHOLAR, AMERICAN ENTERPRISE INSTITUTE

Mr. ANTOS. Thank you, Mr. Chairman and Ranking Member Levin and Members of the Committee. I appreciate the opportunity to talk about this very important issue today.

I am going to focus on the problems created by the way that the tax system subsidizes health insurance and need for Congress to replace the Affordable Care Act's Cadillac tax on high cost, employment-based health insurance with a better approach.

I will first address the tax exclusion.

Premiums paid for employment-based health insurance are excluded without limit from both income and payroll taxes. That reduces the cost of health coverage for the average worker by about 30 percent. In the aggregate the savings amount to more than $250 billion annually.

While the tax exclusion has made workplace health insurance affordable, it has also fueled the rapid growth of health spending, contributed to stagnating wage growth, and is regressive.

The exclusion encourages workers to buy insurance that offers lower cost sharing but higher tax free premiums. That makes consumers less sensitive to prices and promotes the use of medical services, and some of those services may not provide full value to the patient. I think that is the issue. We have waste in our health system. IOM says 30 percent of the money we spend is wasted.

Compensation also has shifted from taxable cash wages to greater health benefits which are not taxed. Between 1999 and 2015, the average employer contribution for family coverage nearly tripled, while wage rates increased by only about half. It is likely that many workers, given the choice, would prefer somewhat lower health benefits for somewhat higher cash wages.

And then finally, workers with higher incomes, of course, benefit the most from the exclusion. The Joint Committee on Taxation found that average savings for tax filers with incomes less than $30,000 was about $1,700 compared to about $4,600 for those with incomes over $200,000. So it is a regressive kind of a tax or kind of a subsidy.

We can restructure the tax subsidy to promote better health insurance choices that will lead to more efficient, higher value care.

The subsidy can be made fairer without eliminating the financial incentive employers have to offer health coverage to their employees, and reforms can free up funds to help stabilize coverage for the 27 million who are left uninsured by the ACA.

Unfortunately, the Cadillac tax is not that reform. The 40 percent excise tax on high cost health insurance was intended to offset some of the excessive health spending arising from the tax exclusion. It is levied on employers. It is levied on insurers and other health plan sponsors, and the tax is paid on the cost of a health plan that exceeds certain thresholds.

Even though it is billed as a tax on insurance companies, workers ultimately bear the burden through lower compensation. Moreover, the tax is regressive. The same 40 percent tax is imposed on the production worker and the CEO regardless of how much they are paid in cash wages. They either pay higher premiums or their health benefits are cut back to avoid having to pay the tax. Either way, there is more cost for workers.

The tax will eventually impact everyone with employer coverage. The cost thresholds are indexed to general inflation. Health care costs rise faster than general inflation, and so ultimately all employer health plans will exceed what the ACA considers acceptable levels of health care coverage.

Simply repealing the Cadillac tax, I think, would be a mistake. First of all, you need to find offsetting budget savings.

Second of all, simply repealing would ignore the problems with the tax exclusion and other tax provisions affecting health insurance.

Reasonable reform would repeal the Cadillac tax and modify the tax exclusion to produce both budget savings and better incentives for the health sector. Two generic options, tax exclusion instead of the refundable tax credit or I mean to replace the tax exclusion with a refundable tax credit. Tax credits would break the financial link that motivates employers to offer health insurance and employers to buy it. There still would be a reason for employers to offer health insurance, but the money would not be there from the taxpayer.

Money wages can be expected to increase with the loss of health benefits and firms to drop their own plans, although some firms will continue to offer the benefit because it is a recruitment tool.

A credit would be a fair subsidy. The amount of the credit could be adjusted to account for regional variations in health care cost, for example. There are lots of ways to design it. It can be very complicated, but fundamentally it is a better system.

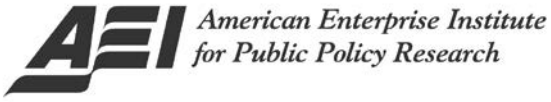
Alternatively, we could cap the amount of the tax exclusion. That would give employers an incentive to offer lower cost plan options, but would not drive employers to offer only low cost plans. Capping the exclusion is a less dramatic reform than shifting to a tax credit and could be a reasonable compromise that would promote more efficient health plans within the current employer framework.

Chairman BRADY. Thank you, Mr. Antos. I understand that you can be with us until 12:15 today?

Mr. ANTOS. Yes.

Chairman BRADY. Great. Thank you very much.

[The prepared statement of Mr. Antos follows:]



Statement before the House Ways and Means Committee

Reforming the Tax Treatment of Health Insurance

Joseph R. Antos, Ph.D.
Wilson H. Taylor Scholar in Health Care and Retirement Policy
American Enterprise Institute

April 14, 2016

The views expressed in this testimony are those of the author alone and do not necessarily represent those of the American Enterprise Institute.

Mr. Chairman, Ranking Member Levin, and members of the Committee, thank you for the opportunity to participate in today's hearing on the tax treatment of health care. I am Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute. The views I offer today are mine alone.

My testimony makes the following points:

- The current tax exclusion provides a strong incentive for employers to offer health insurance to their employees, but it is inefficient and unfair.
- The Cadillac tax discourages employers from offering high-cost health plans, but it does not correct problems with the tax exclusion.
- Congress should not simply repeal the Cadillac tax without offering a real reform plan.
- Capping the exclusion is a sensible compromise that would be both simpler and fairer than the current system, and could be accomplished without disrupting the way most people purchase health insurance.
- Comprehensive reform of the tax treatment of health insurance would address the tax exclusion, the Cadillac tax, and the subsidies offered on the exchanges through the Affordable Care Act (ACA). We should not ignore middle-class persons buying on the individual insurance market, who cannot access either exchange subsidies or subsidies through the employer market.

The Tax Exclusion is Inefficient and Unfair

The largest subsidy in the tax code is the exclusion from federal income and payroll taxes of premiums for employment-based insurance.[1] Nearly all premiums paid by employees or their employers are paid out of "pre-tax dollars," which represents a savings of about 30 percent for the typical worker. In 2015, the average premium for family coverage offered through employers was just over $17,500.[2] The exclusion saved the typical worker buying that insurance about $5,250.

According to the Congressional Budget Office (CBO), the tax exclusion will cost more than $250 billion in fiscal year 2016.[3] Over the next decade, federal tax subsidies associated with employment-based coverage will exceed $3.6 trillion. In effect, the exclusion is the third largest health program after Medicare and Medicaid.

The tax exclusion provides a strong incentive for employers to offer health insurance. Moreover, the substantial taxpayer-financed discount encourages both sick and relatively healthy people to enroll, which stabilizes the insurance risk pool. This year, 155 million people, or about 57 percent of the population under age 65, will be covered by employment-based health insurance.[4]

However, the exclusion is an inefficient and unfair way to promote the purchase of health insurance. It encourages workers to buy generous insurance that offers lower cost-sharing but higher tax-free premiums. Such coverage makes consumers less price-sensitive and promotes the use of medical services, some of which may provide little value. According to the Institutes of

Medicine, 30 cents of every dollar spent on health care in this country is wasted.[5] The exclusion's perverse financial incentives contributes to this problem.

The exclusion distorts how workers are paid. Many workers do not realize that their employer's contribution to the health insurance premium comes at the cost of lower cash wages. This has contributed to a shift from (taxable) cash wages to (nontaxable) health benefits. Between 1999 and 2015, the average employer contribution for family coverage nearly tripled while wage rates increased by only about half.[6] It is likely that many workers, given the choice, would prefer somewhat lower health benefits for somewhat higher cash wages.

The exclusion is regressive. Higher-income workers benefit the most from the exclusion, both in terms of dollar amounts and the percentage of premium that is subsidized.[7] Higher-income workers are more likely to be in jobs that offer health coverage, and they are in a higher tax bracket so the exclusion is worth more to them. According to a Joint Committee on Taxation analysis for 2007, the average savings for tax filers with incomes less than $30,000 was about $1,650 compared to about $4,580 for those with incomes over $200,000.[8] The Urban Institute-Brookings Institution Tax Policy Center finds that families earning $10,000 to $20,000 receive a subsidy of about $1,500, but spend more than one-quarter of their income on health insurance.[9] In contrast, families with income over $200,000 get a subsidy worth more than $4,500 and spend less than 4 percent of their income on insurance.

Experts from across the ideological spectrum have long recognized the structural flaws of the tax exclusion as it is currently configured. The exclusion can be restructured to promote better health insurance choices that lead to more efficient, higher value care. Such reforms can make the subsidy fairer without eliminating the financial incentive employers have to offer health coverage to their employees. Moreover, a well-designed policy can free up a portion of the $250 billion that the exclusion currently costs to help subsidize coverage for the 27 million left uninsured by the ACA.[10]

The Cadillac Tax is No Solution

One of the most controversial provisions of the Affordable Care Act (ACA) is the "Cadillac tax"—a 40 percent excise tax on employment-based health insurance that exceeds specified cost thresholds. The tax does not correct the problems inherent in the tax exclusion, which was left untouched. Instead, it creates financial pressure on employers and insurers to reduce the cost of their health plans below levels that would trigger the tax.

The ACA specified that the Cadillac tax would not be implemented until 2018—4 years after the rest of the legislation would go into effect. That delay may have been intended to give unions and employers a chance to adjust to the tax by paring back their health benefits, but it also served to shift to the next Administration some of the political controversy surrounding this highly unpopular tax. Implementation was further delayed until 2020 in the budget deal signed by the President in December.

As enacted, the 40 percent excise tax would be levied on insurers, employers, and other sponsors of employment-based insurance whose coverage costs more than $10,200 for a single

person or more than $27,500 for couples and families, beginning in 2018. (An inflationary adjustment would be applied to the thresholds in subsequent years.[11]) For example, a family plan costing $30,000 would pay the tax on the amount exceeding the threshold. The plan sponsor would be charged 40 percent of $2,500, or $1,000 for each family plan purchased.

Using political sleight of hand to de-emphasize who faces its consequences, the ACA imposed the tax on insurers and other plan sponsors. Nonetheless, workers will bear the financial burden in two ways. Plans that exceed the thresholds will pay the tax, but that cost will be passed through to workers in higher premiums. Plans that cut back their benefits by increasing cost-sharing requirements and narrowing provider networks may avoid the tax, but the value of the health coverage is reduced. That means higher costs for many patients.

Although the Cadillac tax will not be implemented for several years, it is already working.[12] According to a 2014 survey conducted by Aon Hewitt, firms planned to reduce the generosity of their health plans, implement narrow provider networks, reduce spousal coverage, and other steps to cut costs subject to the tax.[13]

Even taken on its own terms, the Cadillac tax has serious defects. They include:

- Workers are not in charge of their own health insurance under the Cadillac tax. Key decisions on which health plans are offered to workers are left in the hands of employers. Families who would have been willing to pay the tax if they could retain their current health plan may not have that opportunity.
- The Cadillac tax undercuts the use of health savings accounts (HSAs), which promote prudent purchasing of health care services. All contributions to HSAs count towards the threshold limits set by the law. These accounts are an increasingly popular way of financing health care costs, particularly in conjunction with high-deductible health plans.[14] Mercer's Tracy Watts points out that "eliminating pre-tax contributions will be one of the easiest ways to reduce cost for the excise tax calculation while still preserving the basic health care benefits package."[15]
- Low-wage workers are disadvantaged by the Cadillac tax. Although most employers are likely to focus on trimming health benefits to avoid the tax, some firms may reduce hiring and limit wage increases to cover the extra cost resulting from the tax. This will mostly impact low-wage workers, who have fewer financial resources to fall back on than higher-paid workers.
- Workers living in high-cost areas such as New York City or San Francisco are disadvantaged by the Cadillac tax. The use of fixed-dollar limits fails to account for regional variations in health care costs.
- The Cadillac tax will eventually impact everyone with employer coverage. The cost thresholds are indexed to general inflation. Because health care costs generally rise much faster than that, eventually all employer health plans will exceed what the ACA considers acceptable levels of health care coverage.

The President's 2017 budget, released February 9, includes a proposal to tie the tax thresholds to health care costs in each state based on the average premium for "gold" coverage

on the health insurance exchange.[16] According to the White House, this would prevent the tax from "creating unintended burdens" in high-cost states.[17] However, the effect of such a change would be to weaken the incentive to reduce costs, particularly where costs are highest.

This minor tinkering is certain to satisfy no one and will soon disappear from view. Pressure will continue to be applied by unions, employers, insurers, and patient groups to repeal the Cadillac tax, and there is bipartisan support in Congress for repeal.

Simple repeal costs money and ignores the tax exclusion's structural problems. CBO estimates that the Cadillac tax increases federal revenue by $59 billion over the next decade.[18] If future Congresses follow past practice with the Medicare Sustainable Growth Rate, they might delay implementation indefinitely, but that would require annual budget offsets that grow over time. Moreover, this would leave a threat hanging over employment-based health insurance that could not be tolerated for long. Reasonable reform would repeal the Cadillac tax and modify the tax exclusion to produce both budget savings and better incentives for the health sector.

Options for Reform

Thanks in large part to the tax exclusion, most Americans purchase health insurance at the workplace. The substantial subsidy makes employment-based insurance far less expensive than coverage bought in the individual market. Moreover, employers offer health coverage as an important tool in recruiting and retaining their best workers, and employees appreciate the administrative simplicity of having their premiums automatically deducted from their paychecks. However, we can find better ways to subsidize health coverage for workers.

There are two major strategies for reforming the tax treatment of employment-based health insurance: replacing the tax exclusion with a refundable tax credit or retaining the tax exclusion but capping the maximum amount that may be excluded. Under either approach, the Cadillac tax would be repealed.

Tax credits would break the financial link that motivates employers to offer health insurance and employees to buy it. Money wages could be expected to increase with the loss of the health benefit in firms dropping their own health plans. Although employment-based coverage would remain an attractive part of the compensation package in some companies, many workers would shift to coverage on the individual market.

The credit would be advanceable, and could be a fixed dollar amount or could vary according to the regional cost of health care or other factors that could affect the cost of the insurance, including the type of coverage (with higher credits for family coverage than for individual coverage). The credit would be indexed for inflation.

Tax credits could also be tied to the individual's income, similar to the exchange tax credits. However, experience thus far with the exchanges demonstrates the complexity of this approach.

Unlike the tax exclusion, whose value to the employee increases with the cost of the health plan, a credit would have a set dollar value for a given worker. That provides a strong incentive to choose lower-cost coverage.

Alternatively, the tax credit could be set as a fixed percentage of the cost of the plan that a person chooses.[19] In essence, this provides the same "discount" for health-insurance-premium costs for anyone purchasing coverage — whether as individuals or through group-purchasing arrangements. Although the subsidy would not be a fixed amount, this approach would also encourage the purchase of lower cost plans.

Tax credits have long been advanced by economists as the best alternative to the exclusion. Employers would no longer feel obligated to deal with the complexities of health insurance, although some would continue to offer coverage. Employees would no longer be restricted to the limited options typically available now but would have more plan choices on the open market. However, other insurance market reforms would be necessary to resolve existing problems in order to achieve these objectives. Such reforms are unlikely in the current political climate.

Capping the amount of the tax exclusion is a less dramatic reform that represents a sensible compromise that would be both simpler and fairer than the current system. Under this proposal, workers would pay income and payroll taxes on employer contributions above the cap. This is a progressive policy: lower-wage workers have a lower marginal income tax rate, and would pay a lower dollar amount of tax.

Limiting rather than eliminating the tax exclusion would not erode employer-sponsored insurance. Employers would continue to have a financial incentive to offer coverage to their employees. The limit would encourage employers to seek lower-cost plan options, but would not drive employers to offer only low-cost plans.[20]

A cap on the exclusion also has the advantage that it would work within the existing administrative systems used by employers today. Employees would continue to have their premiums deducted from their pay. If the cap is a fixed percentage of the premium for every employee in a firm, the employer would easily and accurately account for the portion of the premium not subject to taxation in preparing their employees' paychecks. A more complex design would complicate administration of the exclusion, but could yield a fairer system.

As with the tax credit, the cap could be adjusted to reflect the cost of health care in each region as well as the type of coverage (individual, family, etc.), and could be indexed for inflation.[21] Such adjustments could be accommodated by existing administrative systems. Other refinements, such as adjusting the cap based on the employee's income or age or occupation (to account for "high-risk" occupations), would add considerably to the complexity of operating this system. Such adjustments have been proposed in the name of greater fairness across individuals, but they could make administration by employers and oversight by the federal government unworkable.

A cap on the exclusion would reduce the subsidy afforded to high-income workers, but not eliminate the financial advantage those workers have compared with workers in lower tax brackets. This policy represents a shift toward a more equitable system that could be implemented without disrupting the way most people purchase health insurance.

We also need a full-scale reassessment of all tax subsidies for health insurance, including the premium and cost-sharing subsidies offered on the exchanges. The ACA exchanges have largely failed to attract middle-income purchasers.[22] That poor result is largely due to the uneven distribution of tax subsidies across different income groups and different insurance markets. In short, a middle-class person buying on the individual market cannot access either the exchange subsidies or the tax exclusion through the employer market. Comprehensive reform would not ignore those individuals.

Conclusion

Former White House official Ezekiel Emanuel predicts that by 2025, fewer than 20 percent of workers in the private sector will receive traditional employer-sponsored health insurance.[23] He argues that the Cadillac tax will help pave the way by discouraging companies from offering those plans.

Whatever one might think about that prediction, the debate over the Cadillac tax has focused policy attention on underlying problems caused by the tax exclusion. Congress should not make the mistake of repealing the Cadillac tax without replacing it with a more sensible policy that comprehensively addresses the way we subsidize health insurance.

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[1] A detailed discussion of the subsidies available through the tax system to employment-based health insurance is provided by Matthew Rae, Gary Claxton, Nirmita Panchal, and Larry Levitt, *Tax Subsidies for Private Health Insurance,* Kaiser Family Foundation, October 2014, http://kff.org/private-insurance/issue-brief/tax-subsidies-for-private-health-insurance/.

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[3] Congressional Budget Office (CBO), *Private Health Insurance Premiums and Federal Policy,* February 2016, https://www.cbo.gov/publication/51130.

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Chairman BRADY. Mr. Roy, you are up next. Welcome.

STATEMENT OF AVIK ROY, SENIOR FELLOW, MANHATTAN INSTITUTE

Mr. ROY. Thank you, Chairman Brady, Ranking Member Levin, and members of the Ways and Means Committee. Thanks for giving me the chance to speak with you today about the tax treatment of health care.

In my remarks today I will focus on three areas. First I will discuss how the tax treatment of health care is the central flaw in our health care system.

Second, I will address arguments made by opponents of health tax reform.

Third, I will discuss the principles of sound reform.

Republicans and Democrats may occasionally disagree on health care policy, but we all agree that health care needs to be more affordable. Nearly all of the growth in future Federal spending and thereby future tax increases is driven by health care, in particular, health care inflation, and the high and rising price of health care is the reason we have so many uninsured.

According to the CBO, 98 percent of the long-term uninsured cite the high cost of health insurance as a barrier to coverage. Only six percent cited poor health status, such as a preexisting condition.

The median worker's paycheck has barely increased in three decades, but overall compensation has grown. The problem is that most of the growth in compensation has been eaten up by the rising cost of health insurance. In 1996, the cost of coverage was 11 percent of per capita income. In 2010, it was 19 percent, nearly double.

The high cost of U.S. care originates in 1940s wage control, as you know, and is enshrined in the employer tax exclusion. Hospitals, doctors and drug companies have a powerful incentive to charge high prices here because the exclusion from taxation of employer-based insurance prevents patients from controlling their own health care dollars and thereby holding companies accountable for the prices they charge.

Today the employer tax exclusion, its value in terms of Federal, state and local income taxes and Federal payroll taxes, exceeds $500 billion a year. So it is extremely important to handle reform of the exclusion with great care.

But that is different from opposing reform altogether. If we want to make health care affordable, done properly we have to reform the exclusion. Health tax reform the right way would put more dollars in the pockets of workers rather than insurance companies.

Some opponents of health tax reform say that employer-based coverage protects us from single payer health care. That is manifestly untrue. The rising cost of employer-based coverage has actually been the principal argument for every major expansion of government-run health care in the United States.

Switzerland, by contrast, has a market-based system in which everyone purchases private coverage on their own individually. That system is not perfect, but it has been a far better check on the government. In 2014, the Swiss rejected a referendum to replace their system with single payer health care by a margin of 62

to 38 percent. People like choosing their own plans and will never allow the government to take away that right if they control it.

There are two keys to high quality health care tax reform. The first is that any reform should give workers more options to buy the coverage that they want.

The second is that reform should be enacted gradually. The ACA's Cadillac tax resembles such reform by taxing high value employer coverage, but that tax contains many exceptions and does not deploy the revenue it raises to aid all those who would like to purchase insurance on their own.

The best way to expand health insurance choices for individuals is to truly equalize the tax treatment of employer-purchased and individually purchased coverage. Congress could design a cap that raised an equivalent amount of revenue as the Cadillac tax, gradually phased in over time while also providing tax relief to those who purchase coverage on their own.

There is wide, bipartisan agreement on the utility of refundable tax credits for expanding coverage to the uninsured. The ACA, of course, deploys tax credits for this purpose, but that law has imposed costly mandates on insurers and individuals that have made coverage less affordable for millions, especially those ineligible for subsidies.

Some say that we should offer Americans an identical tax credit to every American with which to purchase coverage, but such a system would necessarily under-subsidize the poor, the sick, and the vulnerable while over-subsidizing the wealthy.

Tax credits for the uninsured should embrace the best of both worlds. They should be means tested to best help those in need. They should apply to health savings accounts and maximize the ability of people to choose the care and coverage that is best for them.

In this way we can achieve the goals that every member of this Committee shares: ensuring that every American has access to quality, affordable health care.

Thanks, again, for having me. I look forward to your questions and to being of further assistance to this Committee.

Chairman BRADY. Thank you, Mr. Roy.

[The prepared statement of Mr. Roy follows:]

Testimony before the House Ways & Means Committee

April 14, 2016

The Tax Treatment of Health Care

Avik Roy

Senior Fellow, Manhattan Institute for Policy Research

Oral and Written Statement

Chairman Brady, Ranking Member Levin, and members of the Ways and Means Committee: thanks for inviting me to speak with you today about the tax treatment of health care.

My name is Avik Roy, and I'm a Senior Fellow at the Manhattan Institute for Policy Research, in which capacity I conduct research on health care and entitlement reform.

In my remarks today, I'll focus on three areas. First, I'll discuss how the present tax treatment of health care is the central flaw in our health care system. Second, I'll address arguments made by opponents of health tax reform. Third, I'll discuss the principles of sound health tax reform.

Health tax policy: The central flaw in our health care system

It goes without saying that Republicans and Democrats, often don't see eye to eye on health reform. But we all agree that it is extremely important to improve the affordability of American health care.

The high and rising price of U.S. health care is the principal reason that tens of millions of Americans are uninsured. And it's the biggest driver of growth in government spending, and thereby of our debt and deficit.

According to survey data compiled by the Congressional Budget Office, among adults who have been uninsured for longer than 12 months, 98 percent cited the high cost of health insurance. 83 percent cited a lack of access to employer-sponsored insurance. Only 6 percent cited poor health status—such as a pre-existing condition—as a barrier to health coverage.

The high cost of health care also has a profound impact on those who manage to maintain coverage. The fact that the median worker's paycheck has barely increased in three decades is a widely discussed problem. But overall compensation to the American worker has grown. The problem is that most of the growth in compensation has been eaten up by the rising cost of health insurance. In 1996, the cost of health insurance to an individual was 11 percent of per-capita income. In 2010, it was 19 percent. In short, health care inflation is the biggest driver of wage stagnation.

And the CBO's long-term budget outlook indicates that nearly the entirety of the growth in federal spending over the next several decades is driven by two factors: growth in health care spending, and interest on the federal debt. Growth in health spending, in turn, is driven by two factors: the aging of our population, and the rising cost of delivering health care.

Some of these problems are driven by the fact that beginning in World War II, the federal government encouraged employers to replace take-home pay with health care spending, because employer-sponsored health coverage was excluded from the tax code.

Hospitals, doctors, drug companies, and other participants in the health care industry have a powerful incentive to charge high prices in the U.S., because the employer tax exclusion prevents patients from controlling their own health care dollars—and thereby holding health care companies accountable for the prices they charge.

Responding to opponents of health tax reform

Today, the value of the employer tax exclusion—in terms of federal, state, and local income taxes, and federal payroll taxes—exceeds 500 billion dollars a year. That is a greater sum than what federal, state, and local governments spend on Medicaid each year. 154 million Americans gain health coverage through their employers. So it is extremely important to handle reform of the employer tax exclusion with great care.

But that is different from opposing reform altogether. For the reasons I've described, mitigating the tax code's impact on health care inflation must remain a central objective of health reform.

Republican-aligned opponents of health tax reform argue that the employer-based health insurance system is a bulwark against single-payer health care, or another type of government-run system. But that is manifestly untrue. The rising cost of coverage since World War II—primarily driven by the employer tax exclusion—has been the principal argument for every major expansion of government-run health care since then.

Switzerland, by contrast, has a health care system in which every Swiss citizen purchases private health insurance on a regulated market. That system is not perfect, but it has been a robust bulwark against single-payer health care. In 2014, the Swiss rejected a referendum to replace their market-based system with single-payer health care, by a margin of 62 to 38 percent. People like choosing their own health coverage, and will never allow the government to take away that right if they have it.

Democrat-aligned opponents of health tax reform argue that health tax reform would increase costs for workers, especially members of public-sector unions. But the opposite is true: health tax reform, done properly, would put more dollars in the pockets of workers, rather than insurance companies.

Principles of health tax reform

There are two core principles to high-quality health tax reform. The first is that reform should give workers more choice to purchase the kind of health coverage that is affordable for them and their families. The second is that reform should be enacted gradually, so as to give insurers and providers the time needed to bend the cost curve downward.

The so-called "Cadillac Tax" in the Affordable Care Act resembles such reform by taxing high-value employer health benefits. But that tax contains many exceptions and loopholes, and does not deploy the revenue it raises to aid all those who would like to purchase insurance on their own.

The best way to expand health insurance choices for workers is to truly equalize the tax treatment of employer-purchased and individually-purchased coverage, through a cap on the employer tax exclusion that is gradually phased in over time. Congress could design a cap that raised an equivalent amount of revenue as the Cadillac Tax, while considering the additional goal of providing tax relief to every American who purchases health coverage on their own.

Finally, in my limited time, I should address an important aspect of health tax reform: offering premium assistance through refundable tax credits to those with no income tax liabilities. There is wide bipartisan agreement on the importance of such tax credits in expanding coverage to the uninsured.

The ACA deploys tax credits for this purpose, which is laudable. The biggest problem with the ACA is that it burdens the individual insurance market with costly mandates and regulations that make health coverage unaffordable for millions of people that the law was designed to help.

Some scholars endorse a system of uniform tax credits, similar to the one proposed by Senator McCain in 2008, in which every American would get an identical credit with which to purchase the health coverage of his choosing. But such a system would necessarily undersubsidize the poor, the sick, and the vulnerable, while oversubsidizing the wealthy.

Tax reform for the uninsured should embrace the best of both of these concepts. It should be means-tested, so that those who are most in need of assistance can afford health coverage. But refundable tax credits should maximize the opportunity for individuals to choose the health care and coverage that is best for them—including the utilization of health savings accounts—instead of requiring Americans to buy a one-size-fits-all form of coverage designed for them by the federal government.

In this way, we can achieve the goals that every member of this committee shares: ensuring that every American has access to quality, affordable health care. We all know how challenging health reform is to achieve. But we also know how important it is to the future of our country.

Thanks again for having me. I look forward to your questions, and to being of further assistance to this committee.

Chairman BRADY. Mr. Kreisberg, welcome and please proceed.

STATEMENT OF STEVEN KREISBERG, DIRECTOR OF RESEARCH AND COLLECTIVE BARGAINING SERVICES, AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES

Mr. KREISBERG. Thank you very much, Mr. Chairman, and thank you, Ranking Member Levin. It is a pleasure to be here today.

My name is Steve Kreisberg. I am the Director of Research and Collective Bargaining with AFSCME, a large, public employee union of the United States.

And we do not think we can start talking about the American health care system without talking about the Affordable Care Act. This is an Act that we supported. We have a long history of supporting health care reform and expansion of coverage to all Americans.

Now, as public employees, virtually all of our members have adequate health care coverage, which is a great thing. So a lot of folks have asked us why would we be supporting the expansion of coverage. In the view of our union, this is a fundamental piece of what it takes to be a developed Nation. It is a fundamental part of the American dream, is to have health care so you can go on to achieve your full potential.

The Affordable Care Act for the first time really brings that within reach of virtually all Americans. We have expanded coverage. Ranking Member Levin referred to the figures. Unfortunately, we did not expand it as much as we should have or we intended to because 20 states still refuse to extend Medicaid coverage to their citizens. We think that is a mistake, and we think over time we expect to see further expansion of Medicaid.

But our members are also very much focused on cost, and like the other two panelists before me, we recognize that cost in our system is something that must be addressed.

Under the Affordable Care Act, we have seen a moderation of cost increase year over year. This is a trend that we are pleased to see. Cause and effect are often difficult to determine, but we believe the Affordable Care Act has gone a long way in helping us achieve the cost moderation that everybody seeks.

But it is not enough. We all know there is plenty of work to be done, not just with expansion of coverage, but also in cost, and we think the Affordable Care Act and the Obama administration have made a pretty good start in this regard.

The most important aspect of this in our view is the alignment of financial incentives to achieve quality and value in our health care system. We think the problem of cost is on the supply side, not on the demand side, and I think that is very important that you consider the issues in front of you.

I think what Mr. Roy was implying in part is that we need to change consumer behavior, and that will lead to a reduction in our health care expenditures. We do not have faith that that will be an effective solution to our problems. We think that the problem with our health care system is that we do not have a free market and

we never had a free market in health care. It does not operate like other markets.

So we need to align incentives from the payers who are not individual consumers for the big ticket items, but through our insurance companies and form our government, and by that we mean that we have to move away from the fee for service system, and I think there is universal agreement that that is probably a wise approach, and we are starting to do those kinds of things right now.

We also feel we need, and this is part of the same approach, to further expand access to primary care and imbed primary care with your other avenues of care so we're not running into specialists uncoordinated from primary care providers.

We also must address prescription drug prices. They are accounting for the large part of our trend in cost increases. Every other developed nation, including Switzerland, regulates prescription drug prices. We do not do so here. We should consider that or some other alternatives to help bring our prescription drugs under control, and we expand on those remarks in our written testimony.

I do want to talk a little bit more about the tax exclusion. The foundation of our health care system right now is employer-based coverage. We believe changes and caps to the tax exclusion undermine that. In fact, we believe changes and caps to the tax exclusion will have the same aberrant results of the excise tax, which the two panelists oppose. So we cannot figure out how you can reconcile the position on tax exclusion with the position they take on excise taxes.

We think both will have the unintended consequence of shifting more cost to consumers. Now, some consumers may prefer high deductible health plans. When you are young and healthy you do. But those very same consumers hope to get old. This beats the alternative.

When they get old, they are going to want more comprehensive coverage. So we are going to see people perhaps enjoy high deductible coverage when they are younger and healthier, but eventually, as age catches up with them, opt into the higher cost plans and the more comprehensive coverage.

That makes no sense. Everybody should have comprehensive coverage from day one to keep our risk pools intact. We believe the high deductible plans are not the effective way to reform health care. In fact, if you ask your constituents what the problems are with the American health care system, I do not think any of them will say the problem is that they do not pay enough. I think they believe the problem is they pay too much.

Thank you very much.

Chairman BRADY. Thank you, Mr. Kreisberg.

[The prepared statement of Mr. Kreisberg follows:]

AFSCME
We Make America Happen

Testimony of Steven Kreisberg
Director of Research and Collective Bargaining Services

of the

American Federation of State, County and Municipal Employees

before the

Ways and Means Committee of the U.S. House of Representatives

for the hearing on

Tax Treatment in Health Care
April 14, 2016

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American Federation of State, County and Municipal Employees
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Chairman Brady and Congressman Levin, my name is Steven Kreisberg and I am the Director of Research and Collective Bargaining Services for the American Federation of State, County and Municipal Employees (AFSCME), a union with 1.6 million active and retiree members.

In a March 2009 statement submitted for a hearing by the Ways and Means Committee, AFSCME urged the Congress to enact comprehensive health care reform. In that statement, AFSCME highlighted that the nation could not wait while 46 million Americans went without health care coverage. We could not wait as health care costs for workers and employers continued to spiral out of control. We could not wait while millions lived with the illusion of coverage that was too inadequate to protect them from financial ruin. We could not wait to reform a health care system that often fails to deliver high-quality care.

All that was wrong with our health care system was linked, requiring a comprehensive solution. Being without health coverage was not just a crisis for the 46 million who did not have it, but also a significant driver of costs for those who had coverage. AFSCME members and their employers, like other private payers, absorbed higher and higher premiums as the number of uninsured and the amount of uncompensated care grew. The frequent absence of high-quality care is not only an economic waste, but a hardship for patients.

The enactment of the Affordable Care Act (ACA) was a landmark achievement similar to the enactment of Medicaid and Medicare. And while the ACA is by no means perfect, it has improved the lives of millions and put our nation on a path to achieving a health care system that delivers affordable, high-quality care. Six years since President Obama signed the ACA into law, significant achievements have been realized. Our union is proud that our nation joined with virtually all other developed countries to guarantee citizens access to health care benefits.

As a direct result of the ACA, an estimated 20 million people have gained health insurance. Nearly nine in ten Americans have coverage and the peace of mind knowing that care is accessible when they are injured or get sick and that caps on out-of-pocket costs reduce the possibility that a serious injury or illness will become a financial catastrophe for their family.

Health insurance marketplaces have been established providing consumers with coverage options and, for those who qualify, tax credits to help make it affordable. Thirty-one states, including the District of Columbia, have expanded their Medicaid programs to provide coverage to all adults with incomes under 138 percent of the federal poverty level.

Those who were previously denied coverage or were offered limited benefits due to a pre-existing condition are no longer turned away or forced to accept coverage which does not apply when they need it the most. Similarly, the ACA has improved coverage for millions by eliminating lifetime and annual

limits. Those who experience a catastrophic injury or illness no longer fear that they will run out of benefits.

Measures aimed at improving the quality of care are being implemented, including the creation of Accountable Care Organizations and a program to reduce avoidable readmissions to hospitals. These measures will not only improve care, but also help control costs. For example, since 2010, the reduction in avoidable readmissions has saved an estimated $20 billion in health care costs. The Innovation Center at the Centers for Medicare and Medicaid Services, created by the ACA, is developing and testing payment and service delivery models that hold significant promise for achieving better care and lower costs. Already today, 30 percent of traditional Medicare payments are tied to alternative payment models that promote cost savings and improve quality.

Although cause and effect are difficult to conclude, we know that the 27 percent premium growth for family coverage in the last five years (2010 to 2015) is significantly smaller than the 69 percent premium growth seen between 2000 and 2005.[1] Significantly, the median price for "silver" benchmark policies in the ACA marketplaces increased by just 2 percent from 2014 to 2015 and by a weighted average of just 4 percent from 2015 to 2016. There is now a good body of evidence suggesting we may be achieving moderate levels of inflation in health benefit costs.

CRITICAL ELEMENTS OF THE AFFORDABLE CARE ACT

Employer Responsibility

The ACA is built on the foundation of employer-sponsored coverage where a majority of the nonelderly get their health insurance – some 162 million workers and dependents. [2] Employers provide a ready-made, stable risk pooling mechanism, coverage with lower administrative costs, and the institutional skills and expertise to carry out complex negotiations with insurers.

In the ten years leading up to the enactment of the ACA, the percentage of workers and dependents covered by health insurance through the workplace had been gradually decreasing. In 1999, 67 percent received coverage through an employer but, by 2010, this percentage had fallen to 56 percent. Since 2010, the trend has stabilized with 56 percent receiving coverage through their employer as of 2014.[3]

AFSCME is opposed to efforts to weaken employer responsibility requirements under the ACA, whether by eliminating or reducing responsibility payments, reducing the number of workers who must be offered coverage, or through some other mechanism. The fact that some employers do not provide health benefits creates an uneven playing field that puts responsible employers at a competitive

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[1] Family health benefit premiums increased by 27 percent from 2005 to 2010 but the recession limits the use of that figure for comparative purposes. Figures are from the Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2015, Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2000-2015. https://kaiserfamilyfoundation.files.wordpress.com/2015/08/8776-exhibit-b.png

[2] https://www.ebri.org/pdf/briefspdf/EBRI_IB_419.Oct15.Sources.pdf , page 7.

[3] http://kff.org/private-insurance/issue-brief/trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014/ , Figure 5.

disadvantage. The employer responsibility payment helps to reduce that competitive disadvantage. Furthermore, financing our health care system is a shared responsibility between employers, individuals and government. The burden will fall more heavily on individuals and government if employer requirements are weakened. Rather than allowing some employers to shirk that responsibility, we urge the Committee to consider proposals that ask more from employers in order to strengthen this key source of coverage.

Individual Responsibility and Premium Tax Credits

The ACA requires most individuals to obtain health care coverage or to pay a penalty. The purpose of the individual requirement is to ensure that insurance plans purchased through the health insurance exchanges have a sustainable mix of healthy and less healthy individuals in the risk pool. The individual responsibility requirement helps to achieve the same stable risk pooling mechanism achieved in group coverage. Without the individual responsibility requirement, it would not be workable to require insurance plans to accept all customers, including those with pre-existing conditions. Years of experience tells us that high risk pools are not financially viable.

It is critical that along with the requirement that individuals obtain coverage, there is help in the form of premium tax credits. Without the tax credits, low- and middle-income individuals and families could not afford coverage and would be forced to forgo it. Not only would this undermine risk pools and drive up costs for consumers who did purchase coverage, it would increase uncompensated care and shift those costs onto employers and workers.

Essential Health Benefits

The ACA requires health plans to meet standards of coverage to ensure that purchasers have comprehensive coverage. Without standards set by the ACA, consumers would risk purchasing inadequate coverage that could leave them unable to obtain the health care services they need or even expose them to bankruptcy in order to obtain services following a significant injury or illness. Essential health benefits provide a baseline standard of benefits and limit individuals' exposure to unbearable costs that create episodes of uncompensated care.

Medicaid Expansion

While AFSCME was disappointed that the U.S. Supreme Court made the Medicaid expansion optional, we are heartened that the vast majority of states have opted to expand their Medicaid programs. Thirty-one states plus the District of Columbia have expanded their Medicaid programs and taken advantage of the more generous federal payment share for the expansion population. We urge the other 19 states to expand their Medicaid programs in order to cover four million poor, mostly working, individuals who currently lack options for coverage.

HARMFUL PROPOSALS

Eliminating or Limiting the Tax Exclusion for Employer-Sponsored Coverage

AFSCME is strongly opposed to taxing workers on their health benefits and polling during the health care reform debate showed that it was a broadly unpopular idea, opposed by more than 70 percent of voters. Coverage through the workplace evolved in response to tax changes in the 1940s and 1950s that excluded employer contributions from taxable wages. These changes encouraged employers to provide health coverage and also encouraged healthy employees to enroll in workplace plans, providing for the formation of stable and sustainable risk pools.

Eliminating or capping the tax exclusion would undermine employer-sponsored coverage by removing a key incentive that employers have for providing coverage. In addition, taxing benefits would encourage younger and healthier workers to pass up employer-sponsored coverage and seek less comprehensive insurance. The loss of these workers to employer risk pools would drive up the cost of coverage for older and less healthy workers.

Taxing benefits would undermine the quality of coverage by driving highly-paid employees, with higher marginal tax rates, to demand that employers reduce coverage. While highly-paid workers may be able to afford high deductibles and other reductions in coverage, it would be a financial burden for average families.

There is also a strong equity argument against capping or eliminating the tax exclusion because the burden would fall more heavily on some workers than others. For example, coverage is more expensive for employers whose workforces are older or female-dominated. Premiums vary by geography and by industry. Coverage costs more for small employers, compared with large employers. It would be inequitable to tax workers more, for the same coverage, because of who they work for, what they do or where they work.

Limiting the tax exclusion on benefits would punish people who receive what every American should have: comprehensive health benefits, access to a wide variety of providers and affordable out-of-pocket costs. For dedicated workers who have sacrificed salary increases in order to maintain these benefits, it would be extremely unfair to now impose a premium-based tax on their coverage.

Over the last few decades, the middle class has been asked to shoulder a greater share of the responsibility for funding federal services, compared with the wealthiest among us. Eliminating the tax exclusion is a regressive change in policy that would increase working families' share of the federal income tax burden in comparison to wealthier taxpayers.

Capped or Standard Deduction for Employer-Sponsored Health Coverage

Eliminating the tax exclusion for health care and replacing it with a capped or standard deduction would undermine the coverage received through the workplace. A deduction is likely to prompt many employers to drop their plans, leaving many working families without access to affordable health care coverage.

The Republican Study Committee's proposal for a standard deduction of $7,500 for individuals and $20,500 for families would do little to help the uninsured obtain coverage. Those who lose their jobs and have no income to report would receive no help. According to an analysis by the Center on Budget and Policy Priorities, a single, poor adult earning $10,000 would get no income tax benefit and a payroll

tax benefit of less than $600 for a year – a fraction of what it would cost to purchase individual coverage.[4]

The value of a tax deduction increases with an individual's tax bracket. As a result, a standard deduction would provide the greatest benefit to higher income individuals, those least in need of help. The deduction could also encourage healthy and more highly-paid workers to leave employer-based coverage, worsening the risk in these plans and driving their cost up for employers and the workers who remained.

Health Savings Accounts and High Deductible Health Plans

High deductible health plans are promoted by many as a way to make consumers more cost conscious about their health care choices. But health care is unlike most other goods or services that people consume. Patients are deeply dependent upon the advice of health care professionals as to whether they should undergo a procedure or diagnostic test. Health care decisions are often required without adequate time to shop around or research the best option. Often, there is a lack of price and quality transparency which undermines an effective marketplace. Some patients may indeed forgo health care services if they cannot afford them, but they are generally ill-equipped to decide what they may or may not need to stay healthy. Research shows that people forgo essential and nonessential services equally, when cost-sharing requirements are increased.

Research also shows that insured people with chronic illnesses stop using needed services when they are shifted to health plans with high out-of-pocket costs, even when they are provided Health Savings Accounts or similar arrangements to help cover some of their costs.

In a study released a year ago, the Kaiser Foundation found that about one-third of those with private insurance coverage do not have adequate liquid assets to pay a mid-range deductible of $1,200 for single coverage and $2,400 for family coverage.[5] Large deductibles and other cost sharing are often a barrier to obtaining needed health care services and are particularly harmful for low-income families and those with chronic conditions.

According to a 2015 study by the Commonwealth Fund, 31 million nonelderly adults who were insured during all of 2014 had such high out-of-pocket costs relative to their income, they were considered underinsured.[6]

Expanding health savings accounts and high deductible plans would create more barriers to needed care and put more people at risk of medical bankruptcy. It is not a solution for working families.

There is also no valid evidence that high deductible health plans (HDHP) contain costs or lower health benefit cost trends. For example, the Segal Company actuaries projected health care cost trend increases for HDHPs of 7.9 percent and 8 percent in 2015 and 2016 which is almost identical to the

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[4] http://www.cbpp.org/research/republican-health-plan-would-cause-millions-to-lose-current-coverage-and-add-to-the-ranks

[5] http://kff.org/private-insurance/issue-brief/consumer-assets-and-patient-cost-sharing/ , figure 4.

[6] http://www.commonwealthfund.org/publications/issue-briefs/2015/may/problem-of-underinsurance

projection of 7.8 percent and 7.9 percent increases in Preferred Provider Organization (PPO) plans and far higher than the projected trend increases of 6.2 percent and 6.8 percent for Health Maintenance Organization (HMO) plans which typically have the lowest participant out-of-pocket costs.[7] Segal actuaries also projected higher cost trends for HDHPs than PPOs and HMOs in 2013 and 2014.[8]

The failure of HDHPs to produce systemic reductions in health care costs or cost increases is unsurprising. An analysis by Carnegie Mellon economist Martin Gaynor confirms that over 80 percent of health care spending is concentrated among just 20 percent of the population with the top five percent of spenders accounting for half of all health care spending.[9]

Allowing Health Insurance to be Sold Across State Lines

Allowing insurance companies to sell coverage across state lines would promote a race to the bottom among states competing to minimize their standards in order to attract insurance companies to establish a presence in their states. Under such a proposal, consumers could once again find that their health coverage lacked essential health benefits such as coverage for diabetes supplies or chemotherapy. Interstate sales would be a huge benefit to the industry which would have an opportunity to boost sales by cherry picking healthier, low-risk residents of other states. Moreover, it would be harder for consumers to resolve disputes with insurance companies if they were required to appeal to regulators in another state. State solvency requirements could be inadequate for coverage sold around the country, leaving consumers at risk of unpaid bills by inadequately resourced insurance plans. Finally, in the absence of a regulatory role for the federal government, interstate sales of health insurance would place consumers at risk in an unregulated marketplace.

IMPROVEMENTS TO THE AFFORDABLE CARE ACT

In order to build on the success of the ACA, we recommend attention to the following issues:

Reducing the Costs for Health Care Through Payment Reforms

Considerable attention has been paid to payment reform over the past decades and progress has been made. However, much more remains to be done to align financial incentives with health care quality and value. Virtually all health care economists support decreasing the reliance on fee for service systems for health care. Unfortunately, those who advocate for shifting costs to health care consumers by creating higher deductibles, co-payments and co-insurance, are caught up in old ways of thinking. Instead, our focus should be on alternative payment methodologies such as:

- Bundled or episode-based payments which compensate providers with a lump sum payment based on the services and evidenced-based treatments necessary to treat a disease or condition. This method of payment is increasingly effective as the various

[7] https://www.segalco.com/media/2138/ps-trend-survey-2016.pdf
[8] http://www.davidshield.com/download/files/2014percent20Segalpercent20Trendpercent20Survey.pdf
[9] http://www.latimes.com/business/hiltzik/la-fi-mh-the-myth-of-consumer-directed-healthcare-20151214-column.html

providers involved in the treatment participate in the bundled payment.

- Global payments which compensate service providers, typically on a capitated basis, for providing services and treatments to a specific population. Current global payment models do not rely only on managing costs for population, but also require that various quality-of-care metrics, such as participation in preventative care programs, be achieved. The Accountable Care Organization model relies on global payments to produce both value and quality.

Promoting Primary Care

Greater access to primary care, through Patient Centered Health Care Homes or other practice settings, has significant potential to create value and reduce health care costs. Patients with regular access to a primary care physician, and who have access to a health care team that effectively integrates services to promote a patient's health and well-being, typically enjoy better health at lower cost than patients who have no such access. Current barriers to greater primary care include outdated payment models that do not fully compensate providers for the array of services they provide and a lack of primary care providers. Government policies should address both issues.

Addressing Pharmaceutical Costs

American prescription drug prices are the highest in the world, often exceeding the price paid in other developed nations by 50 percent to 100 percent. A study by the AARP concluded, "[i]n 2013, retail prices for 227 brand name prescription drugs widely used by older Americans, including Medicare beneficiaries, increased by an average of 12.9 percent." High rates of cost inflation have not been limited to brand name drugs. In recent years we have seen a significant escalation in the price of generic drugs due to industry consolidation and supply issues. Virtually every developed nation provides for the regulation of drug prices, with the exception of the U.S. Regulation is necessary because drug prices are largely unaffected by the typical constraints of supply and demand. Instead, drug prices are charged based on what the market can bear. A solution that moderates the price of prescription drugs, tames pharmaceutical inflation, and does not have the unintended consequence of impeding research and development is necessary. We urge the Congress to consider alternatives such as:

- *The direct regulation of pharmaceutical drug prices*. This process can take a number of forms including adapting price regulation methods used by various other nations or adapting the protocols used by bodies which regulate prices charged by public utilities. In addition, Congress should permit Medicare to engage in direct price negotiation for prescription drugs. Dean Baker, from the Center for Economic and Policy Research, has estimated that the U.S. could save $31 billion over ten years by paying the same cost as the Canadian government pays for drugs and as much as $72 billion over ten years by paying the same cost as the Dutch government pays for drugs.

- *Direct government investment in research and development and retention of patent rights as a public good*. To the extent that private investments and public funds jointly fund research and development, regulated drug prices should reflect the investment mix.

- *The federal government could purchase the patents of brand name drugs*. Because the purchase price of a patent would reflect fair market value, this action may not lead to lower cost, in aggregate, for a brand name drug. However, once the government holds the patent, it can license greater production and lower the unit cost of the drug so more patients can avail themselves of the treatment. This could be an effective strategy to deal with the high per treatment costs of drugs such as Solvadi which is currently subject to price-based rationing.

Other proposals supported by AFSCME include reducing the exclusivity period for biologics, ending patent evergreening, ending tax write offs for direct-to-consumer advertising, ending anti-competitive pay-for-delay deals with generic firms, requiring drug manufacturers to provide rebates applicable for those dually eligible for Medicaid and those receiving the Medicare Part D low-income subsidy, making greater investment in comparative effectiveness research and requiring that research conducted by pharmaceutical companies for regulators in other countries be made available to payers in the U.S.

Repealing the Excise Tax on High Cost Health Plans

AFSCME supports repeal of the excise tax on high-cost health plans. This excise tax is already eroding health care coverage for working families. According to a 2015 survey by the International Foundation of Employee Benefit Plans, 34 percent of plans are taking action to avoid the tax. A 2014 Aon Hewitt survey of employers found that 33 percent were changing their benefit design by increasing out-of-pocket costs.

Health plans can be costly for many reasons other than the benefit design. For example, premiums are higher in some states because health care services are more expensive. Some plans are more costly because they include higher than average percentages of women, older workers and people with chronic illnesses.

As highlighted by a recent study in the *International Journal of Health Services*, the excise tax is regressive and will disproportionately harm families with low and middle incomes.[10] The federal tax subsidy for health coverage represents a larger share of income for low- and middle-income households, compared with wealthy households. Scaling back the tax subsidy through the imposition of the excise tax will hit these groups the hardest as a percent of income. Looked at another way, raising the annual deductible to $2,000 has a much bigger financial impact on a low- or middle-income family than a wealthy family.

There is broad support for repealing the excise tax among employer organizations, including the American Benefits Council, the Corporate Health Care Coalition and the National Association of Counties. The two-year delay has provided some breathing room for policy makers. We urge the Congress to take action soon to repeal the excise tax altogether.

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[10] Woolhandler S., Himmelstein D.U., "The 'Cadillac Tax' on Health Benefits in the United States Will Hit the Middle Class Hardest: Refuting the Myth that Health Benefit Tax Subsidies are Regressive," *International Journal of Health Services*, 2016.

Improve Financial Protection Provided by Health Insurance

As highlighted above, plans that require high out-of-pocket expenses, such as high deductibles, are a barrier to needed care for many low- and middle-income families. We urge that plans in the ACA exchanges and tax credits be improved to provide more financial protection for families.

CONCLUSION

As you debate changes in the health care system, we urge the Committee to reinforce the policies that we know work. Pooling risk is an important key to making health coverage affordable. We have extensive experience with the ability of public programs and employer-sponsored insurance to pool risk. The ACA health exchanges were designed to create risk pooling for small businesses and those purchasing their own coverage. We should not abandon or undermine the proven pillars of our health care system.

Other countries have been much more successful at constraining health care costs, often spending only half of what the U.S. spends on a per capita basis. Cost containment must include a robust role for federal leadership in aligning provider financial incentives with quality and value. The Affordable Care Act was a significant step in this direction and we should not step back to policies based more on ideology than economic sense.

Chairman BRADY. Thank you for the panelists' opening remarks. We will go to the question and answer period, and I will begin with myself.

I said it in the opening. I want to be perfectly clear. Most Americans get their health care at work, more than 150 million Americans. We are going to preserve incentives to get health care at work.

But the world has changed, and the question is: can we create flexibility and expand and make equal that tax incentive so that Americans have more choices?

Mr. Antos, do you believe we can create or modernize that tax exclusion at work in a way that creates flexibility and keep the important incentives for health care at work?

Can we do both?

Mr. ANTOS. Yes, I think we can. As I mentioned, if you cap the exclusion, that does not mean you remove completely the tax subsidy through employer sponsored coverage, but what it does do is it discourages the purchase of very expensive coverage that tends to have very low cost sharing and which prevents people from understanding what the cost of health care is.

I mean, the fact is that health insurance through the employer is kind of a mystery to most people. Because the premiums are taken out of your pay, you do not often know what your premiums are, and the employer contribution is also a mystery. People think that it is not coming out of their paycheck.

Chairman BRADY. Yes, and it is.

Mr. Roy, we talked about the Tax Code being stuck, you know, in the past because it has been 30 years since we have reformed it, but this tax incentive actually first appeared in 1918, got serious 70 years ago, and effectively is stuck there, but workers are not stuck. Many of them change jobs multiple times throughout their life. Many will go home to start a small business. Others choose to want health care individually so they can raise their families.

How in your view is it appropriate to modernize that tax incentive that worked to be able to create that flexibility for workers to live a 21st Century life because, frankly, their lives are different from then when this first got serious seven decades ago?

Mr. ROY. Absolutely. I would make two points. The first point is that employer-based tax reform or health tax reform is not about having workers pay more. It is actually about workers paying less for their health care. All of these efforts are about making workers paying less for their health care. All of these efforts are about making sure that workers pay less for health care and that health care is more affordable in the future than it is today.

And the second point that I would make is that what is really important, aside from making health care more affordable is putting patients and workers more in control of their own health care dollars. Today those health care dollars are controlled by the government, by employers, by insurance companies, by hospitals, by drug companies. They are not controlled by the consumer, by the worker, by the patient.

And all of our efforts on tax reform are about putting the control back in the hands of that individual and those families.

Chairman BRADY. Well, can I follow up with that? This is sort of my final question. I may have another after that, but this is really about a world where most people are told, "Here is your health care. You will like it. Just take it or leave it, and we will decide what is best for you."

This is about actually giving consumers control, picking a plan that is right for them, not what Washington wants, not what someone else wants, but what they need for their family and their lifestyle. It seems to me in the 21st Century, what we need armed through life is a health care backpack that includes a health plan that works for you and can travel with you whether it is to another job or a home or to start your small business.

You need a health savings account to be able to better afford the day-to-day costs of health care and prevention, and you need easy access to your medical records so you can share that with the doctor or emergency room if you are traveling at the time.

It seems to me that how we modernize, how we get health care to work actually unlocks and creates that flexibility for Americans.

So, Mr. Antos, in your view, what is the best way to modernize this tax incentive at work, and Mr. Roy as well, that creates that flexibility for Americans to control more of their health care plans?

Mr. ANTOS. Well, I think the question is: what are the real bounds here? In the sort of ideal world, I think you would definitely go to a tax credit type of a subsidy which would free workers to buy the kind of coverage that they want on the individual market.

That would, of course, require some additional health insurance reforms.

Chairman BRADY. But in that case you would keep the tax incentives that work, but you have an option for the first time really ever, an option to equalize that tax credit and make some choices.

Mr. ANTOS. Right. I think the key principle is to make it possible for people, wherever they buy insurance to have the same level of support.

Chairman BRADY. Yes, yes, sort of equal treatment.

Mr. Roy.

Mr. ROY. Yes, I would agree with my colleague over here, Mr. Antos, and I would add that one of the important things about giving people that choice to buy the health insurance and the health care that makes sense for them is the profound innovation it would trigger in the health care system.

Today in most states, one health insurance company has 80 percent of the market, and that makes it very, very difficult for people even if they do choose their own health insurance to have true choice. But if you actually give people control of those health care dollars again, give it back to them to spend the way they want, you will see profound innovation and competition in not just how health insurance companies have to compete with entrepreneurs, but also how health insurance would be used versus health savings accounts versus urgent care versus all the other things that are out there.

So people should have those choices, and we will not know. We will not be able to anticipate how the consumers, how individuals

will decide to use those dollars in the future, but it will be much better than it is today. That we can be very confident of.

Chairman BRADY. Thank you.

Because what we have is not working in the Affordable Care Act. There are a number of people in the Eastern Region. They get cancer under Obamacare, can go to M.D. Anderson for the best cancer cure in the world: zero.

This number of PPOs that are now available, and it was zero, by the way, that are available in our part of the world for families under Obamacare, and I cannot count the numbers of the extra dollars out of pocket that people pay now in the exchanges under the Affordable Care Act that they cannot afford.

In fact, in Texas, half of the people who are supposed to be forced in Obamacare have elected to pay a tax than to go into a health care plan they do not want and cannot afford and cannot see the doctors and get the medicines they want.

So we ought to be thinking about a 21st Century option for the first time ever that recognizes what people need, not what Washington needs.

With that, I will now recognize the distinguished ranking member from Michigan, Mr. Levin, for any questions he may have.

Mr. LEVIN. You know, I want to be polite, but let me just say this. I think the Republicans have failed for five years to come up with a plan because there is so much double-talk. You say you do not want to eliminate the exclusion, but then you want to come up with a tax credit and give people control of their health care.

Essentially if you think it through what you want to do is to replace employer-based health care coverage. You do not say that. You kind of modify it. The Cadillac thing, modify it.

So you have been handcuffed because you just talk out of both sides of your mouth constantly. In listening to the two of you, I do not know what your plan would ever be. You say keep the exclusion, but cap it, and then come up with credits. You do not say how much. If it is enough, employers will not provide health care anymore. You are going to destroy the basis upon which we have built.

You can talk about 100 years ago, but this started after the Second World War when employers began to provide health care coverage, and it spawned for the first time most people having health care coverage.

And you talk about Switzerland. I want to say this politely. This is not Switzerland. This is not Switzerland.

Do you favor continuing Medicaid? Yes or no, Mr. Antos?

Mr. ANTOS. You say continuing Medicaid?

Mr. LEVIN. Yes.

Mr. ANTOS. Yes, I favor continuing Medicaid, but with substantial reforms.

Mr. LEVIN. You favor continuing it.

Mr. ANTOS. Yes. We have to help poor people have access to appropriate health care.

Mr. LEVIN. Medicaid provides coverage for more than just poor people.

Mr. Roy, do you favor continuing Medicaid?

Mr. ROY. Yes. If you want to know all about the details of my own views on health reform and how to achieve universal coverage, I have published them at the Manhattan Institute.

Mr. LEVIN. Okay. I understand that. But do you favor continuing Medicaid?

Mr. ROY. Yes. What we need to do though is dramatically reform Medicaid because right now health outcomes for people enrolled in Medicaid are no better than people with no insurance at all, and that is because the system is so poorly designed.

So reforming Medicaid is essential to providing high quality health coverage for the poor.

Mr. LEVIN. So health care under Medicaid is no better than for people with no health insurance at all?

Mr. ROY. According to the New England Journal of Medicine, which published a study looking at Medicaid enrollees in Oregon, people enrolled in Medicaid showed no better health outcomes than people with no insurance at all.

Mr. LEVIN. They were talking about outcomes. That was one study, but that does not mean that people——

Mr. ROY. There are many other studies.

Mr. LEVIN [continuing]. That people who have Medicaid are no better off than people who have no insurance at all.

Mr. ROY. Well, just to be very clear, I support universal coverage. I support health coverage for the poor. I think we should do it in a very different way.

Mr. LEVIN. Mr. Kreisberg, talk a bit if you would about this notion giving people control over their health care.

Mr. KREISBERG. Well, you know, as I indicated in my statement, the health care marketplace simply does not work the way other marketplaces work. When somebody has a disease, they are often in the hands of their trusted physician who will direct them to a lab for tests, direct them to a hospital for services.

What we have now, we group people, and we group them in insurance plans. We group them in self-insured plans offered by employers. And this grouping mechanism provides the ability to negotiate with the provider. At the time that I am diagnosed with cancer, I am not in a position to start shopping around and negotiating with various hospitals who may or may not even give me the time of day in those negotiations.

Those are the big ticket items in health care. We are not talking about a doctor's office visit when I have the flu. Those are not the issues that are driving our health care cost increases. So we have to start from the premise that consumers are not empowered in a health care marketplace and they will not be regardless of what we do.

I think Mr. Roy talked about the fact that there is a monopoly in some states among insurers. How would one individual be able to negotiate with a monopoly? How does that plan, if you will, deal with the issue of a monopolist?

We are better off with large employers and self-insuring to create some confidence.

Chairman BRADY. Thank you all. The time has expired.

Mr. Johnson, you are recognized.

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. Antos, I have a few questions, but I would ask if you would just answer yes or no.

Mr. ANTOS. Sure.

Mr. JOHNSON. First, is it not true that about 155 million Americans receive health insurance through their employer?

Mr. ANTOS. Yes.

Mr. JOHNSON. Next, you stated that the average employer contribution to health care has grown faster than wages, but have health care costs not also grown faster than inflation?

Mr. ANTOS. Yes, absolutely.

Mr. JOHNSON. Now, you also testified that workers would likely prefer lower health care benefits in exchange for higher wages, but depending on how Congress caps the tax exclusion, could the employee not end up paying even higher taxes?

Mr. ANTOS. It is possible. You know, the details do matter.

Mr. JOHNSON. Lastly, your testimony cites a study showing that 30 cents per dollar is wasted, which includes increased spending from consolidation. Do you agree that Congress should also address these issues?

Mr. ANTOS. I think the health system should address the waste in the health system. That is where the solution is going to be.

Congress can help by passing reasonable laws and HHS can help by interpreting them in an appropriate way through regulation, but ultimately it is up to the health system to solve these problems.

Mr. JOHNSON. Well, you know, we always try to pass reasonable laws.

Your answers clearly show that Congress must be very careful though with any changes to employer-provided coverage. The bottom line is that employer health insurance has worked for over 60 years and provides affordable quality insurance to over half of all Americans.

We also cannot lose sight of the importance of promoting free market ideas to reduce cost and increase access, things like FSAs and HRAs and my bill to allow employers to band together to purchase insurance.

I also think this Committee should take a serious look at repealing Obamacare's anticompetitive prohibition on physician-owned hospitals.

Mr. Chairman, I yield back.

Chairman BRADY. Thank you.

Dr. McDermott, you are recognized.

Dr. MCDERMOTT. Thank you, Mr. Chairman.

If Tip O'Neill were here today, he would say, "Well, this is another smoke and mirrors hearing. You blow smoke up in the air, hold up a mirror, and let people see whatever you want."

It has been six years since we passed the Affordable Care Act. We hear rumblings from time to time that the Republicans are about to have a replacement plan, somehow achieving the goals of ACA by tearing it apart.

Now, the truth is we will never get a plan out of the Republicans any different than the ACA. In the six years there has not been a coherent plan in spite of all the attempts to repeal and everything else. They never put anything on the table in writing. It is all smoke and mirrors, folks.

There is good reason they do not have a plan. There is no place to go. The few ideas that have floated would create economic and personal chaos. Paul Krugman wrote a piece in the New York Times this week called "Obamacare Replacement Mirage," and I ask unanimous consent to have it included in the record.

Chairman BRADY. Without objection.

[The information follows:]

The New York Times

The Opinion Pages

The Obamacare Replacement Mirage

April 11, 2016 7:32 am

Hype springs eternal — certainly when it comes to Paul Ryan, whose media image as a Serious, Honest Conservative and policy wonk seems utterly impervious to repeated demonstrations that he is neither serious nor honest, and that he actually knows very little about policy. And here we go again.

But what really amazes me about the latest set of stories is the promise that Ryan will finally deliver the Republican Obamacare alternative that his colleagues in Congress have somehow failed to produce after all these years. No, he won't — because there is no alternative.

Or maybe I should say that there is no alternative to the right. Alternatives to the left do exist. True socialized medicine — an American NHS — would be feasible economically; so would single-payer, in the form of Medicare for all. The reasons we aren't doing those are political.

But on the right, is there a more free-market, more privatized system that could replace the Affordable Care Act without causing the number of uninsured to soar? No, as some of us have tried to explain many times.

Once again: a useful starting point is the problem of people with pre-existing conditions. How can they be offered affordable insurance? You can prohibit insurers from discriminating on the basis of medical history — community rating. But if that's all you do, only sicker people will sign up; many will wait until they get sick to buy insurance; and so costs will be high due to a bad risk pool.

So non-discrimination must be combined with an individual mandate, the requirement that everyone get insurance. But what about people who can't afford it? There must be subsidies to lower-income families, so that they can.

What you end up with, then, is community rating + individual mandate + subsidies — that is, with Obamacare. There's nothing arbitrary about it, and you can't pick and choose from the elements: it's a three-legged stool that needs all three legs to stand. And it can't be made cheaper, either — the subsidies are already on the low end, requiring that the allowed policies can involve higher deductibles than they really should.

And all this, in turn, is the reason Republicans haven't come up with an alternative. It's not because they're timid, or lazy, or stupid (they may be all these things, but that's not why they've come up short). It's because there is no alternative that wouldn't involve taking coverage away from tens of millions.

So no, Ryan isn't going to roll out a magical solution to this problem in the next couple of months. Even if he were the policy wonk he pretends to be, he couldn't do the impossible.

Mr. MCDERMOTT. And it describes Speaker Ryan's problem precisely. It is that there is no place to go. If you want to cover all Americans and secure financial security and control costs, you have limited options.

One is a single payer system. I support that, but we do not have that. So I am supporting what we have and trying to fix it. That cuts the greed and the insurance industry waste out of the program, the single payer system.

The other alternative is to rely on the existing system, while eliminating abuses in the insurance industry, and that would mean community rating and guaranteeing coverage for consumers with preexisting conditions.

Because a system like that would require insurers to cover sicker populations you need a mechanism to balance the pool of people, and that is where the individual mandate comes in. You cannot have a pool of just sick people in the insurance plan and have the sick ones out here waiting for the day when they can run in and get their insurance. They all have to be in.

Now, if you have an individual mandate, you need to be able to afford the coverage. That is a common sense understanding. So you need to subsidize premiums and you need to reduce cost sharing for lower income people. That is also common sense.

In essence, it is the only reasonable alternative to a single payer system. It looks like the Affordable Care Act, and that is why the Republicans have nowhere to go. They will not fix it. We will not have hearings in this Committee about consolidation in health care or on drug prices.

You bring up Switzerland. Switzerland has a highly regulated government system that is run by insurance companies. They negotiate the drug prices in Switzerland. We do not allow the government to negotiate the drug prices in this country because this Committee will not have a hearing, will not have a hearing on what is going on with drug prices in this country.

Now, if you want to get rid of the individual mandate and keep in place the issue for people with preexisting conditions, you put the insurance industry into a death spiral. We did exactly that in an experiment in Washington State in the 1990s, and we lost the individual market because you cannot have guaranteed issue and not have some way to save the insurance companies.

Now, if you want to take away American subsidies, that will mean you are going to have financial hardship for everybody, and you will not be able to have insurance because most people cannot afford it without either employer help or government help.

That is what is going on right now in the ACA, and if you want to continue these hollow efforts to repeal the ACA, what you are saying is one of two things. Either you want to replace the ACA with a single payer system—and I am for that. I will sign up today for that—or, two, you do not want to provide health care coverage for the American people, for all the American people. You only want it for the financially able American people.

The health savings accounts are for rich people. Poor people do not have those things. They cannot use that because they cannot pay the deductibles.

So you cannot have it both ways, and unfortunately we are having another hearing for this smoke and mirrors business. We will not get it without having adjustments to the Affordable Care Act because that is the Republican program.

Chairman BRADY. We may need to call on Switzerland to mediate the differences between the Committee on health care.

Mr. Tiberi, you are recognized.

Mr. TIBERI. Thank you, Mr. Chairman.

You know, one of the things I love about this Committee and my friends Mr. Levin and Mr. McDermott, and I do believe their hearts are in the right spot, but you never cease to remind me as to why I am a Republican, and I appreciate that a lot.

Because I do care about people. Everybody on this side of the aisle like your side of the aisle cares about people, but it is a challenge for me because Mr. Roy said he is for universal health care. I am for universal health care, and in fact, in my state—it is probably different in Michigan—we expanded Medicaid, but I run into people every day when I am back home, whether it is a hospital administrator, whether it is a physician, whether it is somebody on Medicaid or a family member of somebody on Medicaid, who cannot get access to a primary care doctor because the primary care doctor thinks that Medicaid is flawed.

I think that was your point. So, Mr. Levin, Mr. McDermott, to sit up here and say that just because Obamacare passed, everything is well and good and there are no challenges for people, not the rich by the way, is frustrating to me.

Because what Obamacare also did at least in my district, maybe not yours, is that people who were excited about it passing were excited also about the President saying if you like what you have, you can keep it, and I continue to run into people who have not gotten to keep what they had and are paying more and getting less, quite honestly.

I get frustrated up here when every time we have a hearing to try and improve the health care system for patients, for my mom and dad, and we have talked before. Mr. Thompson is looking at me, with respect to this silver bullet of negotiating prescription drugs and how great that is. Well, my dad experienced how great that is not and how wonderful Part D, quite frankly, has been.

I have an aunt who does not have to go to Canada anymore because of Medicare Part D.

So, Mr. Roy, this was supposed to be about the tax exclusion. I have a sister who many years ago had a little boy. He is now going to graduate from Ohio State, Go Bucks, in a couple of weeks, and when he was a little boy, they moved away to Cincinnati, and she came back over the Christmas holiday. He got sick. The former pediatrician gave him a drug to take. During the Christmas holiday she gave him this prescription. He got better, and before New Year's Day, she threw away the prescription.

And I said to her, "What are you doing? If he gets sick again, there is still medication left."

She said, "Do not be so cheap. It costs $3. I will get another prescription."

But the point is, just like what Mr. Brady talked about, she is excluded from the true cost of that drug. My mother-in-law had a

stroke a year ago. My wife is a pretty smart person. She is an accountant. Everything was focused on where to go after the hospital for rehab on what insurance covered, not on quality, not on cost. We do not know to this day how much it cost.

Well, thank goodness we had good quality or she had good quality care, but the consumer, the patient because the system is not patient centered. Whether it is a Medicaid patient who cannot get in to see a primary care doc and ends up in the emergency room in Columbus, Ohio, or my mother-in-law who is going to a rehab facility, the patient is excluded from the cost of the care.

How do we get patient-centered care and patients focused on the cost so that there is not over utilization, so that there is more transparency, and all of us know that there is not just some tree in the backyard we are pulling money off of, and we do not have any competition?

Mr. ROY. The only way to have patient-centered health care is for the patient to control the health care dollars. We do not have patient-centered health care today because employers and insurance companies and the government control the dollar, and that is why we have government centered health care, not patient-centered health care.

I want to bring up a point that was brought up earlier about Switzerland and how it allegedly has regulated prices. What it has is insurance companies that can jointly negotiate prices with hospitals and drug companies, and that is a system that I have written about with Forbes we could have here. All you have to do is have an antitrust exemption for those kinds of negotiations for private insurers in Switzerland or in the United States.

So there are market-based systems elsewhere that we can learn from, but you are never going to have a patient-centered health care system unless the patient is controlling the dollars.

Mr. TIBERI. And you are for quality health care.

Mr. ROY. Absolutely.

Mr. TIBERI. Thank you.

Mr. ROY. And, again, I have written about this extensively. I would encourage anyone who is interested in a detailed plan on health reform to download it from the Manhattan Institute or the American Enterprise Institute, for that matter.

Mr. TIBERI. I yield back.

Chairman BRADY. Thank you.

Mr. Lewis, you are recognized.

Mr. LEWIS. Thank you very much, Mr. Chairman.

Thank each one of you for being here this morning.

I would just like to note whether you believe in health care as a right, as a right, in a country such as ours, health care for all. Do you subscribe to that idea?

Mr. ROY. Is the question addressed to me, sir?

Mr. LEWIS. Any of you.

Mr. ROY. First let me just say, Mr. Lewis, it is always a pleasure to speak with you. You are a personal hero of mine.

I support universal coverage. I think, like many of your colleagues, a country that is as wealthy as ours should strive to provide quality health coverage for every American.

But the way to do that is to maximize the degree to which individuals are controlling those health care dollars and subsidize through tax credits or refundable tax credits those choices for those who need the help.

Mr. KREISBERG. Good morning, Mr. Lewis. Yes, our union definitely supports health care as a right. It is really a matter of——

Mr. LEWIS. A fundamental right?

Mr. KREISBERG. A fundamental right to health care is something that we fully support.

Mr. ANTOS. I agree with Mr. Roy. I would also make the distinction between health care and health insurance. Just because you have health insurance does not necessarily mean you are getting appropriate care.

So I think we need to work on both financing and delivery reform.

Mr. LEWIS. But if you accept the idea that it is a right, in a democratic society such as ours.

Mr. ANTOS. Yes. I agree with Mr. Roy. I think I probably agree with everyone in the room that everyone should have health insurance, and those who need support to obtain that coverage should get it.

Mr. LEWIS. But do you see the Affordable Care Act as a down payment, as a major down payment for all citizens? It is not perfect.

Mr. ANTOS. I am sorry. You referred to the Affordable Care Act?

Mr. LEWIS. Yes.

Mr. ANTOS. Well, it is a down payment in a sense, but I would argue for fairly substantial reforms. Certainly the idea of——

Mr. LEWIS. Will you subscribe to the idea that it is a major down payment?

Mr. ANTOS. So part of the down payment was to change, and I think it is a very important change, to change insurance rules so that if you have a preexisting condition, that cannot be held against you in terms of access to insurance or premiums. I think that is a good change. I do not see us ever moving back from that.

But as far as the way we are financing it, as far as the complicated way we are making people try to understand what options they have, as far as the restrictions on what insurance must cover, I think those are things that need to be dealt with.

Mr. LEWIS. What would you say to the average person who is receiving health care now that did not have it before? What would you say to them if you get rid of the Affordable Care Act?

Mr. ANTOS. Well, I support reforming the law that exists today, and so I would argue that the appropriate reform would, in fact, give everyone access to insurance and give those who need help the most have support from the taxpayer, and that includes the people obviously, most of the people who are signing up on the exchanges.

Most of the people are signing up because they are getting substantial subsidies. The people who do not get substantial subsidies are not signing up, which is a major problem with risk selection in the exchanges.

Mr. LEWIS. Mr. Kreisberg, do you care to respond, sir?

Mr. KREISBERG. Yes. The first thing I would say is I appreciate that everybody does join in the idea of universal coverage, and I

would ask Manhattan Institute and AEI to join AFSCME in going to those other 20 states so we can adopt Medicaid expansion, so that we can really go a lot further in getting to universal coverage.

Because we have 20 states that do not buy into the idea that it is a fundamental human right, and it is a fundamental part of being American to have health care coverage. Because they have that opportunity at no cost to the state, and yet they refused to participate in the Medicaid expansion.

Now, with that said, I think the——

Mr. LEWIS. Is that true in many of the states where the Republicans are governors?

Mr. KREISBERG. Well, you have these Republican governors, Republican legislatures. You know, I do not want to necessarily make it overly partisan, but it is a partisan issue, I suppose. It is ideological. It is ideological opposition to the idea that we are going to have a government program that addresses a real pressing problem that affects real people.

We know that a child will not reach his or her potential if they do not have health care.

Chairman BRADY. Thank you. All time has expired.

Mr. Smith, you are recognized.

Mr. SMITH OF NEBRASKA. Thank you, Mr. Chairman.

And thank you to our witnesses.

I want to focus on consumerism and health care because I do not think the American people are offended that there is a suggestion that we should have health insurance. It is that the government is forcing people to have insurance coverage that many would find personally objectionable.

And I think it is a good idea to have health insurance. I look back at when I had my first real job out of college. I assumed that the group plan was the best for me. So I did not shop around. I would later learn that I could have saved a lot of money by shopping around, and so I was not the best of consumers then.

And I certainly see policies today that discourage consumerism and certainly discourage, well, prohibit people from exercising what I would call freedom to decide what is the best coverage that would be there for their families or themselves as individuals.

So what can we do to encourage more consumerism? And I do not want to take coverage away.

Another concern that I have, is push to expand Medicaid. All the while we know that it pulls people off of private pay in some cases, and Medicaid provides lower reimbursements to hospitals and doctors, and so it becomes this vicious cycle of who loses, consumers, patients, and drives up the debt and fewer choices are out there.

What can we do to encourage more consumerism? Mr. Roy.

Mr. ROY. Yes. So, again, I would say that the biggest thing that you can do to encourage consumerism is to have the patient control the health care dollars. The reason why we do not have an Uber for health care or we do not have the kinds of technological innovations that have changed the rest of our economy. Why is that not happening in health care? It is because those things can only happen when the consumer can direct his or her dollars to the health care service that he or she needs.

When the government or the insurance company or large employers control those dollars, then the consumers are not involved in those decisions. So you have to have the patient in charge of the health care dollars and health tax reform, which this Committee is considering, is the central key step to achieving that goal.

Mr. SMITH OF NEBRASKA. Mr. Kreisberg, in your previous comments, you were talking about the overall health care issue. Is it possible that there would be a good health care plan that would not be drafted or controlled by the government?

Mr. KREISBERG. Of course.

Mr. SMITH OF NEBRASKA. What can we do to head in that direction?

Mr. KREISBERG. Well, I am in a good health care plan that is not controlled by the government. It is in private insurance.

Mr. SMITH OF NEBRASKA. Is it a plan that millions of Americans would not find personally objectionable?

Mr. KREISBERG. I think the plan that I am in, most Americans would be satisfied with.

Mr. SMITH OF NEBRASKA. Okay.

Mr. KREISBERG. But I think to be more precise with my answer, Mr. Smith, we need minimum standards for plans just like we regulate who can call themselves a physician. We need people to have adequate coverage because what happens is if I am in inadequate coverage and I now have a dread disease and this plan does not cover me, in our system and in this country, I am not going to die on the streets, and that is a good thing, but yet I have shirked my individual and personal responsibility to have adequate coverage, and now the rest of you are paying for my health care.

So that is why we have things like an individual mandate and minimum benefits, essential health benefits, so that we can ensure that our plans provide the services that will keep people healthy and treat them when they are sick and they are sufficient.

We cannot just let anything be sold and be told that it is health insurance because when consumers shop for these, they do not know all of the intricacies of that.

Mr. SMITH OF NEBRASKA. But the government should tell people what health insurance is, that individuals themselves should not be able to decide for themselves?

Mr. KREISBERG. I think they can decide for themselves, but I think we need minimum standards. It is just as we regulate many other things in our society. Individual consumers at a point of sale for health benefits have time and again in the individual market been caught by surprise. This is in the old days before the Affordable Care Act. They have been shocked that their plan did not cover certain services, and then they were sick and they were not covered.

Chairman BRADY. Would the gentleman yield?

Mr. KREISBERG. Because of a lot of fine print.

Chairman BRADY. If I may, would the gentleman rest?

Mr. SMITH OF NEBRASKA. Yes.

Chairman BRADY. You know, he has made a key point here. You know, if your employer said, "Here are the clothes you will wear in your personal life and here is the car you will drive in your personal life," most of us would say no, but today they say, "Here

is the health care you will have in your personal life. Just take it or leave it."

And the point I think Mr. Smith was making was that why can we not give Americans more choice over maybe the most personal spending they will ever make in their lives, and I think that is his point.

With that, let me yield back, Mr. Smith, since I took the rest of your time.

Mr. SMITH OF NEBRASKA. No, I think we want consumers with their providers to be driving the bus, not the heavy handed Federal Government.

Thank you.

Chairman BRADY. Thank you.

Mr. Neal, you are recognized.

Mr. NEAL. A quick comment on the chairman's analysis. I think what he is really saying is that under their plan you would have no car and no new clothes because when you consider that there were 30 million people——

Chairman BRADY. And no jobs under Obama.

Mr. NEAL. No 30 million people—we are going to take that question up right now, Mr. Chairman—there were 30 million people without health insurance, at least, and by all objective analysis 20 million people have secured health insurance under the Affordable Care Act.

Now, we all acknowledge that there has been a net gain of about 14 million private sector jobs over the post-recession period, and all of that net gain in employment has been in full-time work. Reform opponents have repeatedly suggested that the ACA is having an adverse effect on jobs. To date there is no evidence that the ACA has had a negative impact on economic growth or jobs, and in fact has moderated health care costs, which is generally accepted.

But, Mr. Kreisberg, based on your experience and analysis, would you address the point that I have just raised? And I am going to give you sufficient time to go through it from A to Z, please.

Mr. KREISBERG. Sure. First of all, I agree with you. I do not think there is any evidence that the ACA has been, as it has been alleged to be a job killer. First of all, it is a very, very difficult thing to ascertain, cause and effect, and I think everybody will agree with that.

And with all due respect to the CBO, they have been wrong far more than they have been right about everything that they have estimated about the Affordable Care Act, and this is one of those things where they have estimated.

But if you read the CBO report carefully, what you will see is they are not saying that people are losing their jobs. They are saying people are withdrawing from the labor force. There is a reduction of labor supply, not a reduction in labor demand because of the Affordable Care Act, and that is a significant distinction.

What we are seeing is people as they are approaching age 65 but are not yet eligible for Medicare and do not feel that they can work any longer, now they have an option not to work.

We are also seeing on the margins, for instance, people in the Medicaid program maybe reducing hours, which is what CBO has

said. We do not know if that is true or not. I think it is really hypothetical, and I think, again, it is very difficult for cause and effect, and it is almost impossible to do the empirical analysis to validate some of the hypothesis that we have made.

But we do know that after the fact you can look back and we know they have been wrong time and again when it comes to the Affordable Care Act.

So I think when we look at labor market effects we really need to focus on the fact that the Affordable Care Act has probably changed more of the supply factors than the demand from employers. So it is not a job killer in that sense, and I do not necessarily think it is a bad thing if people withdraw from the labor market at the age of 62, 63 or 64.

If one of the problems we have in our society is stagnant wages, perhaps a reduction in supply of people who no longer feel they can work will help create a little bit higher wage growth in this country because you have less supply, and demand should be relatively static.

So I think, you know, this could be one of the things that actually help us as we move forward.

Mr. NEAL. Since we have a minute and 44 seconds, Mr. Kreisberg, we had a conversation earlier about the role that deductibles play, and I thought that your analysis of that was pretty interesting. Could you give us a quick analysis?

Mr. KREISBERG. Yes. In our view, the high deductible health plans are really not where the action should be, and I think when we talk about how the consumers should control the dollars, we are really talking about more consumer payments, and I touched on this in my statement.

Very, very few people are responsible for most of our health care costs. Those people are profoundly sick. It is not necessarily the same people year after year, but it is episodes of care that drive our expenses.

The high deductible health care system does not get at that. In fact, what we are also seeing with high deductible health care is the trend in health care cost increases actually exceeds those of the other plan designs. So we are not seeing any long-term moderation, you know, from those high deductible health plans.

And ultimately the shifting of costs to consumers and putting, you know, consumers in control of the dollars, we do not see as very effective because the consumer has no ability, none, to negotiate with a hospital. They may be able to choose their provider and maybe some providers provide better rates than other providers, but the idea is that we have insurance companies and self-insured employers who do those negotiations for us, and they are in a much better position to negotiate with those providers because they represent hundreds of thousands or millions of covered lives as opposed to an individual consumer trying to do the negotiation.

So if we are going to drive down costs, we need to keep the groups together. We need large groups, large negotiating bodies, and most importantly, we need to change the incentives in our health care system. We need to align our financial incentives with quality and value.

Mr. NEAL. Thank you, Mr. Chairman.

Chairman BRADY. Thank you, Mr. Neal.

Mr. Reichert, you are recognized.

Mr. REICHERT. Thank you, Mr. Chairman.

I would like to echo the statements of the chairman and my colleagues about the value of employer-sponsored health insurance. The current exclusion is an important part of why so many of my constituents enjoy quality health coverage today. Employer-based coverage is not only popular, but businesses in my district absolutely need it.

We have heard today, however, there are some issues surrounding the exclusion. Obamacare took one approach to tackling this through the Cadillac tax, and unfortunately Obamacare got it wrong. It is crude; it is complex; and it's wrong policy, and there is bipartisan support for its repeal.

So I would like to look further at some of the shortcomings of Obamacare's approach through the Cadillac tax. So, Mr. Antos and Mr. Roy, does the Cadillac tax currently adjust for health care costs that might be higher simply because they are delivered in a place with a high cost of living?

Mr. ANTOS. No.

Mr. REICHERT. Same answer, I am assuming?

Mr. ROY. No. Yes, actually it does. The Cadillac tax is designed to have a certain band in terms of its thresholds based on health costs in a particular area.

Mr. REICHERT. Okay. Well, I do not think it does either. I agree with Mr. Antos. I think Congress might better address though these geographic variations, and there is a variation in cost of living that should be, considered. The cost of health care varies throughout the country.

How might we address these geographic variations in future reforms, Mr. Antos?

Mr. ANTOS. It is a difficult question. Obviously part of the solution is to reduce some of the unnecessary regulations that are keeping costs up. States are part of the problem, not part of the solution in many cases.

But beyond that we need to have the kind of coverage that promotes a closer relationship between the consumer and the insurance company. I agree that the consumer is not going to negotiate individual prices with the hospital. That is the job of the insurance company.

But right now the insurance company really does not see the driver of this as their consumers. They are being driven by government regulation and the relationship to employers. So we need to turn that around so the consumers are more in charge in that practical sense.

Mr. REICHERT. Another major concern is that employee contributions to their health care through an HSA are counted toward the cost of care that is measured against the Cadillac tax threshold. Likewise, spending on wellness is also counted.

Can you tell me why? Mr. Roy.

Mr. ROY. Yes. This is one of the major design flaws of the Cadillac tax, is that it is designed effectively to prevent people from having more consumer-based health insurance plans. HSAs are inhibited by the Cadillac tax. As you noted, wellness programs are

somewhat inhibited, and also there are a number of loopholes and exceptions in the way the Cadillac tax applies to different constituencies, different employer groups and different areas of the country.

So it would be much cleaner to have a gradually introduce cap on the employer tax exclusion as some others and we have discussed today so that it is a simple system that applies fairly to everyone.

The challenge is if you heavily vary the tax deduction or the tax exclusion based on particular regions of the country, you might actually have the perverse consequence of rewarding high regulation states that drive up the cost of insurance in their state because they do not face the tax consequences.

Mr. REICHERT. Do you have any idea why it was designed this way?

Mr. ROY. I was not in the room when the Affordable Care Act was designed, but I understand that various interest groups lobbied for exceptions and changes to the Cadillac tax so that it could serve their interests better.

Mr. REICHERT. Mr. Antos.

Mr. ANTOS. So one other aspect of this, I think that the philosophy was that we did not want to have any leakages. So we are going to include these other health related benefits in to count the cost. It was basically trying to keep everything, you know, in the same corral and not have leakages that would have employers, for example, subsidizing health savings accounts more fully.

Mr. REICHERT. Thank you.

I yield back.

Chairman BRADY. Thank you.

Mr. Becerra, you are recognized.

Mr. BECERRA. Thank you, Mr. Chairman.

Gentlemen, thank you for your testimony.

Let me see if I can run through a few areas, and first, Mr. Antos, to you and Mr. Roy. I understand you all have put together the elements of a plan that could be an alternative to the Affordable Care Act. Have you asked that that be placed in legislative writing so we could actually see it as a form of a bill?

Mr. ROY. There are two plans. There is a plan that Mr. Antos and I collaborated on with some other colleagues that was published by the American Enterprise Institute. I think there were ten coauthors, if that is the plan that you are referring to.

Then there is the one that I published through the Manhattan Institute individually. Neither of those plans has been introduced as legislation or put in legislative language, but our hope is that that may happen at some point.

Mr. BECERRA. Do you have any supporters on the Hill, on the House or Senate side, for either of those two plans?

Mr. ROY. I think that a lot of the general concepts are being considered in a lot of the working groups that the speaker has organized.

Mr. BECERRA. So we are six years past the enactment of the Affordable Care Act. We were told by those who objected to the Affordable Care Act, didn't vote for the Affordable Care Act, that we need to repeal it, get rid of it, and replace it.

We have yet to see a proposal in legislative language that has been able to garner any kind of support that could pass to replace the repeal of the Affordable Care Act, and I am wondering: can you name any member of Congress who is ready to endorse by submitting your plan into legislation?

Mr. ROY. What I would say is——

Mr. BECERRA. No, no. Can you name me a member in the Senate or the House who is prepared to endorse——

Mr. PRICE. I will volunteer.

Mr. BECERRA. I'm sorry?

Mr. PRICE. I will volunteer.

Mr. BECERRA. Okay. So Mr. Price is willing to introduce your plan. So you have got a taker. Will you submit it to Congressman Price so he could submit that into legislative writing?

Mr. ROY. More than happy to work with Mr. Price.

Mr. BECERRA. So this way we can actually have something to compare because we will need to have the Congressional Budget Office, Joint Tax Committee, everyone do the analysis so we can see what we are talking about. Because until then we are talking apples to oranges. We want to see what your apple looks like. We see what the Affordable Care looks like.

Twenty million Americans today as a result of the Affordable Care Act have health access, health insurance, and I think for those who kept saying that it was going to cost us jobs, in the time that the Affordable Care Act has been in place as a law, we have had close to 1.7 million Americans go to work or go back to work not overall, just in the health care sector. Overall some 14 million Americans have gone back to work.

So it is going to be interesting to see what your plan, once it is scored, out really shows us.

Mr. RANGEL. Will the gentleman yield?

Mr. BECERRA. Certainly, I will yield.

Mr. RANGEL. Dr. Price, I would like to join with you in cosponsoring this fictitious plan that has been out there for six years, and if they can really help the Republicans come up with something, Mr. Roy would you contact my office and Dr. Price's office so that we will get some legislative language to know exactly what you are talking about?

Mr. BECERRA. I am going to reclaim my time. Mr. Roy, you can talk to Mr. Rangel afterwards. I want to reclaim my time so I can ask a couple more questions.

Mr. Antos, Mr. Roy, so I have seen some elements of your plan. High deductible with HSAs, you are trying to make them a little bit more robust. Those are parts of what the plans typically include?

I am not trying to name everything.

Mr. ROY. You can choose a plan. So the key element is——

Mr. BECERRA. I do not want to get into all of it, but I just want to make sure. It does rely to some degree on high deductible plans?

Mr. ROY. No, that is not correct.

Mr. ANTOS. No.

Mr. BECERRA. Okay. I apologize. Do you support high deductible plans?

Mr. ANTOS. As a choice, yes.

Mr. BECERRA. As a choice, okay. And let me ask this. Would you support high deductible plans with access to an HSA, health savings account—because that typically is the way that they are packaged, right, so you can make the most use of them?—for seniors under Medicare?

Mr. ANTOS. Yes, I think that is a feasible possibility, too.

Mr. BECERRA. Mr. Roy.

Mr. ROY. Yes.

Mr. BECERRA. Okay. Final question. I think Mr. Kreisberg answered the question about whether you believe health care is a right in this country for Americans. I do not think I heard you say yes or no. If it is not a right, then obviously it is a privilege that we can try to get access to.

Do you believe it is a right?

Mr. ROY. Let me tell you a story.

Mr. BECERRA. Oh, no, no, no. I do not have time. I have a lot of questions.

Mr. ROY. Because health care——

Mr. BECERRA. I do not have time for a story.

Mr. ROY. You have to understand what health care is.

Mr. BECERRA. Mr. Roy, Mr. Roy.

Mr. ROY. You have to understand what a right is.

Mr. BECERRA. If you do not wish to answer the question that is fine, but I just asked the question. Yes or no?

Mr. ROY. I refer you to an Article I wrote for Forbes called "Yes, Health Care Is an Individual Right."

Mr. BECERRA. Mr. Anthos? Yes or no?

Chairman BRADY. All time has expired.

Mr. BECERRA. Mr. Chairman, if I could just ask him to answer the question.

Chairman BRADY. Mr. Boustany, you are recognized.

Mr. BOUSTANY. Thank you, Mr. Chairman.

Mr. Chairman, I believe I have the time now.

Mr. BECERRA. Mr. Chairman, could I get just five seconds so that the gentleman could answer?

Mr. BOUSTANY. Mr. Chairman, I believe I have the time.

Chairman BRADY. I will tell you what. Another member can ask that question or perhaps you could submit the answer in writing.

Dr. Boustany.

Mr. BOUSTANY. Mr. Chairman, prior to coming to Congress I was a cardiothoracic surgeon, had extensive clinical experience over many, many years, and really got to know our health care system with all of its warts and good things about it at a very intimate level, and now I have had the benefit of serving on this Committee and understanding all of the policy ramifications and how we deal with the problems inherent in the system.

And I could certainly talk for hours about this, but I do want to dovetail off of what my friend from California just talked about when he asked a very, I think, artificial question about creating a dichotomy: is it a right or is it a privilege with regard to health care?

Actually it is neither. It is a personal responsibility. Nobody can be responsible for my health other than me because there are different dimensions to health care. Yes, you need all of the care. You

need the coverage, but what is missing right now in our health care system today is the fact that individual responsibility and education and information is missing, and that is one of the reasons we do not have a good functioning market in health care.

That is one of the reasons I like HSAs and other patient driven forms of coverage that lead to an informed consumer of health products that gets to where we need to be.

And I was very pleased I heard the testimony before I had to step out for just a moment, and, Mr. Roy, you talked about equalizing the treatment, and that is what has been missing in all of this, is equalizing treatment and letting people decide what is best for them.

You cannot get to high quality, low cost health care without a robust doctor-patient relationship. I can tell you from personal experience, clinical experience expanding over many years in my life both here and in clinical practice we have got to inject personal responsibility into this. Otherwise we cannot save on the front end.

I mean, some of the issues with Medicaid, again, it does not lead to a meaningful doctor-patient relationship. The access is very severely inhibited.

So let us explore this concept a little bit about the injection of personal responsibility. Mr. Roy.

Mr. ROY. Health care is a right, and what I mean by that is that it is the right of individuals in this country to choose the health care that they want, to choose the health coverage they want, to choose the doctor they want, the nurse they want, the form of urgent care that they need.

Those rights have been abridged by Congress over an 80-year period, and if we believe that health care is a right, then we have to maximize the ability of people to control their own health care dollars, not the government, not insurance companies, not employers.

Mr. BOUSTANY. Thank you.

Mr. Antos, do you want to comment?

Mr. ANTOS. I completely agree with Mr. Roy. The distinction between personal choice and personal responsibility is often overlooked. You need both.

Mr. BOUSTANY. Thank you.

Mr. Kreisberg, do you want to comment?

Mr. KREISBERG. Yes. You know, I agree in some respects, but I think where we part ways is this idea of personal responsibility because we also——

Mr. BOUSTANY. But is not that the American way of doing things?

Mr. KREISBERG. Well, let me finish please—because we agree with personal responsibility, and I think the approach that my colleagues here take discards personal responsibility because personal responsibility connotes adequacy of coverage. So the government mandates that we sometimes criticize and rebel against are really just providing a basic standard because if I have inadequate coverage because health care is a right, I am still going to get treated. We have a law. EMTALA will take care of me.

Mr. BOUSTANY. But it is not the most efficient, high quality way, and the problem that you are overlooking in all of this, coverage does not necessarily equate to high quality care, and that is

a fundamental problem in our health care system today because whether it is the Medicaid or Medicare system increasingly those individuals do not have access to a high quality doctor-patient relationship. It is in the emergency room. It is treatment after the fact, much later in the disease process.

I can tell you from years of clinical experience you have got to establish a high quality doctor-patient relationship on the front end. Coverage is important, but there are two sides to that equation. There is what the doctor does and recommends, but there is also the personal responsibility element and informational element for the patient.

And you can have the very best surgeon or physician caring for a patient, but if there is no element of personal responsibility or even diminishment in that level of personal responsibility, you are not going to get a good outcome. So you have to empower individuals, and that fits into our American system of economics, economic freedom, individual liberty, and informed consumers.

That is what is missing in our system.

I yield back.

Chairman BRADY. Thank you.

Mr. Doggett, you are recognized.

Mr. DOGGETT. Thank you very much, Mr. Chairman and to each of our witnesses.

Mr. Kreisberg, I believe that you are the first witness to appear in front of our Committee in some time to raise the issue of exorbitant pharmaceutical prices. It has been a concern of mine. I think it is appropriate to raise this morning because high pharmaceutical prices are taxing to the American people. In fact, I think they are overtaxing.

Mr. Chairman, I would respectfully ask that we make part of the record a letter sent to you back on November 5th requesting a full Committee hearing on prescription drug pricing from ten members of our Committee.

Chairman BRADY. Without objection.

[The information follows:]

Congress of the United States
Washington, DC 20515

Chairman Kevin Brady
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Brady,

We urge you to hold an immediate, full committee hearing on prescription drug pricing. As you know, the Committee on Ways & Means has jurisdiction over many areas of law that could be effectively used to address prescription drug prices for families across the nation.

The pricing of pharmaceutical drugs has dramatic repercussions for hardworking American families. A serious health diagnosis is a terrible health care tragedy. In those times of sadness and stress, families should not have to be worried about how they will afford the prescription drugs their loved ones need, which can lead to financial hardship when the cost of some drugs may total more than $100,000 a year.

As we aim to manage health care costs across all sectors, we remain concerned about the growing cost of prescription drugs. Nationwide expenditures on prescription drugs rose more than 13 percent in 2014, reaching a total of $374 billion. Medicare alone spends more than $120 billion annually.

A recent decision by Turing Pharmaceutical to increase the cost of a drug, which helps people with weakened immune systems, from $13.50 to $750 per pill deservedly garnered significant public outrage. Medical experts called this increase "unjustified" and "unsustainable." Under

public pressure, the owner of the drug now announced it would be lowering the cost of the drug to some unspecified amount— raising troubling questions about why this pricing decision was made in the first place. We believe that the Committee can play a valuable role in being responsive to the American people's serious concerns about drug prices and a hearing is an important first step.

Meaningful action to end unfair drug pricing is long overdue and a hearing is necessary to assess how we can address this issue. We look forward to working with you on this vital matter.

Sincerely,

Mr. DOGGETT. Mr. Chairman, that letter emphasized the dramatic impact that high prescription drug prices are having on so many American families and the tremendous financial hardship to not only get a diagnosis of cancer or some other dread disease, but to face a prognosis of personal financial ruin for many drug treatment programs that are exceeding $100,000 a year.

It also pointed to the big impact on taxpayers of the increased cost of public health programs in Medicare, in Medicaid, in other programs because of rising prescription drug prices, and while much of the attention back at the time the letter was written centered on an increase on one particular generic drug from $13.50 to $750 overnight, this is not about one pharmaceutical or one type of pharmaceutical.

As you point out, Mr. Kreisberg, in your testimony, this is not just about brand name pharmaceuticals or generics. It is a systemic problem of which there are many aspects, and you pointed to some of the solutions that might be raised.

I would just like to see our Committee and this Congress recognize that there is a serious pharmaceutical price problem and begin to look for some answers rather than simply to ignore the problem.

You made reference, Mr. Kreisberg, in your testimony to the work that the AARP, the American Association for Retired People, has done on this. In February of this year, since the November letter that we sent requesting that this Committee focus its attention on this matter, AARP put out a report that noted the average cost of a year's supply of a prescription drug has doubled in just the last seven years. It talked about the incredible set of price hikes that have been occurring and referred to a Kaiser Family Foundation study that said that almost half of sick Americans, of people that were not in good health, said they were having serious trouble in paying for their medications.

We see year after year prescription drug prices soaring far in excess of the level of inflation. Among the suggestions that you have made, Mr. Kreisberg, is that we recognize that there is not true competition, that the marketplace does not work for some brand name pharmaceuticals.

I believe there is already a remedy under existing law through a law that was written by Senator Bayh and Senator Bob Dole that would give, when taxpayers have funded the research, would give the National Institutes of Health an opportunity to say if the price has gotten so exorbitant, then we are going to let competition try to bring it down by licensing to competitors.

Do you believe that when taxpayers pay for the research that leads to a new pharmaceutical that we have a stake in the price that consumers will ultimately be charged for that pharmaceutical and that the administration should be asserting its rights?

Mr. KREISBERG. Yes, sir. I absolutely do believe that if the taxpayers have funded the development of a prescription drug, there certainly should be a fair return to the taxpayer. I think we have to recognize for those of us who believe in a free market system that one of the biggest interventions and impediments is intellectual property rights. So if we withdrew intellectual property rights, I mean, that interferes with the free market.

Now, no one is advocating that completely because we do need to fund research and development costs, but in the case you are talking about, if the NIH or some other government agency has funded that research and development, certainly the benefits of that should flow to the American people who paid for the research associated with the brand name drug.

Mr. DOGGETT. Thank you.

Thank you, Mr. Chairman.

Chairman BRADY. Thank you, Mr. Doggett.

Mr. Roskam, you are recognized.

Mr. ROSKAM. Thank you, Chairman Brady, for initiating this hearing.

You know, it is interesting to listen to the back-and-forth a little bit, and let me put this into a little bit of a context. In his opening statement the ranking member talked about a constituent where she said the Affordable Care Act saved her life.

I have a constituent who had a different experience, and her experience was she relied on the President's promises that if you like your doctor you get to keep your doctor; if you like your coverage, you get to keep your coverage, and her experience was as a nine-year breast cancer survivor she found herself very happy with her health care and completely turned around as a result of the Affordable Care Act.

So we can go back anecdote for anecdote, but I think there is a restlessness that is out there, and it was interesting to listen to you, Mr. Kreisberg, about some of the things that you were pointing out accurately. We have got problems as it relates to primary care.

I do not know if you said this, but I am thinking this. We have got problems as it relates to increased coverage for people, and yet those were all promises that the Affordable Care Act were going to remedy. Remember it was, hey, there is going to be all of this primary care coverage. ERs, you are not going to have to see people, and yet none of that has turned out to be true.

So it was oversold. It has underperformed, and it has created a national restlessness. I would argue a restlessness that cost the majority for the Democratic Party, God bless them, the House of Representatives and it cost them the United States Senate.

And what was interesting about the reconciliation bill a couple of months ago was it was the first time that it became clear to the American public that there is only one office that stands between them and the repeal of Obamacare, and that is the White House. That is really interesting, and it is a long-term trend, and it is a restlessness that the country is articulating.

Now, Mr. Becerra makes a fair point, and his point is that we know you do not like the bill. You have been very clear that you do not like the Act. Where is your replacement? And that is a fair criticism, and it is a fair admonition, and I accept that.

So I think what the chairman is trying to do, and I know what Speaker Ryan is trying to do is to do the prelude work because it has been very clear that the President will not sign something that is orthodoxy for him. So rather than bumping our heads up against the wall, let us instead try and do the robust work now.

It also seems to me that sitting back and listening to the totality of the debate is there is nobody that is really defending how we got here with this large employer-based system, and there is a general recognition that there are two things that are really wrong with our health care system. One is it is too expensive and it is irrationally expensive, and many of the cost drivers are not making anybody healthier.

And the second thing is we as a country are essentially now scandalized by the notion that people with a preexisting condition would not have access to coverage. That bothers just about everybody.

And I think the weakness of the Affordable Care Act was rather than focusing on those two core themes and really attacking those around which there was largely a national consensus, the decision was made, and it is the President's prerogative sine he is the President, to go a different direction.

But I think in our democracy, and I have used this phrase now a couple of times, this restlessness, this level of anxiety; so I am heartened by the notion that today we are talking about how it is going back to wage and price controls after 1945. That is an interesting thing because you can contrast it with other insurance markets, and all three of you agree that we do not have a health care market like we have other markets.

Other insurance markets are completely rational. Why? Because if you have auto coverage, you can change. You can move. It is flexible and so forth, and yet the brokenness that came in as a result of the wage and price controls created a distortion.

So I am listening this morning. I am learning from all three of you in terms of your perspective, and I think that there is something significant that is going to be happening in health care because the country is demanding it. The country with Obamacare has oversold and it has grossly under delivered, and God bless my friends on the other side of the aisle who find themselves in the awkward position of having to defend every bit of it as orthodoxy when I think if you scratch underneath the surface, they would say, yes, it really does need to be improved.

And there is nobody that wants to go back. That is also a strawman argument. Like let us go back to the old days. There is nobody that wants to do that.

And so I think what the chairman now is trying to do is say let us move forward. Let us have a discussion about it, but I appreciate the historical context in which you are putting all of this.

I yield back.

Chairman BRADY. Thank you.

Mr. Thompson, you are recognized.

Mr. THOMPSON. Thank you, Mr. Chairman.

I want to thank all of the witnesses for being here.

A couple of things that were mentioned early on I just want to address right up front, and there was some talk about the government controlled, socialized health care and Obamacare, and it was kind of grouped somewhat together.

I am one of those people who has received my health care from both the government-controlled, socialized health care, and that was when I was in the Army, and now I get my health care, as

all members of Congress do, from Obamacare. So I have got a little bit of experience from both.

And I can tell you that I used my government-controlled, socialized health care. I was wounded in Vietnam and spent a lot of time in about five or six different Army hospitals, and as you point out, I did not have a lot of choices with my health care. You show up and you get what they give you, but I got good health care.

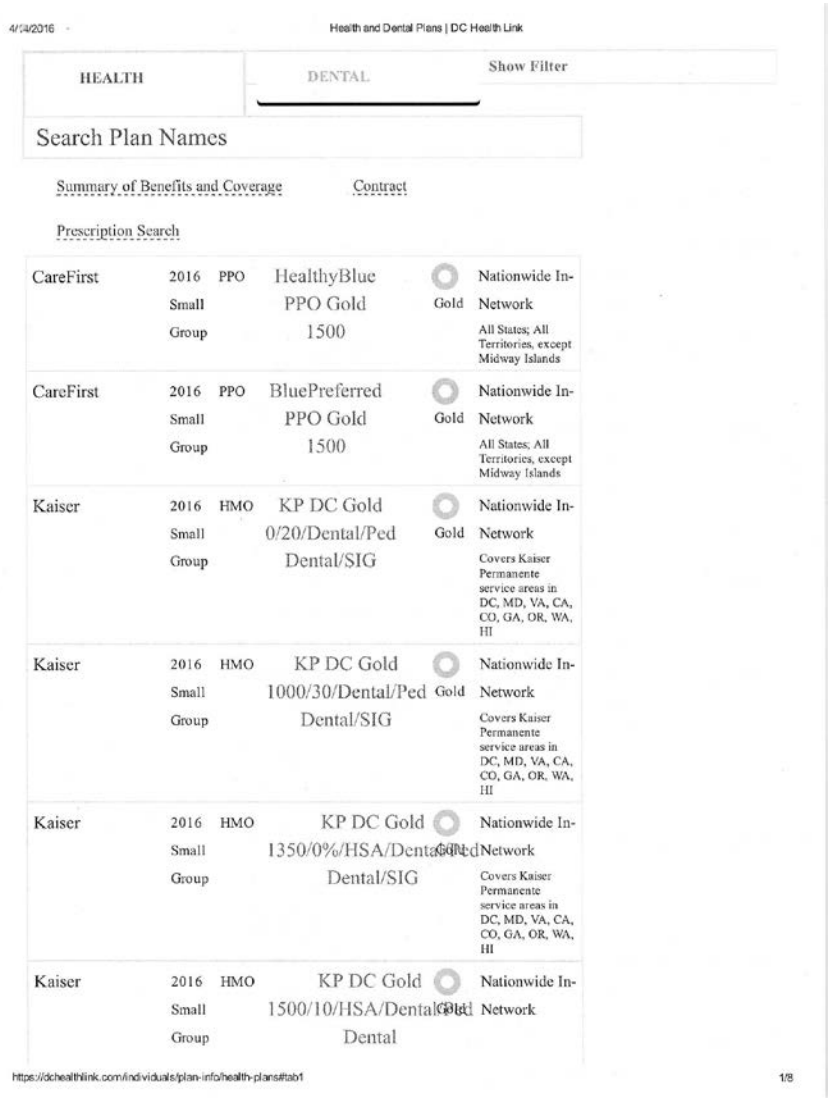
But the idea that Obamacare is somehow the same and it truncates your choices I think is a real stretch. We all have choices. We all get our health care through Obamacare, and we have choices in the private sector as to what health care we purchase.

And I would like to ask unanimous consent to have this list put into the record. It is a list of 54 choices that those of us who buy our health care through Obamacare have when we sit down to decide which one it is we are going to purchase, and I think it is important to note that, that we do have those choices, and in this case for those of us on the dais, it is 54, 54 different private sector plans from which to choose.

Mr. Chairman, I would like unanimous consent to have this submitted into the record.

Chairman BRADY. Without objection.

[The information follows:]



4/14/2016 Health and Dental Plans | DC Health Link

HEALTH | DENTAL | Show Filter

Search Plan Names

Summary of Benefits and Coverage | Contract

Prescription Search

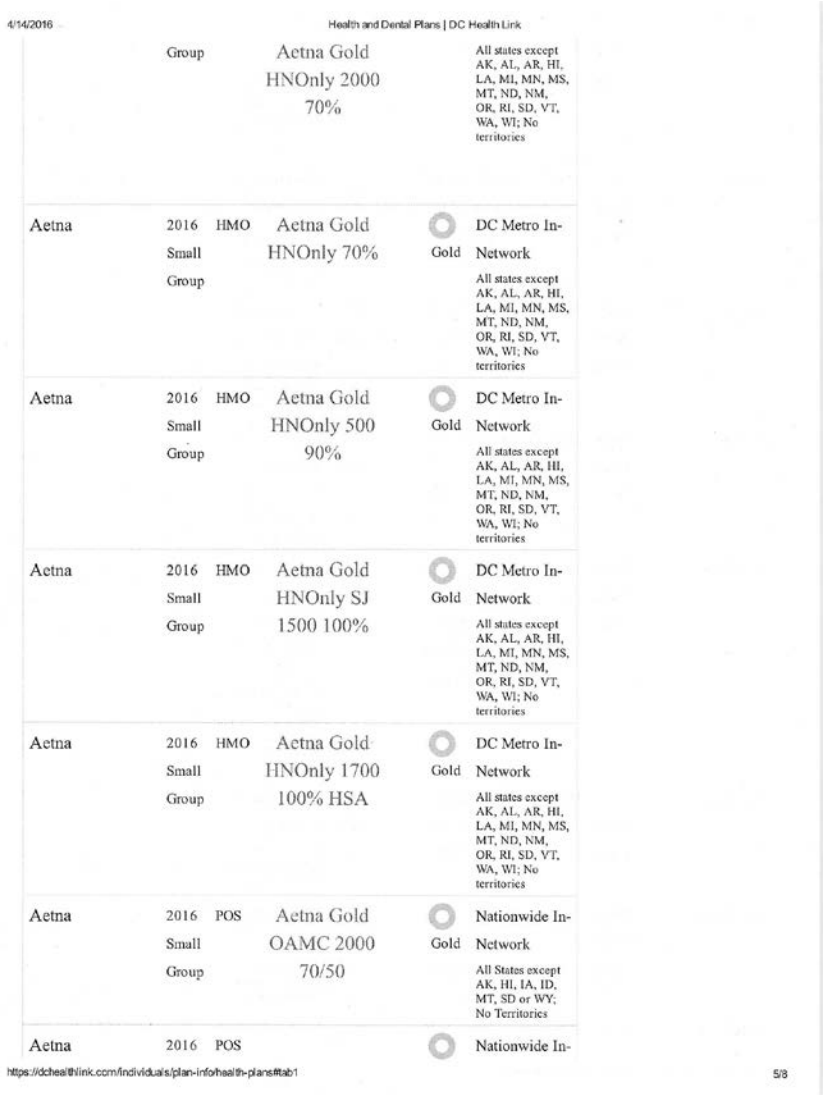
CareFirst	2016 Small Group	PPO	HealthyBlue PPO Gold 1500	Gold	Nationwide In-Network All States; All Territories, except Midway Islands
CareFirst	2016 Small Group	PPO	BluePreferred PPO Gold 1500	Gold	Nationwide In-Network All States; All Territories, except Midway Islands
Kaiser	2016 Small Group	HMO	KP DC Gold 0/20/Dental/Ped Dental/SIG	Gold	Nationwide In-Network Covers Kaiser Permanente service areas in DC, MD, VA, CA, CO, GA, OR, WA, HI
Kaiser	2016 Small Group	HMO	KP DC Gold 1000/30/Dental/Ped Dental/SIG	Gold	Nationwide In-Network Covers Kaiser Permanente service areas in DC, MD, VA, CA, CO, GA, OR, WA, HI
Kaiser	2016 Small Group	HMO	KP DC Gold 1350/0%/HSA/Dental/Ped Dental/SIG	Gold	Nationwide In-Network Covers Kaiser Permanente service areas in DC, MD, VA, CA, CO, GA, OR, WA, HI
Kaiser	2016 Small Group	HMO	KP DC Gold 1500/10/HSA/Dental/Ped Dental	Gold	Nationwide In-Network

https://dchealthlink.com/individuals/plan-info/health-plans#tab1 1/8

					Covers Kaiser Permanente service areas in DC, MD, VA, CA, CO, GA, OR, WA, HI
Kaiser	2016 Small Group	HMO	KP DC Gold 0/20/Dental/Ped Dental/SEL	Gold	DC Metro In-Network
Kaiser	2016 Small Group	HMO	KP DC Gold 1000/30/Dental/Ped Dental/SEL	Gold	DC Metro In-Network
Kaiser	2016 Small Group	HMO	KP DC Gold 1350/0%/HSA/Dental/Ped Dental/SEL	Gold	DC Metro In-Network
Kaiser	2016 Small Group	HMO	KP DC Gold 500/20/Dental/Ped Dental/SIG	Gold	Nationwide In-Network Covers Kaiser Permanente service areas in DC, MD, VA, CA, CO, GA, OR, WA, HI
Kaiser	2016 Small Group	HMO	KP DC Gold 500/20/Dental/Ped Dental/SEL	Gold	DC Metro In-Network
Kaiser	2016 Small Group	POS	KP DC Gold 1000/30/POS/Dental/Ped Dental	Gold	Nationwide In-Network Covers Kaiser Permanente service areas in DC, MD, VA, CA, CO, GA, OR, WA, HI
UnitedHealthcare	2016 Small Group	HMO	UnitedHealthcare Navigate HSA HMO Gold 1300_10	Gold	DC, MD (not available in VA) UnitedHealthcare Navigate HMO
UnitedHealthcare	2016 Small Group	HMO	UnitedHealthcare Core Essential HSA MO Gold 1300_10	Gold	DC, MD (not available in VA)

					UnitedHealthcare Core Essential
UnitedHealthcare	2016 Small Group	HMO	UHC OCI HMO Gold 500	Gold	DC Metro In-Network Optimum Choice HMO
UnitedHealthcare	2016 Small Group	HMO	UHC OCI HMO Gold 1000	Gold	DC Metro In-Network Optimum Choice HMO
UnitedHealthcare	2016 Small Group	HMO	UHC OCI HSA HMO Gold 1300	Gold	DC Metro In-Network Optimum Choice HMO
UnitedHealthcare	2016 Small Group	POS	UHC Choice Plus HSA POS Gold 1300 A	Gold	Nationwide In-Network All States; Territories - Puerto Rico and US Virgin Islands (UnitedHealthcare Choice Plus)
UnitedHealthcare	2016 Small Group	POS	UHC Choice Plus HSA POS Gold 1400	Gold	Nationwide In-Network All States; Territories - Puerto Rico and US Virgin Islands (UnitedHealthcare Choice Plus)
UnitedHealthcare	2016 Small Group	POS	UHC Choice Plus POS Gold 500	Gold	Nationwide In-Network All States; Territories - Puerto Rico and US Virgin Islands (UnitedHealthcare Choice Plus)
UnitedHealthcare	2016 Small Group	POS	UHC Choice Plus POS Gold 1000 A	Gold	Nationwide In-Network All States; Territories - Puerto Rico and US Virgin Islands (UnitedHealthcare Choice Plus)
UnitedHealthcare	2016	POS			Nationwide In-

	Small Group		UHC Choice Plus POS Gold 1000 C	Gold	Network All States; Territories - Puerto Rico and US Virgin Islands (UnitedHealthcare Choice Plus)
UnitedHealthcare	2016 Small Group	POS	UHC Choice Plus POS Gold 1000 B	Gold	Nationwide In-Network All States; Territories - Puerto Rico and US Virgin Islands (UnitedHealthcare Choice Plus)
UnitedHealthcare	2016 Small Group	POS	UHC Choice Plus HSA POS Gold 1300 B	Gold	Nationwide In-Network All States; Territories - Puerto Rico and US Virgin Islands (UnitedHealthcare Choice Plus)
UnitedHealthcare	2016 Small Group	EPO	UHC Choice EPO Gold 1000 A	Gold	Nationwide In-Network All States; Territories - Puerto Rico and US Virgin Islands (UnitedHealthcare Choice Plus)
UnitedHealthcare	2016 Small Group	EPO	UHC Choice HSA EPO Gold 1300	Gold	Nationwide In-Network All States; Territories - Puerto Rico and US Virgin Islands (UnitedHealthcare Choice Plus)
UnitedHealthcare	2016 Small Group	EPO	UHC Choice EPO Gold 1000 B	Gold	Nationwide In-Network All States; Territories - Puerto Rico and US Virgin Islands (UnitedHealthcare Choice Plus)
Aetna	2016 Small	HMO		Gold	DC Metro In-Network



	Group		Aetna Gold HNOnly 2000 70%		All states except AK, AL, AR, HI, LA, MI, MN, MS, MT, ND, NM, OR, RI, SD, VT, WA, WI; No territories
Aetna	2016 Small Group	HMO	Aetna Gold HNOnly 70%	Gold	DC Metro In-Network All states except AK, AL, AR, HI, LA, MI, MN, MS, MT, ND, NM, OR, RI, SD, VT, WA, WI; No territories
Aetna	2016 Small Group	HMO	Aetna Gold HNOnly 500 90%	Gold	DC Metro In-Network All states except AK, AL, AR, HI, LA, MI, MN, MS, MT, ND, NM, OR, RI, SD, VT, WA, WI; No territories
Aetna	2016 Small Group	HMO	Aetna Gold HNOnly SJ 1500 100%	Gold	DC Metro In-Network All states except AK, AL, AR, HI, LA, MI, MN, MS, MT, ND, NM, OR, RI, SD, VT, WA, WI; No territories
Aetna	2016 Small Group	HMO	Aetna Gold HNOnly 1700 100% HSA	Gold	DC Metro In-Network All states except AK, AL, AR, HI, LA, MI, MN, MS, MT, ND, NM, OR, RI, SD, VT, WA, WI; No territories
Aetna	2016 Small Group	POS	Aetna Gold OAMC 2000 70/50	Gold	Nationwide In-Network All States except AK, HI, IA, ID, MT, SD or WY; No Territories
Aetna	2016	POS			Nationwide In-

	Small Group		Aetna Gold OAMC 70/50	Gold	Network All States except AK, HI, IA, ID, MT, SD or WY; No Territories
Aetna	2016 Small Group	POS	Aetna Gold OAMC 500 90/50	Gold	Nationwide In-Network All States except AK, HI, IA, ID, MT, SD or WY; No Territories
Aetna	2016 Small Group	POS	Aetna Gold OAMC SJ 1500 100/80	Gold	Nationwide In-Network All States except AK, HI, IA, ID, MT, SD or WY; No Territories
Aetna	2016 Small Group	POS	Aetna Gold OAMC 1700 100/50 HSA	Gold	Nationwide In-Network All States except AK, HI, IA, ID, MT, SD or WY; No Territories
CareFirst	2016 Small Group	PPO	BlueCross BlueShield Preferred 1000, a Multi-State Plan	Gold	Nationwide In-Network All states, All Territories (except Midway Islands); the statewide networks in AZ, FL, KS, KY, MO, WA, WY are unique to Exchanges, including DC Health Link.
CareFirst	2016 Small Group	POS	BlueChoice Advantage Gold 1000	Gold	Nationwide In-Network All States; All Territories, except Midway Islands
CareFirst	2016 Small Group	POS	BlueChoice Advantage Gold 500	Gold	Nationwide In-Network All States; All Territories, except Midway Islands
CareFirst	2016	POS			Nationwide In-

	Small Group		HealthyBlue Advantage Gold 1500	Gold	Network All States, All Territories, except Midway Islands
CareFirst	2016 Small Group	HMO	BlueChoice HMO Gold 1500	Gold	DC Metro In-Network Regional BlueChoice HMO Network
CareFirst	2016 Small Group	HMO	BlueChoice HMO Gold 500	Gold	DC Metro In-Network Regional BlueChoice HMO Network
CareFirst	2016 Small Group	HMO	HealthyBlue HMO Gold 1500	Gold	DC Metro In-Network Regional BlueChoice HMO Network
CareFirst	2016 Small Group	HMO	BlueChoice HMO Referral Gold 500	Gold	DC Metro In-Network Regional BlueChoice HMO Network
CareFirst	2016 Small Group	HMO	BlueChoice HMO Referral Gold 0	Gold	DC Metro In-Network Regional BlueChoice HMO Network
CareFirst	2016 Small Group	HMO	BlueChoice HMO Referral Gold 80	Gold	DC Metro In-Network Regional BlueChoice HMO Network
CareFirst	2016 Small Group	POS	HealthyBlue Plus Gold 1500	Gold	DC Metro In-Network Regional BlueChoice HMO Network
CareFirst	2016 Small Group	POS	BlueChoice Plus Gold 1000	Gold	DC Metro In-Network

					Regional BlueChoice HMO Network
CareFirst	2016 Small Group	POS	BlueChoice Plus Gold 500	Gold	DC Metro In-Network Regional BlueChoice HMO Network
CareFirst	2016 Small Group	PPO	BluePreferred PPO Gold 1000	Gold	Nationwide In-Network All States; All Territories, except Midway Islands
CareFirst	2016 Small Group	PPO	BluePreferred PPO Gold 500	Gold	Nationwide In-Network All States; All Territories, except Midway Islands

Mr. THOMPSON. Thank you very much.

I also want to just point out, and it has been said a couple of times, that 20 million more people have health care today because of the Affordable Care Act or Obamacare, and I do not think that can be overlooked.

We know also that because Health and Human Services just let this information out that Medicare saved $473 billion between 2009 and 2014 because of the lower growth rate in health care, and that is significant for all taxpayers and all Americans.

Someone brought up the Tip O'Neill. The other thing that Tip O'Neill said is all politics are local, and in my home state, the local part, the premium growth rate slowed from 2011 when it was at nine percent to four percent last year. That is significant. That means something to people.

And in my district, the uninsured rate went from 15.9 percent in 2012 to 9.8 percent in 2014. That is about 50,000 people in my congressional district who because of Obamacare have access to health care coverage today. They did not have it before. It is good for them, and it is good for taxpayers who were subsidizing any health problems that they had prior to that happening.

And so I think those are all good things. The other thing that I want to mention, as one of the folks on the other side talked about, now they want to do the work. It has been pointed out a number of times we have been doing this for six years, and the only work that has been done by my friends on the other side is to repeal the health care access that people did not have before.

And to say we want to do the work now, it is about six years too late, but I do not think anyone on our side has said that we think it is perfect. We have all recognized there are problems. We have all recognized that we are willing to work to try and fix some of those problems.

We could fix the family glitch. We could work on the advanced premium tax credits so people who live in high income areas are able to get health care similar to those who do not live in as wealthy areas.

Mr. Boustany and I have legislation regarding the health reimbursement accounts. They work. We should not penalize people for using those. What we all want to do is make sure people have health care, and just because one particular access point is not within the law, we should not ignore that. We should figure out how to bring it in the law.

So I would hope that my friends on the other side of the aisle are honest in what they are saying, that this is a means by which we can figure out some of these problems and work it out. We are ready to work together. Let us fix this thing. Let us improve it. Let us find out where the glitches are and close those up.

Chairman BRADY. The gentleman's time has expired.

Mr. THOMPSON. Let us stop this nonsense.

Chairman BRADY. Thank you.

Ms. Jenkins, you are recognized.

Ms. JENKINS. Thank you, Mr. Chairman.

And I thank the panel for being with us today.

One particular issue that I have discussed here in committee before and I would like to bring up in the context of this hearing is

that of consumer directed accounts, such as health savings accounts and flexible savings accounts. These types of structures allow individuals to make their health care choices while incentivizing them to be financially prudent with those decisions.

And in Kansas, along with the whole U.S., these accounts are increasing in number every year. For example, in 2010, there were about 82,000 HSAs in Kansas, and in 2015 there were over 134,000 accounts, an increase of over 60 percent.

Mr. Antos, are you familiar with the President's health care law and what they did to HSAs and could you just summarize for us quickly?

Mr. ANTOS. Well, the ACA severely cut back the allowed contributions that can be made and made other limitations, and obviously, the Cadillac tax further penalizes these.

As the health benefits consulting industry knows, the easiest thing to lop off if you are faced with that is an HSA.

Ms. JENKINS. Yes, and did it not require that you have to have a prescription now if you want, an over-the-counter prescription to use one of those accounts?

Mr. ANTOS. Yes.

Ms. JENKINS. Limiting these types of structures or accounts, as Obamacare does, does not help keep health care costs down. If more Americans were empowered to manage their own health care decisions and had more skin in the game, when it came to their health care cost decisions, then what would you predict the impact to be on our health care spending, Mr. Roy?

Mr. ANTOS. So—oh, I am sorry.

Ms. JENKINS. Mr. Antos, go ahead.

Mr. ANTOS. Just quickly, that the added complications will only make it more difficult for consumers to operate in the way that we would like them to do, which is efficiently.

Mr. ROY. It would reduce costs and increase choice and increase quality and increase patient service, customer service. Customer service is lacking so much in our health care sector because the patients do not control the dollars. The government, the insurance companies, and the employer do. So everyone orients and caters to them, not to the patient.

Ms. JENKINS. Thank you.

Mr. ROY. So one thing that is important I want to mention because it has been raised a number of times by one of my colleagues here is this idea that consumers are incapable of making health care choices, that if you are unconscious because you have had a stroke, well, you cannot choose your hospital.

That is true. That is the proper role of health insurers, to negotiate those prices and those networks on your behalf. But there is an enormous ecosystem of health care choices that we can make on our own, the choice to which eye doctor you go to or who you get your primary care from, whether to get knee surgery in your state or a neighboring state from a low priced center or higher quality center.

There is an enormous range of choices that can be opened up to patients to make for themselves, and there can be no doubt that they will make those choices better than the government or their employer.

There was a study done last year that showed there is enormous price variation for common procedures that all of us often use, but we have no transparency into how much those procedures cost because none of us are in control of our own health care dollars.

So the more patients are in control of their own health care dollars, those prices will come down massively because providers will have to compete for patients' business instead of the other way around.

Ms. JENKINS. Great point. One particular limit in Obamacare that obviously has me concerned is the over-the-counter drugs. They were designated as qualified medical expenses by the IRS in 2002, yet Section 9003 of the Affordable Care Act mandated holders of tax preferred accounts, like FSAs and HSAs, seek a doctor's prescription in order to be reimbursed for purchases of these OTCs.

How does requiring a script for products the FDA has already determined safe and effective for over-the-counter use, and the IRS has determined to play a key role in health care delivery, improve customer choice and access to health care?

Mr. ROY. This is one of the least rational provisions of the ACA. It forces you to go to a doctor to obtain a medication that is available over the counter. That is the kind of thing that drives up health care cost, and it was solely done as a revenue raising measure to pay for the ACA's coverage expansion.

That would be a great example of something that this Committee could do something to reform.

Ms. JENKINS. Great. Thank you.

I yield back.

Chairman BRADY. Thank you.

Mr. Larson, you are recognized, and after your questioning, we will go two to one to balance it out.

Mr. LARSON. Thank you, Mr. Chairman.

And I want to thank our witnesses here today as well. As always these are great discussions.

Reuters noted almost six years ago and several other institutions follow that there is, on average, somewhere between $700 to $800 billion annually in waste, abuse, fraud, and a system as it currently existed that is not capable of lowering cost.

Today's discussion seems to have been a little bit all over the place, but nonetheless, as a number of my colleagues have pointed out, I hope as a committee we can get beyond this notion of for the 63rd time we are going to repeal the Affordable Care Act. It has been six years, and the Act is not going to be repealed, and as many on our side have said, it needs to be improved. There are many on our side that would have preferred a single payer act that as, Mike Thompson pointed out, in the military he got pretty good service with that and very efficient service, I might add, as well.

But because of the advance of technology and science and innovation and all the things that entrepreneurialism can bring, you would think that we would even be able to do better because we are Americans. And yet what happens is rather than us sitting down collectively and coming up with a program and a system that is better, for six years we have heard, "We are going to repeal it," instead of, "okay, you guys. We are going to sit down with you and that plan that Mitt Romney submitted in Massachusetts that you

then submitted that we called Obamacare, we are going to work together to make sure that we produce the most efficient outcomes on behalf of patients and people."

Those people cannot have individual responsibility if they are sunk at the bottom and have no means or capability or accessibility to do so. But collectively, just like we did when David Camp said, "Let us get together and work. Let us go into the subcommittees that require us to examine what aspects of health care we can do to help the patient out."

I note that companies like the Aetna, Mark Bartolini may be one of the most progressive and interesting entrepreneurs in the country talking about patient-centric care and making sure they meet the patient at the household and making sure they are doing everything for the patient there to avoid stays in the hospital that cost money; to care for the patient at that level and to do so that will combine both the best that all public health has to offer, meaning governmental public health and common sense solutions along with entrepreneurial, science and technology.

I hope, Mr. Chairman that that is ultimately what we can get to. This is nonsense. This is why the public hates us. We are having a light beer discussion here: tastes great, less filling. Repeal Obamacare.

No, Obamacare has done a lot for people. The public says, "A pox on all your houses. Fix the problem for us."

Today, frankly, you have a solution. I was happy to see Mr. Becerra say it and see Mr. Price join, that the bill will be submitted. The people will be able to look at it. At least that is a start.

This nonsense, this ongoing thing that we are going to repeal Obamacare for the 63rd time drives people crazy. They are concerned about their health and their well-being and want to make sure that it is there for them, and frankly, Mr. Chairman, I hope we can quickly get to a position where the capable people on this Committee can sit down with one another and come up with solutions.

Do you want to know why the general public is so upset with us? It is because we do not do a thing. Six years, you do not like Obamacare? Fine. What is the solution? The solution resides within this room and with the American people. Let us sit down and get it done instead of this light beer commercial that we are having.

Chairman BRADY. Thank you.

Mr. Paulsen, you are recognized.

Mr. PAULSEN. Thank you, Mr. Chairman.

And I also want to thank our witnesses for being here this morning.

I actually want to just focus some of my time on some of the reforms that are needed particularly on the patient-centered ideas. We heard some other comments already about lowering costs, and I want to address some inaccuracies that were mentioned by some of my colleagues, Mr. Levin and Mr. McDermott, regarding health care savings accounts and that only wealthy people use these accounts.

It is important to note that according to IRS data, the IRS, only 20 percent of HSA account holders have family incomes below $50,000. So these are, you know, below $50,000 incomes, and 83

percent of HSA account holders live in neighborhoods with median incomes below $75,000, 83 percent of those account holders, and only two percent of account holders actually even spend or contribute up to the amount of the maximum amount you can contribute to an HSA, which is like 6,550 bucks for a family.

Clearly, if wealthy people are taking advantage of it, are using it, why would they not contribute up to the maximum amount if it was some tax shelter.

And finally, just to mention, 24 percent of Americans, that is like a quarter of the population across the country, have an HSA or an HRA eligible insurance plan that they can participate in, which is actually a really, really big number.

I personally think we need to go more in that direction because people appreciate the choice, the flexibility when it comes to making sure that they can use health care for themselves or for their families. From a consumer perspective, they want to be able to shop around for the best quality care at the lower cost just like they can shop for anything else.

And it is probably one of the reasons why there is such a high percentage of Americans now, 20 million, that are using HSAs actively. In Minnesota, you know, we have a population just over five million people, but 800,000 people have opted now for some health savings account eligible health plan, which is a big number.

And I just really believe, and I think we are hearing some more conversation in some of your testimony today as well, that these HSAs should be a central component of health care; that these accounts give more people more choice on how to use their health care dollars, control over the care that they receive, and ultimately they are going to be smarter consumers.

And I will just say also I have introduced legislation, the Health Savings Act, with Senator Hatch in the Senate that will expand the use of these HSAs and make sure that people are able to lower their costs. The bill would allow more people to access these accounts, including seniors who are on Medicare, active military personnel and active military members, Native Americans who are enrolled in Indian Health Services, and members of health care sharing ministries.

And I will just say off the bat after I introduced the bill, positive comments are coming in from some of my constituents. I hear from Aaron who said, "This is a great idea. I love my HSA as it makes me into a health care consumer."

Robert put out, I think, on Facebook saying, "Thanks for taking this common sense step to help defray our health care expenses."

And then finally Ed responded in saying, "Why are these not available for seniors already?"

So I think this is moving in a positive direction, and also with the bill will make sure that we are going to be expanding what the accounts can be used for, as Ms. Jenkins had mentioned, for instance, but we will be able to include preventative care prescription drugs. Health insurance premiums will be included, over-the-counter medications without that doctor's prescription, physical fitness programs, wellness, nutritional supplements, and membership fees for innovative direct primary care models.

So clearly these accounts can be a key solution for everyone who is dealing with higher health care costs. You know, Mr. Roy and Mr. Antos, I know you have written a little bit about this as well. You have talked about it. Anything else you want to share about the importance of these accounts and how we should make this a highlight of the reforms where we are trying to go?

Mr. ROY. You have made a lot of great points, Mr. Paulsen. One I would emphasize in what you alluded to is that health savings accounts have the potential to transform health coverage for the poor. Imagine if we took the cost sharing subsidies that are on the ACA and converted those into health savings account deposits. That means if you are sick, you can use that HSA deposit to pay off your deductible, but if you are healthy and you stay out of the hospital, that HSA can accumulate and roll over and generate compound interest, and over time that person who today is low income with negative net worth can actually have a positive net worth, pass that nest egg off to their children, and you actually can transform the entire economic trajectory of that family and future generations of that family.

So that is the power of health savings accounts. They can do more for poor people than any other approach to health reform.

Mr. PAULSEN. Mr. Antos, anything else to add in the final seconds?

Mr. ANTOS. Well, we have a long way to go.

Mr. PAULSEN. Right.

Mr. ANTOS. But beyond that, yes, absolutely. A properly funded system that includes HSAs with smarter regulation so that people can actually buy the kind of coverage that they need will take us a long way.

Mr. PAULSEN. Thank you.

Chairman BRADY. Thank you.

Mrs. Black, you are recognized.

Mrs. BLACK. Thank you, Mr. Chairman.

And I thank all of the panelists for being here today. This is a very important topic obviously, and I think my colleague from Illinois used a great word, "restlessness," that we feel restlessness by the people and especially the people in my district as I hear from them about health care and about the uncertainty and all of the things that go along with it.

So I as a health care practitioner for over 45 years being a nurse and having seen that pendulum go from here to here and now back maybe toward the middle, I just wrote down four things that I think are the key pieces of this.

One is choice. One is access. One is portability, and the other is affordability. So I want to go through each one of those just very briefly and talk about choice, which has certainly been a topic here within the panel today.

And one of the things I can tell you is that the Affordable Care Act has not helped with choice in my district. It has limited the number of insurance companies that actually participate in the Affordable Care Act. So I have constituents who tell me, "I really like my doctor. I cannot go to my doctor anymore. I cannot go to my physical therapist. I cannot go to this, that or another." So choice

has really been limited, although it has been lifted up as, you know, like the panacea that has solved everything.

The affordability piece on that is folks will tell me, "Yes, I have a subsidy that helps me pay my premium, but do you know what? I cannot afford my deductible. I cannot afford my copay." So do they really have insurance? No, they do not.

I also know that it has driven the cost up in the private sector. People are telling me now every day, and I am not exaggerating when I tell you every day in my office we get a call or an email about how their insurance has been affected by what has happened most recently with the Affordable Care Act.

So the portability piece and the access.

So let me go to my question before I run out of time. Mr. Roy, I want you to answer this for me. What happens if a person currently with employer-sponsored insurance loses their job? Can they keep their plan?

Mr. ROY. Well, they can have COBRA for 18 months, but it is very difficult to transfer that coverage to individually purchased insurance. There is a gap in the transition. They do not have the ability to protect the exact plan they had before.

Mrs. BLACK. So that brings up a really good point. They have COBRA, and I have constituents who are in this situation. Let us just say that the employee does get the COBRA, but their benefit value for their plan was $3,000. That is probably even low considering what insurance really costs today. But does that employee get to take that benefit with them while they search for a new job and take that $3,000 so that they can help pay their COBRA?

Mr. ROY. I do not believe so. I mean, I think it depends. Joe might know the answer to that.

Mrs. BLACK. Mr. Antos? I think the answer clearly is no. At least that is what I am learning from my constituents.

So you have that insurance, but it is not really portable because you cannot afford the COBRA. Many people will tell me, "I cannot afford the COBRA. Yeah, it is there. It is a benefit for me, but I cannot afford it."

So we put them into a difficult situation where they had employer-sponsored insurance, but they do not really have an option there when they leave because it is really not portable.

So for all the benefits of the employer-sponsored base system, which there are many, and I am not at all saying they are not, but one great drawback is if this employee loses their job, then he or she loses support for the purpose of their health care insurance.

If we were to design from scratch a health insurance system, then how would you mitigate against this profound loss?

Mr. Roy, do you want to answer that?

Mr. ROY. Yes. You know, one analogy that was made earlier or one comparison that was made earlier today was between auto insurance and health insurance. I think that is a really great way to think about what health insurance should look like.

We do not expect auto insurance to pay for our gasoline or our oil changes or our wiper fluid. We expect it to protect us against catastrophic and financial loss if our car gets totaled, if it gets stolen, if it gets cracked, we get into an accident.

That is what health insurance should be. Health insurance should protect every American from bankruptcy due to medical bills, but the moment we expect it to dominate all of our health care choices is the moment that it becomes too expensive.

And to your point, we do not ask our employer to sponsor our car insurance for us. That would be completely irrational, and similarly, it would make a lot more sense for individuals to have the ability or the option to choose their own health insurance.

Now, there are arguments for employer-sponsored health insurance. It should continue because there is a certain scalability. If you have a large group with 300 employees, the ability to purchase health insurance that is more affordable for that population is greater sometimes than if you purchase it for your own.

But that should not just be about large employers or even small employers. That should be your church group. That should be a professional association. That should be any group of people that wants to get together to pool their risk and pool their options.

Mrs. BLACK. So there are other options out there which we should be speaking about, and just to conclude, if you have somebody who is on the Affordable Care Act, they really do not have a lot of choice either, and that is not portable either because if they want to take those subsidies that they get from the Federal Government and purchase something outside of the system that they are required to use, they do not have that choice either.

Mr. ROY. Let me make an analogy there. You know, the choices in the Affordable Care Act are you can buy a car from GMC or Honda or Ford or Toyota so long as it is a green pickup truck.

Mrs. BLACK. My time has expired. More than my time has expired. Thank you.

Chairman BRADY. Thank you.

Mr. Pascrell, you are recognized.

Mr. PASCRELL. Thank you, Mr. Chairman.

This is the first time I have ever heard anybody testify and compare one's health to one's automobile, and I would just like to note perhaps when we get to that point which should not be covered in terms of your own health. I think people have some debate over that.

That is exactly what got us into trouble from the very beginning. The fact is, sir, that we cooperated after Plan D was defeated, the very prescription drugs you are talking about here. We cooperated, even those of us, myself included, who voted no against that plan. We voted. We sat down and worked out, and then finally when we got ACA, we changed the law so that we would not have that gap where people were paying premiums and not getting any benefits.

We can do this. So this is about myth. I take Mr. Larsen, my brother here. You know, he talked about light beer. This is the age of mythology. There are now two ways about it.

Yesterday we had the mythology of blaming the IRS for everything except the weather, and then when we found out they are the people we can most rely upon in government and we looked at the Treasury Department, which had the lowest tax delinquency rate in the Federal Government, and guess where we were. They are 1.2 percent, and we are 5.1 percent, and the general public is eight percent.

This is about myth. That is what it is about, and we are going to dispel that myth between now and November. Let us make it clear. We are not going to be the foolish folks that ran away from this after they voted for it in 2010. Those days are over. They are done.

A conversation, if it produces a plan at all that is centered around idea that we know will not provide the same level of consumer protections that the ACA will do, will not result in as many people getting coverage and will not help balance risk pools. We have not even talked about that today, have we? And which is key to keeping premiums down is what we should be discussing rather than trying to tear down what is the law.

Sixty-three times, how many times can we do this? Obviously maybe 100. There is no cap.

Let me ask this to you, Mr. Kreisberg. We have yet to hear about a concrete alternative. By the way, we not only do not have an alternative plan. We do not have what we are going to do in the transition period when we tell the 20 million new people who have insurance, "Wait, because the new plan is on the way. It is in the mail."

So this alternative, one of the favorite centerpieces when talking about the alternative to the ACA is that they would allow people to buy insurance across state lines. Every state had a different insurance commissioner. Every state has different insurance lines. You hear these presidential candidates talk about why can we not go across the state. They should know the facts, unless they are talking without them knowing what the system is, like immigration. If you do not know what the system is now, how can you criticize it and say let us have reform?

Allow people to buy insurance across state lines. That is the fix, generally without any regulatory role for the Federal Government. With a policy like that, what kind of impact would that have on the consumer, sir?

Mr. KREISBERG. Well, it would have virtually no effect on rates. I think there have been a number of studies that, you know, since the Affordable Care Act has been adopted, we have essential minimum benefits across state lines now from the Federal Government.

There are a number of state benefit mandates which those states are entitled to enforce within their own states, and we have always supported that. We have always opposed interstate sales because we think it is a violation of states' rights in this particular regard.

So we do not think it has right now much of an impact on rates. We think it is adverse to consumers. We think you lose regulatory oversight. You may have some difficulties with reserve requirements that insurance companies are allowed to hold, and ultimately I do not think it serves any productive purpose at this time.

Mr. PASCRELL. One final question. The last myth we have time for today, and that is it is a job killer. Now, I have seen data from different universities, Labor Department. I cannot find that. Would you help me?

Mr. KREISBERG. Sir, it is not a job killer. It is not a job killer whatsoever.

Mr. PASCRELL. Well, then spell it out.

Mr. KREISBERG. As I indicated before, even CBO has said that it is really a matter of labor supply. People may now have the ability to get insurance outside of their workplace and withdraw voluntarily from the labor market as opposed to employers laying off employees because of the Affordable Care Act.

Mr. PASCRELL. Thank you.

I yield back.

Chairman BRADY. Thank you.

Mr. Kelly, you are recognized.

Mr. KELLY. Thank you, Chairman.

What I am going to start off with is the actual purpose of the hearing, and so the purpose of this hearing is to learn about the different health care tax expenditures in the Tax Code and determine those in need of reform, and I think as so often, everything gets lost in the translation.

So when we talk about tax expenditures, what we are talking about is the government giving up anticipated revenue to subsidize, and each of you is here today representing a certain agency. You are all either 501(c)(3)s or 501(c)(5)s, right? Those are nonprofit organizations. By definition in the Tax Code, you pay no taxes.

Each of you for the organizations that you work for have health care supplied by those people. You do not have to pay for it. The question today was about who pays for this because we talked initially, and I may be wrong on this, Chairman, about 150 million people being covered by employee-sponsored insurance. Part of the Patient Protection and Affordable Care Act is how are you going to pay for it? Because we always worry about how are you going to pay for it.

So let us say all of a sudden employers said, "We are just not going to do it anymore." You would lose 150 million who are paying for their own insurance to begin with, right?

Now, is it true that we are talking about a loss of revenue, tax revenue here? This is what we are talking about of all the different Tax Codes right now, right? This is money that will not be garnered by the Federal Government.

And so we are saying that in some cases we have to subsidize those plans for people who cannot pay for them. I just want to read to you. "A subsidy is a sum of money granted by the government or a public body to assist an industry or business so that the price of a commodity or service may remain low or competitive."

My question to each of you: who supplies the money for the subsidy?

Mr. KREISBERG. In both cases it is the worker, right? You, Mr. Kelly, had said that——

Mr. KELLY. I am with you. It is okay, Mr. Kreisberg. Mr. Roy, I will come back to you. I will come back to you. I understand, but who pays for the subsidy?

Mr. ROY. If you are talking about the——

Mr. KELLY. I am talking about subsidies.

Mr. ROY. The advanced premium tax credit on the Affordable Care Act exclusions?

Mr. KELLY. I am talking where does the revenue for the subsidy come from?

Mr. ROY. It comes from the taxpayers.

Mr. KELLY. Taxpayers.

Mr. ANTOS. Right, from the taxpayers.

Mr. KELLY. It is all generated by hard-working American taxpayers. It is not generated by the government. The government looks at every single dollar we make and says, "We are going to allow you to keep a fractional part of what you earned."

The government says to every hard-working American taxpayer, "We are going to allow you a portion of each dollar that you earned."

The government will take from taxpayers the amount of money they need to run programs and say, "We will use it better because we know how to use it better, but you will supply it." Am I wrong on that?

Mr. ROY. No.

Mr. KELLY. Okay.

Mr. ROY. And one thing about the employer tax exclusion that is———

Mr. KELLY. I am running out of time, Mr. Roy, and I do not want to get a lecture, but the purpose of this meeting was to talk about tax expenditures and capping what an employer is allowed to deduct.

I happen to be in a private business. I have always provided health care for my people. Now I am being told that you are not going to be able to deduct that as a cost of doing business because you have actually gamed that in order to avoid paying taxes.

Yes, excuse me. And, by the way, the people that receive that benefit, they should be taxed on that because that was actually revenue.

We are trying to adopt some source of revenue from hard-working American taxpayers again. All of this stuff is being driven by taxes.

Mr. KREISBERG. It is not to raise taxes. It is actually to lower taxes and increase out-of-pocket——

Mr. KELLY. Mr. Roy, do you pay taxes on your health care plan?

Mr. ROY. Yes, I do.

Mr. KELLY. Do you really?

Mr. ROY. Absolutely.

Mr. KELLY. Okay. It is provided by the agency you work for.

Mr. ROY. We all pay taxes.

Mr. KELLY. You pay wage taxes.

Mr. ROY. Our taxes pay for the cost of our health care system.

Mr. KELLY. Okay. I get that part. I get that part. Listen. I understand that world. I get that part.

The reality of it is it comes from people who go to work and earn income and companies that are profitable. That is where the taxes come from, and the other part of it is we get it from printing money or borrowing money, which, by the way, we have every single taxpayer sign on because they are cosigners on that debt.

But the purpose today was to talk about different health care expenditures, and I am just submitting to you that we are forgetting the most important part of this, and that is the people that provided the revenue. There is nobody here that says they do not want health care for people. The question is how do you pay for it.

And at the end of the day, it is going to be by Americans.

Mr. ROY. Let them make that choice.

Mr. KELLY. And there are going to be some that can afford their own, some that cannot. I get that whole part of it, but we are going to change the Tax Code in order to collect more revenue, and when the government says they are losing revenue, what they are actually saying is, "Mr. and Mrs. Taxpayer, you are going to get to keep more of your own money. It is going to stay in your pocket. You can decide how to spend it."

That is what it is about. It is about a loss of tax revenue. That is all this meeting is about. All the rest of it is political talking points or election year talking points. It is not about the issue which we have all been addressing, and that is: how do we pay for this? And the answer is every hard-working American taxpayer is going to contribute to it.

My question, and it always comes down to the same thing. I love the fact that as an employer I have been able to do things for the people that I work with, but I do not think I should be held to only using that as a tax. Then the people you give it to should be taxed for it. We are looking at a cap on what employers are allowed to deduct as a cost of doing business.

I would submit to you there is a heck of a lot more to running a business——

Chairman BRADY. All time has expired.

Mr. KELLY. Thank you. I yield back.

Chairman BRADY. Mr. Renacci, you are recognized.

Mr. RENACCI. Thank you, Mr. Chairman.

I want to thank the witnesses for being here.

It is interesting. I said this yesterday. The American people, if they wanted this, they would get very frustrated, and as my friend Mr. Larsen said, they get frustrated, but it is not because we are talking about ACA. They get frustrated because we are talking at each other instead of listening, and that is the problem.

We need to listen to our witnesses. We need to listen to the people we represent.

So I am going to go back. I am glad that Mr. Kelly got us back on track as to what the hearing was about.

You know, employers cover, according to the CBO, 63 percent of health care through an employer-sponsored plans. You guys would agree with that, right?

Mr. ROY. The worker is paid that because it is part of the worker's overall compensation.

Mr. RENACCI. I understand, but employers are covering——

Mr. ROY. When an employer hires someone, the cost of their overall compensation is calculated.

Mr. RENACCI. We are going to get to that. We are going to get to that.

So employers, in fact, cover 155 million people through employer-sponsored health care. I think, Mr. Antos, you said yes to that.

So I go back in the district and I talk to my employers. I talk to my employees, too. Do you know what my employees say? They say, "I do not want the responsibility of trying to find my own health care. It is complicated. I like the idea of an employer covering my health insurance."

And by the way, I have hired many employees, and do you know what they say? "I want a good wage," and you hire them for a good wage, and then you give them health insurance. So the health insurance does not stop me from paying them a good wage.

You guys are saying that it is reducing. They do not come in there saying, "I am only going to work for this and you should pay me more because of health insurance." Most of them love that we are covering health insurance.

So they say to me, when I talk to the employees, "We do not want to be burdened with trying to select. We like the idea of the employer doing this. We like the idea of the employer covering everything. We like the idea of being part of a bigger plan because I cannot do it on my own." That is the other thing they say.

Then I go to the employers, and I ask them, and do you know what they say to me? "Congressman, that big wet blanket the government keeps throwing on top of us, you are raising our costs for health insurance. You are raising our cost," which has shown for the last couple of years with the Affordable Care Act and other ways, "and now you want to cap it and cut it at the top. You want to hurt us again."

That is not fair to the employer. It is not fair to the employee. We have to go back to what the basis is. If we went to those 63 percent and asked them are they happy they are covered with health insurance, they would say I bet you they are happy they are covered with health insurance.

So here is my concern. We know health care costs are going up. We want to capitate it and say, "Mr. Employer, you can pay it, but anything above that is going to be a tax increase to you because we are not going to have it as a deduction." That is a problem.

So the only way, in my estimation, and this is what drives me crazy, and I now come to you Mr. Roy. You keep saying an employer-sponsored plan does not give the employee choice, but I would ask you this. Are there not employer sponsored plans that give and could give employees a choice over their health care decisions, if structured properly?

Mr. ROY. So there are a couple of points to make in response to that. The first is that——

Mr. RENACCI. I do not have a lot of time.

Mr. ROY [continuing]. Nobody is talking about tax increases. People are talking about letting patients control those dollars themselves, increasing their take-home pay, and letting them——

Mr. RENACCI. I know that, but let us get back to it.

Mr. ROY [continuing]. Decide what they want to fund.

On the issue of choice for health insurance plans——

Mr. RENACCI. If the plan is structured properly.

Mr. ROY [continuing]. Employers can decide whether to offer one plan or two plans or three plans, but should workers not have the choice to choose between their employer-sponsored plan and 100 different plans that are out there independent of their employer?

Mr. RENACCI. They can do that right now. They can do that right now.

Mr. ROY. It is much harder for them to do that because the inequities in the Tax Code made that much more expensive.

Mr. RENACCI. They can do that right now, but I guarantee if you talk to the employees, and you see this is what happens. The American people get frustrated with us in Congress because they want us to listen to them. They do not want to make those decisions. They like the idea of selecting a plan that their employer gives them, and they definitely do not want to have somebody come to us and say, "This is what we think is best for you."

They know what is best for them. They want us to represent them. That is what is so frustrating, but that is what is great about these hearings because I do like to hear some of your thoughts, and I have listened.

The next question I have, Mr. Antos: will more people lose their employer-sponsored plan if we cap the employer exclusion?

Mr. ANTOS. More people will move off of employer-sponsored plan, but let me clarify something.

Mr. RENACCI. Wait a minute. Will they lose——

Mr. ANTOS. What you and Mr. Kelly said I believe is incorrect, which I do not think anybody is proposing that the employer's ability to take off their top line legitimate costs of doing business, which includes their contributions to all forms of compensation for employees, nobody is talking about capping that or eliminating that in any way.

What we are talking about is limiting what the employee can essentially exclude form his income taxes, but it is not going to affect the employer.

Mr. RENACCI. That is even worse.

Mr. ANTOS. Thank you.

Mr. RENACCI. Now you are going to add taxes to the employee. Again, if the American people hear what you just said, they are going to be really upset.

I yield back.

Chairman BRADY. The time has expired.

Mr. Davis, you are recognized.

Mr. DAVIS. Thank you very much, Mr. Chairman.

And I, too, want to thank all of our witnesses.

Newsweek has an article written March 3rd titled "How Obamacare May Lower the Prison Population More than Any Reform in a Generation." It was written by Elijah Wolfson. Toni Preckwinkle, who is president of the Cook County Government, second largest county in the country with one of the largest jails in the country, responded to that article by writing a letter to the editor, and here is what President Preckwinkle wrote.

She said, "I commend Newsweek for recognizing the vital connection between Obamacare and safer communities." She went on to say that in November 2012, Cook County was granted a Medicaid waiver that has already allowed us to provide health insurance to over 86,000 low income residents, including 2,600 formerly detained individuals.

Mr. Chairman, I would ask that both of these articles be inserted into the record.

Chairman BRADY. Without objection.

[The information follows:]

U.S.

HOW OBAMACARE MAY LOWER THE PRISON POPULATION MORE THAN ANY REFORM IN A GENERATION

BY ELIJAH WOLFSON ON 3/3/14 AT 3:56 PM

Proponents of the Affordable Care Act believe that it will lower rates of incarceration and recidivism, and save the country millions

JOHN MOORE/GETTY IMAGES

U.S. OBAMACARE PRISONS

While many have focused on the individual mandate, and the online (and glitchy) insurance exchanges, one of the most potentially impactful elements of the Patient Protection and Affordable Care Act (ACA) has flown more or less under the radar. It may be the biggest piece of prison reform the U.S. will see in this generation.

On the face of it, there's no direct connection between the ACA and what experts refer to as the "justice-involved population." There's no mention of prisons or jails or even crime in the language of the law. However, in what proponents of the act are considering a happy public policy accident, the ACA may inadvertently change the makeup of the U.S. prison population by getting early help to those with mental health and drug abuse issues, ultimately reducing recidivism rates and saving states millions, if not billions, of dollars annually.

For years, the prison population in the United States stayed more or less the same, hovering between 150,000 and 200,000 total incarcerated in either state or federal correctional facilities. In the early 1980s that number began to skyrocket, and by 2010, 1.57 million Americans were incarcerated.

There's very little argument why. The "epidemic of incarceration over the last four decades," as Josiah Rich, a professor of medicine and epidemiology at Brown University, and co-founder of The Center for Prisoner Health and Human Rights at The Miriam Hospital, puts it, can be mostly attributed to two diseases: addiction and mental illness. "The natural history of these diseases, when not treated, leads to behaviors that, in our society, result in incarceration," Rich tells *Newsweek*.

History backs Rich up. In 1980, the number of Americans incarcerated for drug-related offenses was around 41,000. Then, in 1982, the country's "War on Drugs" officially commenced, and by 2011, that number had shot up to 500,000. In conjunction with funding the front on drug users, President Ronald Reagan defunded federal mental health programs, dropping total mental health spending by over 30 percent. As a result, many of the nation's mentally ill lost what was essentially their home and place of work, and many ended up on the street.

Today, a good portion of those make their beds in prisons and jails. The last major study on mental health in prisons, conducted by the Bureau of Justice Statistics, found that 64 percent of inmates in state and federal prisons met the criteria for mental illness at the time of their booking or during the twelve months leading up to their arrest. For comparison, the rate of mental disorders among U.S. citizens stands at around 25 percent, according to the NIH. Sixty-nine percent of the country's prison population was addicted to drugs or alcohol prior to incarceration.

When mental institutions closed a few decades back, the process was "not accompanied by sufficient outpatient support," Rich tells *Newsweek*. "As a result, too many fell through the cracks and got picked up by the criminal justice system, which has limited options to deal with them." Instead of seeing these people as sick, the country began to see them as criminal. As Rich puts it, if all you have is a hammer, pretty soon, everything looks like a nail.

Health and crime have become inextricable in the U.S. Health issues such as drug addiction and severe mental health disorders directly lead to illegal activities and eventual imprisonment. A high percentage of those incarcerated are guilty of crimes directly related to medical issues, such as illegal drug use or theft to support an addiction.

This population – the poor, homeless, addicted, and mentally ill – has never had any health safety net. With no jobs or income, they are highly unlikely to have private insurance, and Medicaid – the federally-funded health coverage option meant to protect the poorest Americans – is actually only available to a select group of individuals. Though it varies state by state, eligibility is always categorical, which means besides having a low income, Medicaid is only available to five types of people: pregnant women, children below a certain age, parents of Medicaid-eligible children, the disabled, and seniors.

Essentially, Medicaid left out poor, single, male adults without dependant children. – the same demographic most likely to end up arrested and incarcerated. Starting in January 2014, however, the categories have been eliminated (at least in the states that have chosen to take the medicaid expansion – it is an optional aspect of the ACA).

"That means that a lot of people who are going to jail for mental illness or substance abuse related crimes could potentially avoid jail," says Marsha Regenstein, a professor of health policy at George Washington University.

Of course, these people are hard to reach, and eligibility doesn't ensure coverage or healthier behavior. That's why the bigger opportunity, according to many health and justice policy experts, is to reach and help this population at the points where they do become involved with the justice system. Regenstein and Rich argue in a pair of papers published this week in the journal *Health affairs* that better access to health care could not only keep people from committing crime in the first place, but could keep former inmates from repeat offenses.

Thats because the criminalization of mental illness and addiction has created an interesting contradiction: while the mandate of the correctional system is to rehabilitate criminals, it also has a constitutional obligation to provider all inmates with health care – the Supreme Court ruled that to deny health care services constituted a form of cruel and unusual punishment. As a result, the U.S. prison system has become a de facto public health care provider.

And while the quality of care varies from institution to institution, some prisoners end up receiving the best health care of their lives. For example, studies have shown that 40 percent of inmates are first diagnosed with a chronic medical condition while in prison. And Alex Sonriente, who worked for the Prison University Project at San Quentin Prison in California, tells *Newsweek* that in her experience "prisoners had more access to health care than they did on the streets."

However, the right to health care only applies to the length of a person's sentence. "We take them to the end of incarceration and just drop them off a cliff and say 'good luck,'" Rich tells *Newsweek*. "The transitions are the most dangerous time from a health perspective." The problem is pervasive; a 2013 report in California, for example, found that 90 percent of prisoners had no health care upon release. Once released, prisoners are likely to discontinue their meds, delay seeing primary care doctors (out of concern for costs), and, as a result, end up in

emergency rooms — where high treatment costs are passed on to everyone else via insurance premiums.

This is not just a public health issue; it's a public safety concern. Lack of care for chronic conditions creates additional long-term problems, like being physically or mentally unfit for employment. In conjunction with a lack of appropriate care for their drug problems and an inability to effectively medicate their mental health disorders, the formerly incarcerated are likely to return to a life of crime.

Many hope and believe that change is on its way. The Justice Department estimates suggest that with the expansion of Medicaid, 5.4 million ex-offenders currently on parole or probation could get the health care they need. (It's important to note that 25 states plus Washington, D.C. have implemented the Medicaid expansion as of 2014. However, many policy experts expect the remaining states to fall in line, citing the historical example of how CHIP was initially rejected by many states when it rolled out in 1997, but is now utilized in every state in the country.)

Even with coverage, those ex-offenders will still need to actually *utilize* those health benefits, and the key will be making the connection at the time of release. The biggest challenge will be getting state justice systems and health systems – not exactly happy bedfellows in past years – to work together to create coordinated discharge planning between jails and community healthcare. Currently, there are very few incentives in place to facilitate that cooperation, but Rejenstein believes the new health care climate under the ACA is an evolutionary step in the right direction. "As the greater healthcare system figures out ways to communicate better," she tells *Newsweek*, "there will be models for jail communities to provide care better."

A pilot program started in 2006 called The Transitions Clinic is a great example. The clinic, operating in a number of locations across the country, acts as a liaison for newly released prisoners, placing them into the immediate care of a health care provider who knew that they had been in prison, and understood the risks related to being incarcerated. The results are encouraging: those who had gone through the clinic had 50 percent fewer ER visits than those who didn't.

Visits to the ER are a huge financial burden on states; the National Institutes of Health recently found that the average emergency visit is billed at an amount equalling 40 percent more than an average American's month's rent. But keeping people locked up is an ever bigger cost. A 2012 study by the Vera Institute calculated an annual $39 billion hit to taxpayers to keep corrections facilities running country-wide.

Tracie Gardner, whose advocacy group the Legal Action Center has been a key driver in developing coordination of criminal justice and health in New York, agrees. "We see, over and over again, that wonderful moment of 'a-ha!' on the faces of everyone involved at every level in both systems," she tells *Newsweek*. "There is recognition that the landscape has aligned to reap major benefits for improving public safety, improving health and savings millions of dollars."

The cost savings associated with keeping former prisoners out of the ER and out of prisons will likely lead leadership at the highest levels – state governors, for example – to push for the types of collaboration that will keep ex-offenders healthy and out of trouble. And Rejenstein believes that on a smaller scale, local jail personnel will *want* to make sure there is a smooth transition into health care. After all, these are the people who actually see the inextricable health/crime

cycle. They see the same faces over and over again, back behind bars for the same crimes committed months or years earlier. If they believe they can break the pattern, Regenstein says, they will.

Ultimately, because there is no precise directive in the ACA, the choice on how to handle these issues will be made independently in every state, and in every county. In some cases, reform will be swift; in others, life may go on as though Obamacare never happened. "I think it depends on the system," Rich tells *Newsweek*. "If you know one jail, you know one jail."

Join the Discussion

Preckwinkle responds to Newsweek Magazine's March 4, 2014 article: "How Obamacare May Lower the Prison Population More Than Any Reform in a Generation".

To the Editor:

Cook County, home to 130 municipalities including the City of Chicago, is the second largest county in the United States. As President of Cook County's Board of Commissioners, I am charged with overseeing an overburdened criminal justice system which includes one of the nation's largest jails.

I commend Newsweek for recognizing the vital connection between Obamacare and safer communities ("How Obamacare May Lower the Prison Population More Than Any Reform in a Generation," March 4, 2014.) In November 2012, Cook County was granted a Medicaid waiver that has already allowed us to provide health insurance to over 86,000 low income residents, including 2,600 formerly detained individuals.

For the first time, many of these people are now receiving mental health and substance abuse treatment supported by preventive physical health care in their communities. These efforts mean those with criminal records are less likely to return to our jail, while others will never make that first trip into detention. When a young person struggling with depression gets treatment instead of access to street drugs, it puts him or her on the path to a productive life. We can realize lower rates of incarceration and recidivism in 2014 by seizing the opportunity Obamacare has created.

Toni Preckwinkle
President, Cook County Board of Commissioners

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Mr. DAVIS. Since we have not seen any alternative to what is often called Obamacare, except a national health plan, preferably single payer, let me mention a few of the accomplishments and benefits our country has experienced from the Affordable Care Act.

Twenty million people have gained health insurance coverage who did not have it. The gains since 2013 have been the fastest and most rapid since the decade following the creation of Medicare and Medicaid. The uninsured rate is below ten percent for the first time in the history of this country. The uninsured rate among young adults, ages 19 to 25 has fallen by 52 percent through the third quarter of 2015.

We know that states that expanded their Medicaid programs have seen rapid gains in health insurance, much more than those states that have not. Millions more workers are now protected against unlimited out-of-pocket spending.

Since the Affordable Care Act became law, health care prices have risen at the lowest rate in 50 years. Hospital readmission rates have fallen sharply since the passage of Obamacare. The private sector has added jobs every month since the Affordable Care Act became law.

Thanks to the Affordable Care Act an estimated 20 million people have gained health insurance, and for the first time in history nine of ten Americans have health insurance.

Among African American adults, the uninsured rate declined by 53 percent. Among Latino adults the uninsured rate dropped by 27 percent. The gains for women have been rapid, and among young adults has dropped 47 percent.

It prohibits coverage denials and reduced benefits and protects 129 million people who have some type of preexisting health condition. More than one million Illinois residents have obtained health insurance coverage, and on March 22nd of this year, the Department of Health and Human Services announced that Medicare spent $473.1 billion less on personal health care expenditures between 2009 and 2014 than previous spending trends would have indicated.

Mr. Kreisberg, let me ask you: have you heard of, seen anything or know of anything that would do a better job of meeting the health needs of our country than that?

Mr. KREISBERG. I do not think there is anything in the current dialogue today, Mr. Chairman, given where the American people are that would do a better job than what the Affordable Care Act has done in terms of expanding coverage.

As I said earlier, I do not think we have met the full potential, and I think we do need to work on fully implementing the Medicare expansion provisions of the Act so we can bring some of the benefits that you have described to more people.

Mr. DAVIS. Thank you very much. I yield back.

Chairman BRADY. Thank you.

Mr. Meehan, you are recognized.

Mr. MEEHAN. Thank you, Mr. Chairman.

And I appreciate the panelists here today. I wish they had a chance to actually answer questions instead of being lectured to because I guess this is hearing.

But in any event, look. I thank you for your work, and I know one thing. When I go back in my district and I talk to my employers, Obamacare is not working to them, and the frustration level is the highest I have ever seen. Eight percent costs per year in increase, but I also have questions about how we work this system.

So I am going to ask four things if you can address them as best you can. If we are going to do some sort of a cap, and it is designed to make it more available to everyday people, not just to the benefit of the more wealthy members in that; so if we try to create caps, how do we keep the young, healthy employees inside that system?

My second question is: if we are going to create a tax system that does some kind of a refundable tax credit, how do you deal with people or families that do not currently have access to employer-sponsored programs?

And what do you do with those who have an income level below, you know, the 300 percent?

A third question that my colleague talked to: how do you make consumers understand what to buy when they have a doctor tell them they are sick? First they are sick. It is a hard time to make a lot of choices.

Second, you do not understand what you are buying. You are being told you have got to get this test.

And then the last question. I have thrown a lot at you if you have it. I am anxious to hear us make this, but how do you know that employer is not going to keep the savings themselves and not pass it on in the form of wages that will increase?

A lot of questions, but if you can, help me.

Mr. ROY. Those are all great questions. I think you have asked the right questions.

So on the issue of whether the employer will keep the money or raise wages, the economic literature is overwhelming in indicating that there is an exact one-to-one correlation because it is overall compensation that the employer thinks about, and it is a competitive market, right? If you want to retain those workers and not lose them to a competing firm, you have got to pay them what the market is paying them.

So if health care costs go down, the cost of insuring your workers goes down. That gets returned to workers in the form of higher wages. So we can be optimistic about that.

On the question of patient choice and how if you got to the doctor you do not actually know. The doctor says you are sick. How do you deal with that? It is a classic problem in health care.

There is a flip side to that, which is a lot of times you as a patient know a lot more about why you are sick and your family history and your background than the doctor does who is just glancing at your chart, has forgotten a few things. Your medical records are all over the place.

So there is asymmetry in both directions, and the more the consumer is in charge of his own health care dollars, the more that doctor has an incentive to be really responsive to that patient and that patient's needs and that patient's unique medical history, and that is what our current system works against.

And so if I missed anything that you have addressed, please.

Mr. MEEHAN. Well, no, I asked two other questions. I want to know about young, healthy employees. How do you keep them in if we cap this system?

Mr. ROY. Right. So the issue of whether the young, healthy employees will withdraw from employer-based care and go off and shop on their own, you could see that to some degree, but you could also see that a lot of people stay, and the reason why they would stay in the employer-based system is because of the economies of scale that come from a large employer or even a smaller employer purchasing health insurance in bulk for a group of its employees and having that negotiating power that comes with that versus being an individual shopping for coverage.

So I think employers should retain some confidence that they have a lot to offer to that employee, and they can provide other incentives to say, "Hey, you know, we want you to stay in our risk pool. Here are some other things that we can offer you that if you brought insurance on your own, maybe you would not get as good of a deal."

Mr. MEEHAN. Okay. I wish we had time for follow-up questions, but I wanted to get my fundamental questions answered, and the last one was: how about a refundable tax credit for somebody that is not in an employment situation?

Mr. ROY. That is essential. So if you only have a nonrefundable tax credit, then people who do not have income tax liabilities, they cannot get the financial assistance they need. So refundable tax credits are a very important part of equalizing the tax treatment of health care.

Mr. MEEHAN. Mr. Antos, have you got any response or any thoughts on any of those issues?

Mr. ANTOS. Well, one other aspect has to do not just with wages, but also with people being able to keep their jobs. You know, there are many margins of adjustment that employers face, and by giving more flexibility to the system we will not only have people with higher wages, but in some cases when there are loose labor markets, when the labor markets are not doing well, the people will less likely be laid off.

Mr. MEEHAN. Thank you. I appreciate that.

Chairman BRADY. Thank you.

Mr. Holding, you are recognized.

Mr. HOLDING. Thank you.

Mr. Roy, in your testimony you stated that reform should give workers more choice to purchase the kind of health coverage that is affordable for them and their families, but you know, unfortunately many of the new requirements of Obamacare made employer-sponsored coverage increasingly unaffordable, with higher deductibles, premiums and cost sharing. Employees are also presented with fewer choices as we have discussed when it comes to employer coverage.

So rather than dictating exactly what benefits must be offered, would it make more sense to allow employers to provide a defined contribution to their employees so that they can shop around and find the products that meet their needs a little bit better?

Mr. ROY. Absolutely. That would be a tremendous innovation in the delivery of health insurance in the employer market. You have

a defined contribution that they can then say, "Look." Let us say it is $5,000. If I want to spend $6,000, then I can do that with my additional funds. If I like the $5,000 health insurance plan, let me buy whatever we want.

There is an intermediate way of getting there, which is private health insurance exchanges that some large employers like Walgreens are using to say, "We are going to give you this much money. Buy whatever health insurance among these ten plans that are on the exchange."

There are a number of people working on improving that modality for delivering health coverage to the employer market.

Mr. HOLDING. Well, defined contributions are pretty common practice in the world of pensions.

Mr. ROY. Yes.

Mr. HOLDING. But not health benefits. So is there something in the Tax Code or Federal law that treats defined contributions differently than defined benefit plan?

Mr. ROY. Yes. Unfortunately, if you just give them the money to buy whatever health insurance they want, it does not qualify for the employer tax exclusion, except in these private exchange contexts where you can convert it in a certain way.

With the self-insured population you have a little bit more flexibility than through the conventional employer tax exclusion.

Mr. HOLDING. So do you think that treating defined contributions in the same way we do defined benefits under the Tax Code would help to make the health care costs more manageable and predictable for employers, employees and employers?

And similarly, do you think it would give employees more flexibility in their insurance coverage?

Mr. ROY. Absolutely, and you know, there has been a lot of concern expressed today about if you reform the employer tax exclusion, would that disrupt coverage in the employer market for those who prefer it, and one of the best ways to ensure that employer-based health coverage continues to be robust is to give employers exactly the option that you are describing, to say, "Do you know what? We are going to get out of the business of picking the health insurance plan for you, but we are going to be allowed to have a defined contribution which then you can use to shop for coverage that you want," because that is a benefit that employees would love to have and would loath to give up.

Mr. HOLDING. Now, importantly, on the flip side do you think this would create incentives for insurers to compete for this business? Correct?

Mr. ROY. Absolutely.

Mr. HOLDING. And competition ultimately would drive costs down because your insurers are competing, correct?

Mr. ROY. It would drive costs down. It would also improve quality and customer service because, again, insurers would have to compete for your business.

Mr. HOLDING. Thank you.

Mr. Chairman, I yield back.

Chairman BRADY. Thank you.

Mr. Dold, you are recognized.

Mr. DOLD. Thank you, Mr. Chairman.

And I want to thank our witnesses again for your time, and I, too, join my colleague, Mr. Meehan, in hoping that this could have been more question and answer to hear from you as opposed to taking the short period of time really more for speaking at you.

I will kind of try to get to some questions, but I will tell you as a small business owner the frustration level that is out there not only amongst the employers, but amongst those looking and seeking to provide insurance for their families is extremely high. They are frustrated largely because as an employer, and I am a small employer, we see our premiums and have seen traditionally year after year, even before the Affordable Care Act, they would rise up pretty significantly, sometimes 44 percent a year, and yet certainly as someone that runs a multi-generational business, we consider the people that we work with part of our family.

And honestly, that is where that trust comes in because many, especially in these small businesses that are out there, they trust the people that they have been working with for ten, 15, 20 years and trying to provide or make the choices that they believe would be best.

As we look at the flexibility which I think is absolutely critical, I think we are also getting away from the idea that what our goal should be is that we want quality care for everyone, and we want to make it as affordable as possible, more recently we have seen premiums go through the roof. Deductibles have gone sky high, and so for a family of four, it would not be uncommon for them to pay $2,500 a month in premiums and have a deductible of $12,000-plus.

So for that family of four, they are paying, you know, 20-some odd thousand dollars of insurance before they get dollar one of coverage.

And we have done a masterful job of actually disguising the costs of health care, right? How much does it cost to go to the pediatrician? Well, I will tell you some people say it is just $20. No, no, that is the copay.

And so really what we have done is we have taken consumers completely out of the equation, and what we really need to be focused on is how do we enable that competition.

And the other thing that I would argue, we would like to have the flexibility for employees not to feel trapped into a job because if I leave I am going to lose my health coverage and, therefore, I potentially might not be able to have that coverage as I move forward for my family, and that is really terrifying, obviously, for those that have family members that have great need.

I am reminded of a study that was done up in Wisconsin. Hospital A had a knee replacement. It was $57,000 for the knee replacement. Hospital B, three miles down the road, not far and still basically right there in the neighborhood, was $38,000.

Now, we associate better care with $57,000, and yet what was amazing was better outcomes actually happened at the hospital for $38,000. My point is: should we not know that? Should we not be able to get that data out there and drive more people to the hospital that is doing it for $38,000?

Mr. Antos, what happens to the hospital that is doing it for $57,000?

Mr. ANTOS. They are making a lot more money.

Mr. DOLD. Well, but what happens to them if we are able to figure out that the hospital three miles down the road is doing a——

Mr. ANTOS. Well, if there is actually usable consumer information about their cost and the quality of the services, what is going to happen is that it is going to drive the expensive hospital to revamp the way it does its business. It is going to drive the hospital to talk to their doctors about how you manage care.

Mr. DOLD. Ultimately what we are trying to focus on in this hearing is what can we be doing with regard to our Tax Code to make better decisions, and frankly, we do not want to talk about an increased tax on hard-working taxpayers. We want to encourage those employers to be able to continue to do it.

Because I would argue as a small business person, we want to make sure that we are able to attract and retain good people. But I do believe that we have to come up with a mechanism that provides that flexibility for employees, for those hard-working taxpayers to say, "I have good quality care," regardless of where they are working and for those even that are not working.

And that is where I think that refundable tax credit really has to come into play.

Can you talk to us about what we can really be doing in terms of focusing on that flexibility, so we do not have the job lock, as it were, Mr. Roy?

Mr. ROY. Yes. So as both of us described in our prepared remarks, if you gradually cap the taxable exclusion in a way that is revenue neutral so that it would involve no tax increase on any worker relative to what current law is, you give people the flexibility to opt out if they want to and shop for coverage on their own.

And also if they change jobs, they own their own health insurance plan just like with auto insurance. Your auto insurance does not change when you switch jobs. It is your auto insurance, your life insurance, et cetera.

The same with health insurance. It should work the same way. You should be able to transition. You should be able to continue your coverage, and it should not have to be sponsored by the employer to do that.

And one mechanism to do that and integrate it into the employer-based system is what we were talking about just a minute ago, which is to have a defined contribution at the employer level, which then the individual can take and use to buy the insurance and keep the coverage as he changes jobs.

Mr. DOLD. I would love to hear the responses, but my time has expired, Mr. Chairman.

Chairman BRADY. Thank you, Mr. Dold.

Mr. DOLD. Thank you.

Chairman BRADY. Mr. Rangel, you are recognized.

Mr. RANGEL. Thank you, Mr. Chairman.

And let me thank the panel for your patients and indulgence in coming here to share with us.

Mr. Roy, you know, facetiously Dr. Price and I said we will adopt your policy, but I will be serious to find out is it at all possible for you to present the plan that you have to us for us to look at?

And how soon could we get it?

Mr. ROY. I would be happy to do it at any time that is convenient to you and your office, Mr. Rangel, at any time that you on your Committee or anyone in the Congress.

Mr. RANGEL. Can you send it to us directly? And then I would arrange with Dr. Price and others to be able to discuss it because it pains me to have struggled so long for expansion of health care to find people that would be anxious to repeal it and not to have a plan to suggest how the vacuum will be filled.

Mr. ROY. Absolutely, and you know what I would say, Mr. Rangel, is that I have reached out many times to Democrats both in the——

Mr. RANGEL. No, no, no.

Mr. ROY [continuing]. House and in the Senate.

Mr. RANGEL. You do not have to reach out any further.

Mr. ROY. It sometimes is very difficult.

Mr. RANGEL. You also are a journalist, right?

Mr. ROY. Say that again?

Mr. RANGEL. You are a journalist as well?

Mr. ROY. Yes.

Mr. RANGEL. You can prepare the press release now that I have said that I am anxious to see what is on your mind because with all of the activity on the floor to repeal the Affordable Care Act, I have not seen an alternative, and you are prepared to show that to me.

Now, you are not a health care provider, are you?

Mr. ROY. No. I am a——

Mr. RANGEL. But you are considered an expert in delivery of health care, are you not?

Mr. ROY. Well, I will defer to this Committee that invited me here as to whether I have expertise or not.

Mr. RANGEL. Well, you have provided this advice to Governor Mitt Romney, have you not?

Mr. ROY. I was an advisor to Mitt Romney in the past year.

Mr. RANGEL. And as well as Rubio. You advised him.

Mr. ROY. Yes.

Mr. RANGEL. And Rick Perry?

Mr. ROY. Yes, sir. And so in addition to an expert in health care, you also could be considered political analyst in terms of providing political advice as relates to health care. Is that true?

Mr. ROY. I provide policy advice, not political advice.

Mr. RANGEL. But you have given a lot of policy advice to outstanding Republican politicians, right?

Mr. ROY. I am happy to give policy advice to anyone who asks, and it is mostly Republicans.

Mr. RANGEL. I know you would. You do get paid for giving advice, do you not?

Mr. ROY. No, I was a volunteer on——

Mr. RANGEL. Have you ever been paid to give advice?

Mr. ROY. Have I ever been paid to give policy advice?

Mr. RANGEL. Policy advice as relates to health care.

Mr. ROY. Well, I am an employee of the Manhattan Institute. So I do research on policy.

Mr. RANGEL. So what I am saying is of course, you would welcome giving advice. No Democrat ever accepted your services.

Mr. ROY. But I would be eager to provide that.

Mr. RANGEL. Okay. Now, what group did you mention, the Financial Institute? Are you with them now?

Mr. ROY. The Manhattan Institute for Policy Research. That is the nonprofit think tank.

Mr. RANGEL. Are you with them now?

Mr. ROY. Yes. I am a senior fellow with the Manhattan Institute.

Mr. RANGEL. Did you ever work for J.P. Morgan?

Mr. ROY. I did many years ago, yes, before I started working in health care policy.

Mr. RANGEL. And when you went to work for health care policy, did you form or become partner in a firm called Tarea Funds?

Mr. ROY. No, I was not a partner in Tarea.

Mr. RANGEL. Were you a part of Tarea?

Mr. ROY. I was an outside consultant. I worked with some of their individuals.

Mr. RANGEL. So you gave advice to Tarea?

Mr. ROY. I was a consultant, yes.

Mr. RANGEL. Does consultant mean giving advice to them?

Mr. ROY. Sometimes, yes.

Mr. RANGEL. And is Tarea a hedge fund organization?

Mr. ROY. No.

Mr. RANGEL. Do they advise a hedge fund organization?

Mr. ROY. No, they mostly advise companies, such as biotechnology companies that are trying to develop new therapies.

Mr. RANGEL. Have you been described as an advisor to hedge fund investors?

Mr. ROY. Yes, I have sometimes given advice to investors as I give advice to policy makers and other people who are——

Mr. RANGEL. But since your specialty is in health care, would you have concentrated in giving investment advice or policy advice to hedge funds that are concerned with providing health care? That is where your expertise is.

Mr. ROY. I am not sure I understand the question. If the question——

Mr. RANGEL. I am trying to connect you with hedge fund providers. That is what I am trying to do.

[Laughter.]

Chairman BRADY. That has become clear, Mr. Rangel, yes.

Mr. RANGEL. And so I do not know what it is. What part of my question is it that you do not understand?

Mr. ROY. So after I——

Mr. RANGEL. Hold it. You are not a doctor. You are not a health provide——

Mr. ROY. I worked as an investor.

Mr. RANGEL. Please, just one minute.

Mr. ROY. Sorry.

Mr. RANGEL. You are not a doc. You see, you took my time away, but perhaps the chair might afford you some time to separate yourself from hedge fund investors as relates to health care.

Mr. ROY. My policy advice is entirely independent of my previous career as an investor in the health care system.

Chairman BRADY. Thank you.

Mr. Roy is an acknowledged expert and credible witness on health care reform. We welcome your attendance today.

Mr. Rice, you are recognized.

Mr. RICE. Mr. Kreisberg, you work for a big public sector labor union, correct?

Mr. KREISBERG. Yes, sir.

Mr. RICE. And you do design work and consulting, I guess, for their health plans?

Mr. KREISBERG. For the staff health plan?

Mr. RICE. For whatever health plan they have.

Mr. KREISBERG. I have collectively bargained health plans covering hundreds of thousands of workers.

Mr. RICE. How many of those workers are covered under the Obamacare exchanges?

Mr. KREISBERG. I am sorry. I am having a little bit of trouble——

Mr. RICE. How many of those workers are covered under the Obamacare exchanges?

Mr. KREISBERG. The ones that I negotiated for are not in the exchanges, but other members of ours are in the exchange.

Mr. RICE. What percentage would you say?

Mr. KREISBERG. Of our members in the exchanges?

Mr. RICE. Yes, yes.

Mr. KREISBERG. I would probably say five percent, if that high. Excuse me. We do have more in the Medicaid expanded coverage program.

Mr. RICE. Do you think if you moved all of your members to the exchanges that that would increase their satisfaction with their health care coverage or decrease it?

Mr. KREISBERG. I believe it would decrease their satisfaction.

Mr. RICE. The Cadillac tax, you know, you are sitting here saying that you like the Affordable Care Act, but you do not want your members on it.

Mr. KREISBERG. That is not what I said.

Mr. RICE. Okay. Well, explain it to me then.

Mr. KREISBERG. Well, for many of the people who are covered in the health care exchanges, they had coverage in the individual market, which was not working well at all or they had no coverage at all. So we believe the Affordable Care Act health care exchanges are very positive things for those members.

But we are a firm believer in the traditional employer-sponsored insurance, which our members are fortunate enough to normally be able to access.

Mr. RICE. All right. Well, Jonathan Gruber testified that when he was helping design the Affordable Care Act that the Cadillac tax was specifically designed to increase the cost of employer provided insurance over years and thus force everybody into the exchanges, and what I am asking you is if the Cadillac tax works as Mr. Gruber designed it and forces all of the employer-provided health insurance to become so expensive that people cannot do it and all of your members are transferred onto the exchanges. Are they going to be happy with that or are they going to be disappointed?

Mr. KREISBERG. Well, first of all, I think Gruber is wrong.

Mr. RICE. Well, he designed the plan.

Mr. KREISBERG. Some controversy over that, but he is wrong in terms of what would happen. What would happen, I would argue——

Mr. RICE. Excuse me. Mr. Roy, is Gruber wrong or is he right?

Mr. ROY. Is Gruber wrong about what specifically?

Mr. RICE. That the Cadillac tax was designed to make employer-provided health insurance more and more expensive so that people would eventually be forced onto the exchanges?

Mr. ROY. I do not believe he said that the Cadillac tax would make health insurance more expensive and that people would go on the exchanges. I do not believe he said that.

Mr. RICE. Employer-provided insurance.

Mr. ROY. I think he has stated that the Cadillac tax was designed, because it is back-loaded in terms of the way it appears, as the way it comes in, that would be less transparent.

Mr. RICE. It was back-loaded so that people will not figure it out until years later. He said the American public was too stupid to figure it out.

Mr. ROY. Its convoluted design was what he was celebrating because people would not understand how it worked.

Mr. RICE. It does not apply until 2018, and then it is indexed based on inflation, not on inflation in health care cost.

So, Mr. Antos, moving to you, that would result in employer-provided health insurance becoming more and more expensive, correct?

Mr. ANTOS. Absolutely right. In fact——

Mr. RICE. And it would force people onto the exchanges, correct?

Mr. ANTOS. Well, it might force them out of insurance altogether.

Mr. RICE. So, Mr. Kreisberg, coming back to you, when the health insurance that you collectively bargain for and that you provide to your population becomes so expensive that you cannot collectively bargain for it anymore because of the Cadillac tax and your guys get moved back onto the Obamacare exchanges, are they going to be happy with that?

Mr. KREISBERG. Well, what would happen is that the health plans that they are in would change so they would fit under the cap. We would not necessarily lose our coverage. We would still probably have a——

Mr. RICE. But you would lose your benefits.

Mr. KREISBERG [continuing]. But it would be less valuable.

Mr. RICE. I am sure they would be happy with that.

Mr. KREISBERG. They would not be happy with that, which is why we oppose the excise tax.

Mr. RICE. Over half the American population is covered by employer health providers. A large part is covered by Medicare. A large part is covered by Medicaid. Poor people are covered by Medicaid. Retired people are covered by Medicare.

Most of the rest of the people are covered by employer-provided health insurance, and they really like it, right? Is the Affordable Care Act not an attack on employer-provided health insurance?

Mr. ANTOS. Well, former White House official Ezekiel Emanuel argued that the Cadillac tax would pave the way towards eliminating the employer market altogether.

Mr. RICE. Thank you.

I yield back.

Chairman BRADY. Thank you.

Mr. Reed, your final question?

Mr. REED. Well, thank you, Mr. Chairman.

You are at the end, and I guess this is the penalty for showing up late, and I take responsibility for having the last five minutes.

First, I just want to make sure this is clear, and I was offended by my colleague on the other side of the aisle who referenced that somehow the Republican agenda is to take away health care for people in America. That is just not accurate, and our Committee is better than that, and I will talk to that member personally to make sure that we always raise our discourse.

Because I think what is here between us on both sides of the aisle is a recognition that the health care system is not working in America, and that we have to get to the issue of health care cost in particular.

And I understand that the heart of this conversation today is about employer-sponsored health care, and it is a big change if we go down the path of removing that exclusion in the Tax Code, and I am very concerned about that. But I am willing to put all options before us to have a wide open debate in order to make sure that we are attacking the fundamental problem, and that is health care cost and accessibility for our fellow American citizens.

That being said, we are six years into this experiment with the Affordable Care Act, Obamacare. So let me ask you a question. Who has been to the doctor in the last 60 days on the panel?

[Show of hands.]

Mr. REED. Anyone else?

How much did it cost?

Mr. ROY. I do not know.

Mr. REED. You do not know, right?

Mr. ROY. Well, because it was covered by insurance, and I do not really get a bill that explains to me how much it cost.

Mr. REED. So each of you had indicated that you have insurance through your employer. What did you pay last month for that insurance?

Mr. ROY. I do not know.

Mr. REED. Mr. Kreisberg, do you know?

Mr. KREISBERG. The insurance plan that I am covered in, my employer pays for it. It costs probably about $2,500 a month.

Mr. REED. How much does it cost you?

Mr. KREISBERG. I do not pay a premium.

Mr. REED. You are 100 percent covered by your employer.

Mr. KREISBERG. Yes.

Mr. REED. And it is approximately how much by your employers?

Mr. KREISBERG. Approximately I would believe somewhere about 23 to——

Mr. REED. You would guess, right?

Mr. KREISBERG [continuing]. 23 to $2,500 a month. Yes, I am guessing.

Mr. REED. You are guessing.

Mr. KREISBERG. An approximation.

Mr. REED. Does that not illustrate the point? You are three leading experts testifying before the U.S. House of Representatives' Ways and Means Committee. Is this not the point?

Mr. ROY. Absolutely, and it is a question I often ask.

Mr. REED. You do not know. You do not know the answer to that fundamental question, and does that not in a large part drive the problem we are facing in America's health care?

Mr. KREISBERG. I think your conclusion is wrong from the point you are trying to make.

Mr. REED. The lack of transparency by you as an expert not knowing the cost, not knowing how much it cost you in the system is not causing the problem or at least contributing?

Mr. KREISBERG. No.

Mr. REED. Would you concede it contributes to the problem?

Mr. KREISBERG. The problem is not what can consumers know about cost. The problem is what the costs are. As you are trying to point out, the cost——

Mr. REED. Hold on. Mr. Kreisberg, hold on. I waited two and a half hours to have this time.

Mr. KREISBERG. Yes.

Mr. REED. This is the issue. There are in my mind two tools that we can use to control costs: market pressure driven by people or government mandate driven by D.C. Are there any other tools out there that you can think of?

I see a bunch of noes across the table here, right?

Mr. KREISBERG. Yes.

Mr. REED. What we are trying to do is to say to the American people we stand on the side of you. We stand on the side of a market. Now, you may not agree that it could work in the health care industry, and there are going to be situations where a true market does not exist in health care. I get that.

But our fundamental tool that we are trying to use is market driven pressure to drive the cost down. The other side when they celebrate the Affordable Care Act they are saying government is going to drive those costs down. I am concerned about that as well as the hundreds of millions of people across America that say if a government can tell you how we are going to drive that cost down in a personal transaction such as health care, that is an extensive, big government type of power being exercised over us.

So I am open to try to empower individuals to have that market-based pressure giving them their money in an employer-based situation. I have great concerns about it. I will be perfectly honest with you because we have all become accustomed to it, but I do understand the power of what that would represent.

Is that not what we are trying to do by recognizing the exclusion and saying if we give that power to the employee, that they may be in a better position to determine and put that market pressure on the system to drive the cost down?

Is that what we are trying to get to, Mr. Roy?

Mr. ROY. I thought you laid it out beautifully.

Mr. REED. Well, thank you.

As we end on that, I yield the balance of my time, and thank you to the entire panel for that exchange.

Chairman BRADY. Thank you.

We would like to thank our witnesses for appearing before us today.

The question is as we preserve the incentives for employer-sponsored health care, can we update this tax incentive, provide more options in the 21st Century world to workers at work or those who want health care outside their work in a way that works for their family and their lives.

And we have had great testimony and very constructive dialogue today. I appreciate the witnesses.

Please be advised I would like to submit for the record an analysis from the Congressional Budget Office that shows that drug price savings are not obtained by negotiating with Medicare.

[The information follows:]

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Peter R. Orszag, Director

April 10, 2007

Honorable Ron Wyden
United States Senate
Washington, DC 20510

Dear Senator:

You asked a number of questions relating to the Medicare drug benefit and options for allowing the Secretary of Health and Human Services (HHS) to negotiate over the prices paid for drugs under that benefit. The Medicare Modernization Act contained a provision that prohibits the Secretary both from interfering in the negotiations between drug manufacturers and the prescription drug plans (PDPs) that deliver the Medicare benefit, and from requiring a particular formulary or instituting a price structure for the reimbursement of covered drugs.

Responses to the questions you raised are below.

Could negotiating by the Secretary over drug prices obtain savings for the Medicare program if those negotiations were limited to selective instances?

As the Congressional Budget Office (CBO) indicated in a previous letter, negotiations limited to a few selected drugs or types of drugs could potentially generate cost savings.[1] For example, negotiations could be focused on drugs with no close substitutes or those with relatively high prices under Medicare. In such cases, CBO assumes that the effect of the Secretary's actions—if he or she took advantage of the new authority—would primarily reflect the use of the "bully pulpit" to pressure drug manufacturers into reducing prices.

Although cost savings might be possible in selective instances, the impact on Medicare's overall drug spending would likely be limited. Bully pulpit strategies would probably be effective only if they were constrained to a small number of drugs; otherwise, the pressure of the spotlight would be dissipated. Consequently, spending on the small number of affected drugs would likely account for only a small fraction of expenditures under the Medicare drug benefit. Furthermore, even if the Secretary focused on a select number of drugs, the effect might be limited because pressure from PDPs and public relations concerns already affect pricing—so the incremental effect of giving HHS additional options for exerting pressure would generally be small. Finally, drug manufacturers could seek to limit the impact of the Secretary's actions by setting higher initial prices for their drugs, to offset any potential price concessions from negotiations with the Secretary. As a result, CBO expects that the overall impact on federal spending from

[1] See Congressional Budget Office, Letter to the Honorable Ron Wyden regarding the authority to negotiate prices for single-source drugs for Medicare beneficiaries (March 3, 2004).

negotiations targeted at selected drugs would be modest. Beyond that general conclusion, the precise effect of any specific proposal would depend importantly on its details.

Recent negotiations over Cipro and FluMist showed significant savings relative to prevailing commercial prices, but several factors substantially limit their relevance to Medicare negotiations. In the case of Cipro, which can be used to treat anthrax, the relevant negotiations were conducted in the climate of a national emergency immediately following the attacks of September 11th and deaths from anthrax-laced letters. Furthermore, Cipro's patent protection was close to expiring and several manufacturers were poised to produce that drug once the patent expired. That set of circumstances gave particular force to the threat issued by Secretary Thompson to seek authority for generic production of Cipro, which was apparently instrumental in bringing the negotiations to a close. FluMist, a nasal form of flu vaccine, was relatively new at the time of the relevant negotiations. The manufacturers of that product apparently overestimated demand for it and therefore had large stockpiles on hand that would have little or no use once the flu season ended. Although HHS was able to negotiate price reductions for FluMist in December 2003, its manufacturer chose soon thereafter to give away a substantial quantity of the vaccine free of charge—and even then demand apparently remained low. The exceptional circumstances associated with those two examples limit their applicability to the case of drugs covered by the Medicare benefit.

If the Secretary were given authority to negotiate by Congress and used that authority, would it be possible to obtain savings to Medicare?

The key factor in determining whether negotiations would lead to price reductions is the leverage that the Secretary would have to secure larger price concessions from drug manufacturers than competing PDPs currently obtain.[2] When several drugs are available to treat the same medical condition, PDPs can secure rebates from selected drug manufacturers by giving their drugs preferred status within formularies. Because enrollees are encouraged to use such preferred drugs (through lower cost-sharing requirements), manufacturers are willing to offer price concessions to the PDPs in order to give their drugs preferred status and thereby increase their market share.

By itself, giving the Secretary broad authority to negotiate drug prices would not provide the leverage necessary to generate lower prices than those obtained by PDPs and thus would have a negligible effect on Medicare drug spending. Negotiation is likely to be effective only if it is accompanied by some source of pressure on drug manufacturers to secure price concessions. The authority to establish a formulary, set prices administratively, or take other regulatory actions against firms failing to offer price reductions could give the Secretary the ability to obtain significant discounts in negotiations with drug manufacturers. In the absence of such

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[2] See Congressional Budget Office, Letter to the Honorable William H. Frist, M.D., regarding CBO's estimate of the effect of striking the "noninterference" provision as added by P.L. 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (January 23, 2004); and Congressional Budget Office, cost estimate for H.R. 4, the Medicare Prescription Drug Price Negotiation Act of 2007 (January 10, 2007).

authority, the Secretary's ability to issue credible threats or take other actions in an effort to obtain significant discounts would be limited. Broad negotiating authority would not necessarily result in the type of targeted approach that could produce savings. CBO thus estimates that providing broad negotiating authority by itself would likely have a negligible effect on federal spending.

Since 2003, has anything changed—other than the Secretary saying he would not negotiate—that would indicate whether such negotiation would be successful?

Since the enactment of the Medicare Modernization Act, HHS has issued certain regulations to implement the drug benefit that suggest a reluctance to limit the availability of drugs to enrollees, even if the result is somewhat higher drug spending.

Under the act, PDPs are required to cover at least two drugs in each therapeutic class of drugs that treat the same condition. Because a common definition of therapeutic classes did not exist, the law also provided for U.S. Pharmacopoeia, a private standard-setting entity, to establish a model set of classes, which PDPs were encouraged but not required to follow. In its regulations, HHS required PDPs to cover all or substantially all drugs in several important classes, including antipsychotic medications. (That requirement was established on the grounds that failure to cover such a broad set of medications would discourage individuals from enrolling in the benefit or in a drug plan that provided less extensive coverage.) In addition, those regulations encouraged PDPs to cover at least one drug in each subclass of drugs that U.S. Pharmacopoeia specified, even though that was not required under the legislation. The regulations reduced the rebates that PDPs can secure and raised the cost of the drug benefit.[3] The motivations affecting those regulations would presumably also affect the negotiating stance of the Secretary, limiting the likelihood that the negotiations would yield lower drug prices. At the same time, the regulations have reduced the rebates obtained by PDPs and thus created some potential for additional savings.

The current HHS Secretary has indicated that he would not pursue drug price negotiation if given the authority to do so, and it is difficult for CBO to predict what actions future HHS Secretaries might or might not take. Simply put, it may be difficult through legislation to force a Secretary to pursue negotiations aggressively if he or she is reluctant to do so.

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[3] See Congressional Budget Office, *An Analysis of the President's Budgetary Proposals for 2006* (March 2005), Appendix A, and Congressional Budget Office, Letter to the Honorable Joe Barton and the Honorable Jim McCrery regarding potential effects of disclosing price rebates on the Medicare drug benefit (March 12, 2007).

Honorable Ron Wyden
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I hope this analysis is helpful to you. If you would like additional information on this subject, CBO would be pleased to provide it. The staff contacts for this analysis are Tom Bradley and Philip Ellis.

Sincerely,

Peter R. Orszag
Director

cc: Honorable Max Baucus
Chairman
Committee on Finance

Honorable Charles E. Grassley
Ranking Member

Chairman BRADY. Please be advised Members have two weeks to submit written questions to be answered later in writing. Those questions and answers will be made part of the formal hearing record.

With that, again, thank you for being here. The Committee stands adjourned.

[Whereupon, at 12:56 p.m., the Committee was adjourned.]

Questions for the Record

From Representative Jason Smith of Missouri:

Question 1:

Dr. Boustany has a bill that I would like to highlight, because it hits the prevention side of the tax code and could help encourage physical activity.

The Personal Health Investment Today, or PHIT Act would make it easier for people to be physically active. The PHIT Act would allow people to use their HSAs and FSAs for certain sports and fitness expense, like gym memberships, athletic league dues, and sports and fitness equipment used exclusively for participation in physical exercise.

In other words, we would use the tax code to encourage active, healthy activities.

Mr. Antos– do you see a benefit to working towards reducing our long-term health care costs with such policy investments on the front end?

Do you have any ideas of various other policies that we might want to consider to help reduce the barriers to entry in these struggling, mostly low-income, areas for physical activity?

Response: We have become a largely sedentary society, which has led to an increasing incidence of obesity and chronic diseases that could be prevented if we became more physically active. One barrier to physical activity is personal: we have to make the time and effort to take a walk or engage in some other activity. It is important to instill in our children an enthusiasm for sports or other physical activities that they can engage in over their lifetimes. School programs can help, but children follow the lead of their parents. A parent who is active sets an example for his or her children that they can follow. Financial barriers can also discourage healthy physical activity. Allowing people to use some of their HSA/FSA funds for sports and fitness expenses can help, but the success of such a policy would depend on the individual taking the initiative to engage in physical activities. People in low-income areas may not be able to make substantial contributions to an HSA/FSA. For them, local communities could invest in community sports and fitness facilities, offering free or reduced-cost memberships.

Question 2:

Thank you for holding this important hearing, Mr. Chairman. Our tax treatment of health care can and must be improved.
Under current law, starting in 2018, the "Cadillac Tax" will equal 40 percent of the costs of employer contributions to health benefits above a certain threshold.
Time and time again I hear from employers all across South and Southeastern Missouri that the Cadillac tax suppresses their ability to raise wages and properly compensate their employees.

Some folks across the aisle have made it clear that they have an answer to the ESI exclusion: the Cadillac Tax.

Democrats will say, "The Cadillac Tax already does limits to exclusion." Some might ask why we won't work with Democrats to fix the tax instead of all this replace nonsense?

The reality is that the Cadillac tax is a crude, complex, and flawed policy.

And it – like the rest of the Presidents' health care law – must be replaced.

But we can improve upon the concept of the Cadillac Tax to actually target high cost employer-provided plans, protect the employer-sponsored market and limit an open-ended tax benefit that increased premiums and suppresses wage growth.

Mr. Antos, can you walk us through some of the shortcomings of the Cadillac Tax?

What would be a simpler and less administratively costly way to limit some of the negative effects of the ESI exclusion while maintaining the popular employer-sponsored health care system generally?

Ultimately, who does JCT project will be responsible for the Cadillac Tax? Who ends up picking up the tax and being burdened by it the most?

Response: The Cadillac tax is a 40 percent excise tax on employment-based health benefits that exceed specified cost thresholds. Although the tax is nominally paid by employers, insurers, and other health plan sponsors, the cost will be borne by the workers. If the employer or plan sponsor cuts back benefits to avoid the tax, then workers will face higher health costs and restricted access to physicians and other providers. If the employer does not cut back benefits, then the tax will be paid by workers through higher premiums.

Problems with the Cadillac tax include the following:

- **Low-wage workers and those living in high-cost areas (such as New York City or San Francisco) are most disadvantaged by the Cadillac tax. Low-wage workers have less financial ability to absorb the higher costs that will be shifted to workers. In addition, the tax's thresholds do not account for geographic variations in the cost of health care, which means that a worker in a high-cost area is more likely to be affected by the tax than one in a low-cost area.**
- **The Cadillac tax undercuts the use of health savings accounts (HSAs), which promote prudent purchasing of health care services. All contributions to HSAs count toward the threshold limits set by the law.**
- **The Cadillac tax will eventually impact everyone with employer coverage. The cost thresholds are indexed to general inflation. Because health care costs generally rise much faster than that, eventually all employer health plans will exceed what the ACA considers acceptable levels of health care coverage.**
- **The Cadillac tax imposes new reporting requirements on employers and insurers, and creates new costs of enforcement and tax collection.**

A better alternative to the Cadillac tax is to cap or limit the amount of employment-based health benefits that can be excluded from a worker's income. Capping the exclusion would promote the purchase of more efficient health coverage while retaining incentives for employers to offer coverage to their employees. The cap would encourage employers to seek lower-cost plan options, but would not drive employers to offer only low-cost plans. The cap could be tied to the actual cost of health insurance rather than setting it at a fixed dollar amount. That would maintain a substantial subsidy for employment-based coverage even when health costs rise rapidly.

A 2013 Urban Institute study finds that a cap set at the 75th percentile of premiums and other medical benefits offered by employers would produce $264 billion in new revenue over 10 years while preserving 93 percent of the tax subsidies provided to workers under the current policy. Such a policy would also reduce the regressivity of the current tax treatment of employment-based insurance.

From Representative Tom Price of Georgia:

Question 1:

The American people need choices and portability. We have one tax benefit that's tied to a job. And another that's tied to a broken website. We have to get money in the hands of the American people that is actually portable, that can actually be used to buy the plan of their choice, without Washington mandates and regulations increasing costs. Do you agree that one solution to provide improved portability of health coverage is to give employers the ability to provide their employees with a defined contribution so they may purchase health coverage within the individual market?
a. Do you agree this would help to equalize the tax treatment between the employer and individual market?
b. Do you agree that such an arrangement would encourage more employees to exit the employer market and enter the individual market?

Response: Lack of portable health insurance has long been a problem. Although COBRA gives workers the right to continue their employment-based coverage after they leave their jobs, the worker is responsible for up to 102 percent of the total cost of the group plan. Except for short periods between jobs, this is not a long-term solution for most people because of the cost. The ACA exchanges were intended to resolve the "job lock" of workers remaining in unsuitable jobs to keep their health coverage. This has proven not to be a solution for the middle class, who are not eligible for substantial subsidies and have largely not purchased exchange health plans.

Workers who participate in their employer's health plan pay the full cost of that plan with pre-tax dollars, which represents about a 30 percent savings on federal income and payroll taxes and additional savings if the worker is subject to state and local income taxes. Workers who purchase insurance on the individual market rather than from their employer do not receive that tax subsidy. Under current tax rules, employees must pay taxes if they are given a cash "defined contribution" by the employer to help them buy insurance on the individual market. As a result, such defined contributions are rarely if ever provided, and most workers buy health insurance from their employers.

Equalizing the tax treatment of employer contributions to health insurance premiums regardless of where the coverage is purchased would result in a shift toward the individual insurance market. However, employment-based coverage would continue to be popular for some time because it is more convenient and easier to navigate for most workers. A greater shift will occur if the plan options available on the individual market are more attractive than employment-based plans and if the shopping experience improves.

Question 2:

What can we do to encourage consumers to take a greater interest in their own healthcare costs?

Response: Consumers are naturally interested in (and concerned about) the out-of-pocket payments they must make for health services, which accounts for about 12 percent of total health spending. They are less aware of the payments made by insurers on their behalf or of the total cost of health care. However, consumers ultimately pay those costs as well through health insurance premiums and taxes to finance Medicare, Medicaid, and exchange subsidies.

Shifting from first-dollar coverage to high-deductible health plans with health savings accounts would make consumers more aware of the full cost of health care, and would reduce spending somewhat. The study by Lo Sasso and colleagues (*Health Services Research*, 2010) shows that HSA enrollees spent roughly 5–7 percent less than non-HSA enrollees.

More should be done to promote cost awareness. For many services, neither the patient nor the physician know in advance what the full cost or the patient's out-of-pocket share will be. Initiatives to require hospitals to post prices, for example, are claimed to improve cost awareness. But such measures overlook the complicated system of discounts and cost-sharing requirements that determine the final price to the insurer and to the patient.

To resolve this lack of information, efforts must be made jointly between providers and insurers to provide relevant cost information on a timely basis. With improvements in data processing, it soon should be possible to provide accurate and timely information on the cost of routine services and the patient's share of that cost. That will require real-time processing by the insurer to account for whether the patient has paid his deductible, whether the providers of service are in- or out-of-network, and other factors that influence the patient's out-of-pocket cost. For more complex services, a range of costs can be developed reflecting the typical experience of patients.

Patients need information on both cost and quality. More work is needed to develop reliable and understandable information about the effectiveness of alternative treatments and the ability of their providers in delivering those treatments. There is much talk about promoting value in health care, and better information with greater patient involvement is central to that effort.

Question 3:

How do we justify an open-ended tax benefit in the employer market, yet no tax benefit in the individual market?

Response: The preferential tax treatment of employment-based health insurance unfairly penalizes individuals who do not have access to good company health plans, and disadvantages low-income workers and others who are not working but need coverage. Perversely, we are providing larger subsidies to high-income workers and no subsidies to those who are outside the employer-based insurance market. Moreover, the open-ended nature of the tax break promotes wasteful spending and inefficiency in the health care system. Capping the exclusion would free up funds that could be used to provide subsidies for those purchasing individual health coverage. A more complete reform would address the uneven distribution of tax subsidies across different income groups and different insurance markets, including the exchange subsidies which are unavailable to middle-class purchasers.

Question 4:

Would you agree that denying Americans (especially wealthy Americans) a tax break in the individual market artificially incentivizes them to seek insurance through an employer? What's the solution?

Response: Under current law, workers in higher tax brackets benefit the most from the exclusion. The Joint Committee on Taxation found that the average savings for tax filers with incomes less than $30,000 was about $1,650 compared to about $4,580 for those with incomes over $200,000. Without such substantial tax benefits, the individual insurance market would have developed and the employer insurance market would not have flourished. Most employers are not in the health insurance business, and few would have wanted to add health insurance to their main activities without the tax break.

We should move to a system that provides fairer subsidies and promotes more efficient health insurance choices. One approach is to replace the tax exclusion with a refundable tax credit for everyone who purchases insurance, either from their employer or from the individual market. Under that system, an individual would receive a "defined contribution" subsidy that would allow him to decide whether to purchase more or less generous coverage and pay any additional premium above the value of the subsidy.

A step toward that reform would cap the tax exclusion and provide a tax credit to workers who choose to buy their insurance on the open market. Capping the exclusion reduces its regressivity and preserves employers' incentive to offer health coverage to their workers. This could serve as a transition to a tax credit for everyone.

Question 5:

If the President's health care law were repealed and the ESI exclusion was reformed such that it were no longer unlimited, what kind of complementary tax benefit could be put in place to level the playing field in the tax code between those who received employer-sponsored insurance and those who do not?

Response: Capping the exclusion and repealing the ACA would free up substantial funds to finance a tax credit for everyone purchasing on the individual insurance market (not just those buying through the exchanges as at present). The ACA experience shows the complexity of tying the credit to the family's income: it is often difficult to accurately predict one's income in advance, and it is difficult to correct mistakes (either under- or over-payments). An alternative is to relate the credit to a person's age, with higher subsidies for older people reflecting their greater use of health services, and family composition. Adjustments could also be made to account for regional variations in average health cost. It is essential that the credit be provided as a defined contribution to avoid biasing the decision about what kind of coverage to buy.

In addition, the tax code should equalize the treatment of contributions made to HSAs in the group and non-group markets. Currently, people purchasing a high-deductible health plan in the individual market may make contributions to an HSA that are deductible from their income taxes but not from their payroll taxes. A fair policy would allow full deductibility from both income and payroll taxes for such contributions wherever the individual buys health insurance.

Question 6:

What is the effect of the ESI exclusion on ESI premiums? Why? [CBO found the ESI exclusion increases average premiums for employment-based plans by 10% to 15%.]

What are the anticipated effects of capping the ESI exclusion?

Response: The tax exclusion subsidy encourages relatively healthy workers to buy coverage from their employer, which broadens the risk pool and tends to reduce cost per enrollee and premiums. However, the stronger effect is to encourage the purchase of more extensive coverage than workers or employers would have chosen without the subsidy. Since $1 worth of health insurance costs less than $0.70, at the margin workers will buy more health insurance. That is the basis for CBO's estimate that the exclusion increases average premiums for employment-based plans by 10 to 15 percent.

Capping the exclusion would reduce but not eliminate the subsidy workers receive when they purchase high-cost coverage. As a result, employment-based coverage would tend to become less extensive, average premiums would fall, and some workers would drop coverage (although many of those would purchase insurance on the individual market). The size of the effect depends on where the cap is placed.

Question 7:

What are the advantages of age-adjusted tax credits are preferred over means-tested tax credits?

Response: The ACA experience has demonstrated the difficulty of implementing income-related tax credits for health insurance. Purchasers on the exchanges are required to predict their family income more than a year in advance. An individual may be between jobs or underemployed and qualified for a subsidy when he applied for exchange coverage. But if he gets a better paying job and never notifies the exchange, he will have to repay the excessive amount of subsidies. Similarly, if income was overestimated, then the individual will be due a refund, which will be forthcoming after the tax return is filed the following year. This also means that many people who have never filed an income tax return have had to do so solely because of this subsidy system, and many are likely to have paid a tax preparer to help them through a confusing process.

In contrast, there is no uncertainty about the ages of family members. Older people would get larger subsidies reflecting their tendency to use more health services. Adjustments could also be made to account for regional cost variations, with more expensive areas receiving higher fixed payment amounts. There would be no need for a low-income person to file a tax return solely because of the credit.

The dollar amount of the exchange subsidy is difficult for purchasers to determine in advance since there is a sliding scale. In contrast, the amount of an age-adjusted credit would be presented in a simple table that does not require calculations.

Both income-related credits and age-adjusted credits would be adjusted if there is a change in family composition (such as a birth or a death). In both cases, individuals would have to report the change in a timely manner to the agency responsible for the credit. However, because the age-adjusted credit is more predictable, fewer people will have to do the paperwork necessary to correct errors in payment.

Question 8:

The federal government provides a tax break for mortgage interest paid—it doesn't directly pay a portion of people's mortgage bills. Likewise, why would we want to directly pay people's health insurance bills as if it were some kind of "single payer"? Why not give the option to receive a direct benefit as a tax refund, for instance?

Response: The ACA premium subsidies are advanceable. For most enrollees, the subsidies are paid directly to the insurer on a monthly basis rather than to the enrollee. The subsidies are also refundable, which means that an enrollee can choose to receive the payment as a refund on the following year's income tax filing instead of having them paid in advance. Because subsidy recipients are low income and would have cash flow problems paying the monthly insurance premium, the refund option is not commonly taken.

It is worth noting that many people receiving the premium subsidy would rather have less health insurance and more money to spend on food and clothing for their children. The ACA subsidy is not a general grant and cannot be used for any purpose other than coverage on the exchanges. The advance subsidy payments typically do not cover the full monthly premium. A significant number of people who qualify for the premium subsidies fail to make their share of the payment every month even when the insurer continues to pay medical bills on their behalf.

From Representative Charles Boustany of Louisiana:

Question 1:

Another major concern, and frankly point of confusion, is that employee contributions to their HSAs and FSAs associated with their employer-sponsored insurance coverage is included in the ACA's calculation of the "Cadillac Tax".

Mr. Antos, can you explain to me why savings for future healthcare cost needs of employees is included within a calculation that's purportedly used to indicate overly-generous health coverage?

If you can project out 1, 2, or even 5 years into full implementation of the Cadillac Tax, as currently written in the ACA… can you tell me what impact dis-incentivizing employee contributions to HSAs and FSAs will have on the larger healthcare market?

Response: Although the Cadillac tax is typically described as a tax on high-cost health insurance, it is based on the total cost of an employer's health benefits including HSAs, FSAs, wellness programs, and on-site medical clinics. Those costs include both the employer's contribution and the employee's contribution. Consequently, any amount contributed to an HSA or an FSA by a worker from his paycheck and by his employer is potentially subject to the tax.

If the purpose of the Cadillac tax is to discourage overly generous health coverage and give workers more "skin in the game," subjecting HSA contributions to the tax makes no sense. By definition, HSA contributions are used by the worker to pay for health expenses that are *not* paid by insurance. Every penny is the worker's own money, and the worker has clear incentives to spend that money in the best way possible. Money from such accounts does *not* promote wasteful use of health services.

By including account contributions in the calculation, the designers of the Cadillac tax have undercut a financing mechanism that promotes efficient health care and cost-awareness. A 2010 study by Anthony Lo Sasso and colleagues in *Health Services Research* finds that HSA enrollees spent roughly 5–7 percent less than non-HSA enrollees. By making account contributions less attractive, we can expect greater health spending than would otherwise be the case, but not necessarily greater value in terms of improving patient outcomes.

From Representative Mike Kelly of Pennsylvania:

Question 1:

As you know, millions of Americans decline to carry health insurance for religious or ethical reasons. Many Americans cover their medical expenses by becoming members of a health care sharing ministry (HCSM). This is not insurance but rather a form of mutual aid. Members help each other pay their medical bills in a personal, faith-filled way.

The tax code recognizes health-care sharing as a legitimate alternative to traditional insurance.

The issue is that uncertainties exist with respect to the appropriate tax treatment of these arrangements with regard to Health Savings Accounts (HSA) and deductibility.

In recognizing HCSMs in the Affordable Care Act, Congress did not update the HSA section of the code (Section 223) that effectively bars hundreds of thousands of American families from having an HSA. Because of its voluntary, non-contractual nature, membership in a HCSM probably does not qualify as health insurance for purposes of the medical expense deduction under tax code although it serves a similar function.

I believe Congress needs to clarify the tax code on these questions. As such, I've introduced legislation to correct this problem. H.R. 1752 would treat membership in a health care sharing ministry as coverage under a high deductible health plan. This bipartisan bill currently has 112 cosponsors.

Would you agree that federal tax policy should correct this oversight in current law that bars health care sharing ministry members from having access to a Health Savings Account, if they want one?

And do you agree that health care sharing should be treated like traditional health insurance for tax purposes and therefore should be deductible as a qualified medical expense on the same basis as health insurance premiums?

Response: Health care sharing ministries are a nonprofit alternative to traditional health insurance. Members of an HCSM collectively share the cost of care for the members. Because HCSMs are typically small organizations with members sharing common ethical beliefs, they are likely to discourage wasteful use of services—unlike large impersonal insurance plans, where there is no ethical compulsion to be as efficient as possible in using health services.

As a general principle, any alternative to health insurance that fulfills the same function should be accorded comparable status with respect to the tax code. Making the tax treatment of HCSMs comparable to that of health insurance would encourage this more efficient approach to health financing. However, such action could lead to greater federal and state regulation. For example,

because HCSMs are not considered insurance, they are not subject to the essential benefits rule. Efforts to treat HCSMs like traditional health insurance for tax purposes should also clarify regulatory and other issues that are involved.

Submissions for the Record

Statement of the
Alliance of Health Care Sharing Ministries
Hearing on Health Care Related Tax Reform
Committee on Ways and Means
U. S. House of Representatives
Washington, D.C.
April 14 2016

The Alliance of Health Care Sharing Ministries (the Alliance) is pleased to offer these comments on behalf of our members on the important topic of health-care-related tax reform.

About the Alliance

The Alliance of Health Care Sharing Ministries (the Alliance) is a tax exempt 501(c)(6) Christian advocacy ministry founded in 2007 by two of the largest health care sharing ministries: Christian Care Medi-Share and Samaritan Ministries International. The Alliance serves the common interests of faith-based ministries that facilitate the sharing of health care needs—financial, emotional, and spiritual—by individuals and families.

I. What Is Health Care Sharing?

A health care sharing ministry (HCSM) is a voluntary, cost-sharing arrangement among persons of similar and sincerely held religious or ethical beliefs, administered by a not-for-profit charity acting as a clearinghouse between those who have medical expenses and those who desire to share the burden of paying for those medical expenses.

- HCSMs serve more than 580,000 Americans, with participating households in all fifty states.
- HCSM participants share more than $500 million per year for one another's health care costs.
- HCSMs strive to be accessible to participants regardless of their income. Shared amounts are a fraction of the cost of insurance rates.
- HCSMs receive no funding or grants from government sources.

Health care sharing helps people with less do more.

II. Health Care Sharing Is Not Insurance

Health care sharing is not insurance but rather a form of benevolent mutual aid in which the

members help each other pay their medical bills in a personal, faith-filled way.

HCSMs are not insurance companies. They do not assume any risk or guarantee the payment of any medical bill, and thus fall outside the purpose and scope of insurance regulation. Twenty-nine states recognize this fact in their insurance code. A thirtieth state, Alaska, has passed similar legislation which the governor is now reviewing.

III. Health Care Sharing Is ACA-Compliant

The federal tax code recognizes health-care sharing as an alternative to traditional health insurance. Health care sharing satisfies the Affordable Care Act requirement that individuals purchase health insurance or pay a penalty-tax. To meet the federal definition, an HCSM must be a long-established, bona fide charity as defined at 26 USC 5000A(d)(2)(B).

The three largest HCSMs (Christian Health Care Mission [CHM], Christian Care Medi-Share [CCM], and Samaritan Ministries International) have received letters of certification as recognized HCSMs from the Centers for Medicare and Medicaid Services, an operating division of the U.S. Department of Health and Human Services.

The IRS has issued Form 8965 along with finalized instructions explaining how members of a recognized HCSM are to report that they qualify for the individual mandate exemption.

IV. Needed Clarifications of the Tax and Regulatory Treatment of Health Care Sharing

Because health care sharing is not health insurance, but does help protect people against excessive medical bills, federal tax and regulatory policies should treat health care sharing ministries as a new category that is neither “health insurance” nor a “health benefit plan” nor a “group health plan” as those terms are defined in federal law. Perhaps the best way to think of an HCSM would be as a “non-traditional medical-expense benefit.”

Apart from the exemption from the ACA mandate, federal law has not been updated to reflect the existence of health care sharing. HCSM members and their employers are not yet on a level playing field with traditional insurance in terms of tax treatment. Uncertainties exist that affect current and potential HCSM members. For example, it is unclear whether shared amounts qualify as a deductible medical expense and whether member-to-member assistance, when facilitated by an employer, is excludable from income in the same manner as traditional employer-provided health benefits. We urge Congress to clarify these questions.

Following are several specific issues that the Alliance hopes Congress will clarify in its next tax-reform package.

Issue 1: HSAs for Health Care Sharing Families (Section 223)

Health Savings Accounts (HSAs) offer a vital option for millions of American families. HSAs are not, as some have suggested, a tax haven for the rich. Rather, they can be an additional option for middle and lower class families and the working poor who need help obtaining affordable medical care. HSAs help families save money and promote patient access to preventive and wellness services. They are especially favored by families with members who, due to chronic conditions, must make regular expenditures for medical supplies or treatments. The ability to roll-over and not lose unused savings is an additional benefit that stands only to help those with limited means. HSAs are also a great alternative for small businesses, many of whom cannot afford to provide full health insurance benefits but can afford to put a fixed amount of money (say, $2,500 a year) in an employee's HSA.

Although more than 17 million Americans are currently enrolled in an HSA, health care sharing families are barred from doing so. To qualify for an HSA, a taxpayer must have a high-deductible health plan (HDHP), which by definition is a form of insurance. Health care sharing, as we've seen, is not insurance, and many HCSM members do not want to participate in insurance for religious or ethical reasons. In recognizing the validity of HCSMs in 2010, Congress did not update the HSA section of the tax code (Section 223), an oversight that effectively bars hundreds of thousands of American families from having an HSA.

To correct this oversight, Rep. Mike Kelly of Pennsylvania has introduced H.R.1752, which would make HSAs available to health care sharing families by defining health care sharing assistance to be an HDHP for purposes of Code Section 223. HSAs and HCSMs are naturally complementary, since both promote consumer awareness and involvement in their own health care decisions. They're a "match made in heaven."

The Alliance urges the Committee to pass H.R.1752 and include it in its next tax-reform package.

Issue 2: Deductibility of Health Care Sharing Assistance (Section 213)

The Alliance recommends that the Committee clarify 26 U.S. Code Section 213(d) to recognize health care sharing assistance as a deductible medical expense.

Because of its voluntary, non-contractual nature, it is unclear whether membership in an HCSM qualifies as health insurance for purposes of the medical expense deduction under Code Section 213 ("Medical, dental, etc., expenses"), although it serves a similar function. As a result of this uncertainty, amounts shared via an HCSM may not be able to be deducted as a qualified medical

expense, even though they are medical expenses. The IRS has not spoken to this issue.

The Alliance urges the Committee to remove this uncertainty by clarifying Section 213(d) to recognize health care sharing assistance as a deductible medical expense.

Issue 3: Tax Treatment of Employer Help for Health Care Sharing Assistance (Sections 104-106)

Neither Congress nor the Treasury Department has spoken to the question of how health care sharing should be treated for tax purposes relative to employer-provided health plans. As a result, more than 350,000 HCSM members are uncertain as to their reporting and tax liability with respect to the assistance they may receive for medical expenses from an employer.

The Alliance recommends that the Committee clarify the Code (as, for example, at Section 106) to ensure that employers are able to provide medical-expense related assistance to their employees who are HCSM members on a level playing field with their other employees who are not HCSM members. For example, Section 106 could be clarified to recognize such assistance as a tax-free fringe benefit.

Issue 4: HCSMS and ACA Employer Mandate Penalty (Fines) (Sections 4980D, 5000(b)(1))

The IRS has announced that certain employers who provide a "group health plan" that does not meet all the coverage requirements of the ACA (IRS Notice 2013-54) are liable to an excise tax penalty of $100 per day, per employee. It is unclear whether the IRS will penalize an employer who pays or reimburses an employee's health care sharing amount. In Notice 2015-17, the agency clarified that an "employer payment plan," by which an employer pays or reimburses the health insurance premiums of an employee's individual health insurance policy, is not a compliant "group health plan" for purposes of this provision and is therefore subject to the penalty tax. Although membership in an HCSM is neither insurance nor a group health plan nor an individual health insurance policy, and indeed HCSM membership is ACA compliant, there is a danger that the IRS could sweep health care sharing into the definition of group health plan or an individual health insurance policy for purposes of imposing this penalty. The agency could rely on Section 5000(b)(1), which defines "group health plan" very broadly to include "a plan … contributed to by an employer … to provide health care (directly or otherwise) to [employees]." Such an interpretation would be wrong, since Congress specifically declared HCSMs to be compliant under the ACA.

The Alliance urges the Committee to clarify Section 5000(b)(1) to protect employers from the $100 per day, per employee, excise tax who pay or reimburse an employee's health care sharing amounts. Additionally, it may be prudent for Congress to amend the definition of "group health plan" in the Public Health Service Act (42 USC 300gg-91) to clarify that an HCSM is not a

group health plan.

Issue 5: HCSMs and ACA Employer Mandate Penalty (Formula) (Section 4980H)

The Alliance urges Congress to correct a serious problem in the ACA employer mandate penalty formula that affects companies that employ members of HCSMs. Although by law HCSM members are exempt from the ACA's individual mandate, the employer mandate still applies to employers (including HCSMs in their capacity as employers) whose employees are HCSM members. This creates a serious problem.

Under Code Section 4980H ("Shared responsibility for employers regarding health coverage"), large employers, which are defined as those with 50 or more employees, can be faced with substantial employer-mandate penalties if some or all of their employees rely on an HCSM in lieu of traditional insurance. Those employees are counted toward the 50-employee threshold, even though they have chosen not to receive employer-provided health benefits., and are meeting their ACA individual responsibility by being HCSM members. The employer is liable for penalties through no fault of his own.

The Alliance urges Congress to remedy this inconsistency. The simplest way to do so would be to exempt employees who are members of HCSMs and their participating employers from the employer mandate penalty formula at Section 4980H(c)(2)(B) ("Exemption for certain large employers").

Conclusion

Health care sharing is not health insurance or a health plan. Rather, it is a federally recognized alternative to traditional insurance that has been chosen by hundreds of thousands of Americans to help meet their health care and spiritual needs.

While health care sharing serves some of the functions of traditional health insurance, and should receive similar tax treatment, it is not a "health plan" as traditionally understood and cannot be regulated like an insurance company without destroying its charitable and spiritual character.

To sum up, the Alliance urges the Committee to clarify certain tax issues, ideally in its next tax-reform package:

1. Make HSAs available to HCSM members. (Sec. 223.) (Enact H.R.1752, Rep. Kelly.)
2. Recognize health care sharing amounts as a deductible medical expense. (Sec. 213.)
3. Place health care sharing on a level tax playing field with excludable, employer-provided health benefits. (Secs. 104-106).

4. Clarify that it is not a "group health plan" under federal law.
5. End the inconsistent inclusion of HCSM members in the ACA employer mandate penalty. (Sec. 4980H.)

These changes are needed. Our hundreds of thousands of members look to this important Committee for relief. We are grateful for your help and leadership.

Thank you again for this opportunity to comment on the important topic.

* * *

About the Alliance

The Alliance of Health Care Sharing Ministries (the Alliance) is a tax exempt 501 (c) (6) Christian advocacy ministry founded in 2007 by two of the largest health care sharing ministries: Christian Care Medi-Share and Samaritan Ministries International. The Alliance serves the common interests of faith-based ministries that facilitate the sharing of health care needs—financial, emotional, and spiritual—by individuals and families.

The Alliance is committed to advocacy in the public policy arena on issues of importance to health care sharing ministries. Our mission is to: a) inform legislators of the important work and benefit of health care sharing ministries; b) protect the liberty of our member ministries to practice their religious convictions in health care; c) seek exemptions from mandates requiring our members to purchase health insurance; d) seek exemptions from mandates requiring employers to provide health insurance; e) seek parity with other health care solutions with respect to federal and state tax codes; and f) encourage our member ministries to continue serving their members with this crucial, private sector, charitable solution to challenges in the health care arena.

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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

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[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.

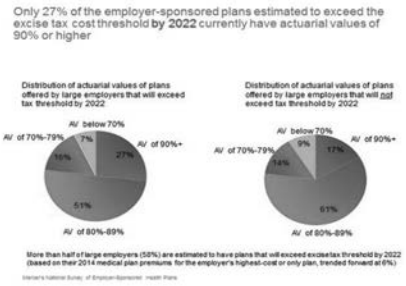
[4] American Health Policy Institute: http://www.americanhealthpolicy.org/Content/documents/resources/AHPI_STUDY_Cost_Per_Covered_Life.pdf

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. Increased cost-sharing will force workers to pay

[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://aon.mediaroom.com/2014-10-16-New-Aon-Hewitt-SurveyShows-Majority-of-Companies-Taking-Immediate-Steps-to-Minimize-Exposure-to-Excise-Tax.

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].

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 calculating the tax. The administration has also requested a study of the impact of the 40% tax on sick

[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

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 that result in triggering the "Cadillac Tax," if the Committee explores options that rely on premium

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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/.

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

CAMPAIGN TO END OBESITY
ACTION FUND

April 28, 2016

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth HOB
Washington, DC 20515

The Honorable Sander Levin
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth HOB
Washington, DC 20515

Dear Chairman Brady and Ranking Member Levin:

The Campaign to End Obesity Action Fund is the nation's leading obesity advocacy organization and convenes leaders from academia, public health, industry, and patient and disease communities to push for needed policy changes to reduce obesity rates in America.

We applaud the Committee on Ways and Means for hosting its recent hearing examining the tax treatment of health care. We encourage the Committee, as part of its deliberations, to consider specific tax policy changes to help combat obesity – the largest driver of rising health care costs in the United States - and, in doing so, save taxpayers billions of dollars.

Nearly 100 million Americans currently suffer from obesity, which costs taxpayers over $200 billion in unnecessary health care costs every year. Left unchecked, some estimates show that obesity rates could climb as high as 50 percent by 2030 and cost taxpayers, employers, communities, and families even more. This is a problem that we can no longer afford to ignore – particularly in economically-disadvantaged communities - and we believe that the Tax Code can and should play an important role in addressing elements of the challenge.

With this in mind, in 2014, 23 leading organizations – from the American Heart Association to Humana to the United States Soccer Foundation – signed onto the attached letter encouraging the Committee to use the Tax Code to "advance cost-effective policies that can bolster healthy lifestyles in key populations and hold promise for halting or reversing the nation's costly and unsustainable obesity epidemic."

It is our hope to work with the Committee on policy changes that will spur private interests to boost access for Americans of lesser means to nutritious food and safe, health-promoting physical activity spaces. These policies can target communities

most at risk for obesity and other chronic diseases in both rural and urban locations that are "food deserts" as well as communities with higher than average rates of physical inactivity. Some examples of such policies could include making the New Market Tax Credit permanent, enacting new incentives for private infrastructure investments or charitable donations of resources to bolster access to nutritious food outlets and safe, health promoting physical activity spaces, as well as creating incentives for employers to provide food and nutrition education to customers.

We appreciate your attention to this important matter and look forward to working with the Committee to advance tax policy proposals that can help ensure at-risk communities have access to the resources they need to enable all citizens to lead healthy lifestyles, reduce obesity and other chronic diseases, and in doing so, create tremendous long-term budgetary savings for all taxpayers.

Sincerely,

Chris Fox
Senior Director, External Affairs
Campaign to End Obesity Action Fund

CAMPAIGN TO END OBESITY
ACTION FUND

January 23, 2014

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Orrin Hatch
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Dave Camp
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Sander Levin
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Chairmen and Ranking Members:

We are writing to encourage you to use the opportunity presented by ongoing efforts to improve the Tax Code to advance cost-effective policies that can bolster healthy lifestyles in key populations, and hold promise for halting or reversing the nation's costly and unsustainable obesity epidemic.

As you know, the nation's obesity epidemic has the potential to bankrupt the healthcare system. Today, there are nearly 100 million Americans – children and adults – with obesity. American taxpayers spend nearly $200 billion on medical costs associated with obesity each year. Current projections show that, absent major changes, 50 percent of the American population will have obesity by 2030, driving health care costs even further.

There is an important role for the Tax Code in addressing elements of this challenge. Indeed, the Tax Code has long been used to reward priority corporate and individuals' actions which are valued by society and which are likely to yield benefits to the taxpayer base as a whole.

Against this backdrop, we ask you to champion new tax policies that can drive private sector efforts to bolster access among high-risk populations to improved food options and opportunities for safe physical activity. We believe that tax policy should include measures specifically designed to promote the type of infrastructure investments that will help make healthy lifestyles more accessible in communities where they currently are not.

Specifically, we believe that tax policy should embrace new approaches that will:

- Spur private interests to increase access to healthy, affordable foods in economically disadvantaged communities;
- Yield increased access by these communities to safe recreational spaces;
- Support economically disadvantaged individuals specifically for their efforts to adopt health lifestyle choices that are likely to reverse or prevent obesity and other chronic diseases, as well as businesses who invest in tools and resources for these consumers to effect such choices; and
- Be targeted to benefit those individuals and communities most at risk for obesity and other chronic diseases.

We look forward to working with you to advance more specific measures which can fulfill these principles and, in doing so, yield crucial and urgent health and economic benefits for our nation.

Sincerely,
Campaign to End Obesity Action Fund
American College of Preventive Medicine
American College of Sports Medicine
American Council on Exercise
American Heart Association
American Hiking Society
Arena Pharmaceuticals
Change Lab Solutions
Health Education Council, Break Free Alliance
Hepatitis Foundation International
Humana
International Health, Racquet and Sportsclub Association
MEND Foundation
MomsRising.org
NAACP
National Association of Chronic Disease Directors
National Association of County and City Health Officials
National Center for Weight and Wellness
National Coalition for Promoting Physical Activity
National Hispanic Medical Association
Orexigen Therapeutics, Inc.
United States Soccer Foundation
Weight Watchers International

National Association of Specialty Health Organizations
An AAPPO Partner Association
NASHO
www.nasho.org

April 28, 2016

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady,

The National Association of Specialty Health Organizations (NASHO) is writing to voice our support for the current exclusion of the employer-sponsored insurance (ESI) from federal income and payroll taxes. At the April 14 Ways and Means Committee hearing on the tax treatment of health care, the Committee discussed changes to the exclusion, including limiting the amount an employee could contribute to their own health care premiums tax-free. While some argue the exclusion increases the cost of health care, we believe that the exclusion makes specialty health services more affordable and accessible, ultimately improving the health and wellness of employees.

NASHO is a membership organization representing health plans and provider networks that facilitate and support the delivery of specialized health care services. NASHO member organizations provide services to over 250 million Americans. Specialty care includes services such as: behavioral health, chiropractic, complementary care, dental, hearing, pharmacy benefit management, physical therapy, radiology management, vision, ancillary specialty care, and other services that compliments core health care benefits .

The tax exclusion is the foundation for our present employer-sponsored-insurance system. Most people under 65 get their insurance through their employer. Considering the average annual premium costs in 2015 are $6,251 for individual coverage and $17,545 for family coverage, this exclusion provides a significant benefit for many employees.[1]

NASHO is concerned about the unintended consequences of changing the tax treatment of ESI. ESI provides a way to create large pools of individuals in which to spread risk. Without the tax exclusions, employers may decide to stop offering coverage for their employees.

Under proposals that would cap the exclusion, employers would provide less generous coverage to their employees. Employees could face a loss of benefits and increased cost sharing as employers seek to lower their premium costs to come in under the cap. This could result in a loss of specialty health services that:

- deliver preventive services to help keep people well,

[1] Employer Health Benefits 2015 Annual Survey, the Kaiser Family Foundation and the Health Research & Educational Trust.

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- detect and treat problems early to prevent health care complications and/or comorbidities,
- reduce tertiary care costs,
- support people in behavior change and wellness behaviors,
- control costs by improving the efficiency of services and investing in prevention,
- improve the safety of medications and services, and
- improve overall health outcomes.

Caps based on employer premiums could create inequities for workers that are older, that work in high-cost areas, or that work for small businesses. These employees could face disproportionately higher taxes. Additionally, removing the tax exclusion for ESI would increase the cost of the provision of health insurance and as these costs rise, beneficiaries will look for ways to reduce their spending—potentially eliminating efficient and effective specialty health benefits.

We urge the Committee to consider the impact employees could face when changes to the tax treatment of the ESI are contemplated. **NASHO opposes any policy changes that will limit access to specialty care and urges Congress to preserve the long-standing tax exclusion of employer-sponsored insurance**.

For additional information or questions, please contact NASHO Executive Director Julian Roberts at 404-634-8911.

Sincerely,

Julian Roberts
Executive Director
NASHO

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AARP
Real Possibilities

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April 13, 2016

The Honorable Kevin Brady
Chairman
Committee on Ways & Means
301 Cannon House Office Building
Washington, DC 20515

The Honorable Sandy Levin
Ranking Member
Committee on Ways & Means
1236 Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady and Ranking Member Levin:

Thank you for holding this important hearing about the way in which the federal government utilizes the tax code to improve and provide health care access to many Americans. We appreciate the opportunity to offer written testimony on one aspect of how the tax code impacts health care affordability -- the medical expense deduction. In particular, a recent change for taxpayers under age 65 – and one that is scheduled to impact taxpayers age 65 and over in 2017 – has reduced affordability for those with high health care costs.

In 2013, the income threshold to be able to claim this deduction increased to 10 percent (from 7.5 percent) of income for those up to age 64. The threshold – which has remained at 7.5 percent of income for those 65 and older – is set to increase to 10 percent on January 1, 2017, representing a tax increase on millions of seniors.

AARP, with its nearly 38 million members in all 50 States and the District of Columbia, Puerto Rico, and U.S. Virgin Islands, is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

Since the 1940s, Americans with high health care costs have been able to deduct medical expenses from their taxes. For the approximately eight to ten million Americans who annually take this deduction, it provides important tax relief which helps offset the costs of chronic medical conditions as well as long term care. Medical expenses can include amounts paid for prevention, diagnosis, treatment, equipment, qualified long-

term care services, and limited amounts paid for any qualified long-term care insurance contract.

Last September, Rep. Martha McSally (R-AZ), Rep. Krysten Sinema (D-AZ) and others introduced the bipartisan *Halt Tax Increases on the Middle Class and Seniors Act*, H.R. 3590. This legislation, endorsed by AARP in January, would return the income threshold to deduct medical expenses back to the pre-2013 threshold of 7.5 percent of income. Importantly, it would prevent the looming tax increase scheduled for next year on those who are both ages 65 and older and have high health costs.

AARP believes this deduction – with a threshold based on a percentage of income – is truly middle class tax relief. According to 2013 estimated IRS tax data:

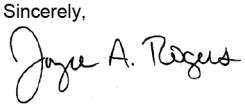
- 73 percent of those claiming the deduction reported income of $75,000 or less;
- 52 percent of those claiming it reported income of $50,000 or less;
- At least 25 percent of all returns claiming the deduction had at least one member of the household who was age 50-64; and
- 56 percent of all returns claiming the deduction had at least one member of the household age 65 or older.

In December 2015, Congress voted – and the President signed into law – delays of the medical device tax, the excise tax on high-cost employer sponsored health plans (known as the "Cadillac Tax") and a tax on health insurance. While these tax delays only indirectly affect consumers, the medical expense deduction is a direct tax benefit that helps millions of moderate income Americans each year.

On behalf of our 38 million members and all older taxpayers, we urge that the scheduled increase in the medical expense deduction be reversed, maintaining the current 7.5 percent of income threshold for those age 65 and older and restoring the previous lower threshold for all Americans.

Thank you for the opportunity to submit written testimony on this important tax issue to improve health care affordability. If you have further questions, please feel free to contact me or have your staff contact Andrew Schwab on our Government Affairs team at aschwab@aarp.org or 202-434-3770.

Sincerely,



Joyce A. Rogers
Senior Vice President
Government Affairs

ERIC The ERISA Industry Committee

The Only National Association Advocating Solely for the Employee Benefit and Compensation Interests of America's Largest Employers

1400 L Street, NW, Suite 350, Washington, DC 20005 • (202) 789-1400 • www.eric.org

Statement by The ERISA Industry Committee re: House Committee on Ways and Means' April 14, 2016 Hearing on the Tax Treatment of Health Care

Chairman Brady, Ranking Member Levin, and members of the Committee, thank you for this opportunity to submit a statement for the record on behalf of The ERISA Industry Committee (ERIC), regarding the hearing on the tax treatment of health care. ERIC is the only national trade association advocating solely for the employee benefit and compensation interests of the country's largest employers. ERIC supports the ability of its large employer members to tailor retirement, health, and compensation benefits for millions of workers, retirees, and their families. ERIC's members provide comprehensive health and retirement benefits to millions of active and retired workers and their families. Preserving and enhancing the employer-sponsored health and retirement systems and the tax incentives that support them are key policy goals of ERIC and its members.

About 175 million Americans currently enjoy health benefits provided by their employer under the uniform, national framework established by the Employee Retirement Income Security Act (ERISA). Most of these Americans receive a generous subsidy from their employers towards their health insurance premiums, and the portion of the premium paid by employees is paid with pre-tax dollars. However, the tax treatment of premiums is only one of the numerous benefits that employees in employer-sponsored plans enjoy.

Trusted, Expert Intermediaries

Plan sponsors serve as a trusted intermediary on behalf of employees. They compare offerings from insurers or third party administrators (TPAs), and select the vendors that best meet the needs of their employees. Employers negotiate on behalf of employees, working to ensure good provider networks, affordable premiums, fair drug formularies, and reasonable cost-sharing. Major employers have staff expertise or engage with external vendors that allow them to ensure high-quality coverage for the lowest price possible. Because employers negotiate on behalf of hundreds or thousands of workers and their families, they are able to maximize the benefits for their employees. In some cases, when an employee's claim is denied, an employer may advocate on behalf of the patient to get them the care they need.

Changes to the tax code that would reduce or eliminate the ability or willingness of employers to sponsor plans would cause these advantages to disappear. Although individuals may be pooled by insurers, they would have no ability to negotiate with insurers. Assertions that managed competition would solve this problem have not been borne out in reality. Individuals lack the expertise of employers in comparing numerous health plans, benefits covered, formularies and prescription tiers, and provider networks. Giving individuals a tax credit instead of preserving the employer-sponsored system would in no way make up for the loss of this trusted, expert intermediary, and would leave most Americans worse off, require them to invest more time and effort in enrolling in health insurance, and would deny them the benefit of strength in numbers. And if someone on the individual market has a claim denied, their only recourse is a government-mandated appeals process.

It is true that there is a subset of people who do not have an offer of affordable health insurance from an employer, are not eligible for subsidized insurance through an exchange, and are not covered by safety net or entitlement programs. Those individuals do face a real disadvantage in not being able to purchase insurance with pre-tax dollars, and Congress should pursue tax equity for them. But Congress should not attempt to offset the cost of this tax change by implementing a tax on the benefits currently enjoyed by 175 million Americans. Congress should also be aware that providing individuals with a tax credit will not replace the value that employers bring to the system.

Pursuing Quality, Value, and Affordability

Employers are at the cutting edge of developing and implementing efforts that increase health care quality, maximize the value of health care and benefits, and improve affordability for employees and their families. Employers pioneered directing employees to centers of excellence and the highest quality providers in order to ensure high quality care. Employers were on the front lines of funding patient-centered medical homes for employees, ensuring they received coordinated care. Employers created incentives for providers to avoid "never events" and to increase medication adherence. Employers have championed consumer-driven health care, and to support that effort, have been consummate advocates for health care cost and quality transparency and health savings accounts and health reimbursement arrangements. Employers took the lead in transitioning to health information technology and e-prescribing. And employers fund fraud prevention efforts to keep premiums affordable for employees.

Employers have engaged in these activities because they have both health expertise and a common interest with employees to ensure employees and their families receive high-quality, affordable care. If employers are removed from this equation, individuals will lose a tireless force advocating for investments of time and money to implement efforts such as these. Providing individuals with a tax credit and transitioning away from the employer-sponsored system will not give them the purchasing power or expertise necessary to demand insurers engage in appropriate efforts to promote more quality improvement and to maximize affordability. Instead, it will deprive Americans of an innovative force that has worked on behalf of employees to maximize quality, value, and affordability for decades.

Care, Not Just Insurance

Many employers go beyond simply financing health insurance, and actually help meet the medical care needs of their employees. Some employers have developed onsite clinics where employees can receive care, and onsite fitness facilities to help employees stay healthy. Others have funded and participated in health information exchanges for their plan employees or telemedicine services to make it easier for employees to access needed care. Others have implemented company-wide electronic health records for employees. Employers help connect employees with vaccines, creating convenience for employees and reducing the rate of transmission of many significant diseases. Employers engage in pandemic preparedness efforts in case their regions experience a medical emergency. And many employers offer comprehensive wellness programs, designed to improve the health of plan employees, in turn helping to control premium costs.

Employers engage in these activities to control costs, to maximize worker productivity, and to benefit employees and their families. They do it because they can and they know it helps. Disrupting the employer-sponsored system will remove the funding and innovation behind these activities, and providing individuals with a tax credit will not fill this gap.

Cadillac Tax by Any Other Name

The Affordable Care Act (ACA) is partially financed through the Cadillac tax (the 40% excise tax on high cost employer-sponsored coverage). The Congressional Budget Office's estimate of the revenue this tax would generate (presumably to offset the costs of other parts of the ACA) is based on the erroneous and baseless assumption that employers will increase employee compensation to offset the cost of paying for health care. There is no evidence that employers will increase pay in lieu of paying health care costs – it is a purely theoretical argument.

The Cadillac tax has virtually the same effect as capping the employee exclusion for employer-provided health care, but it was cleverly tailored to appear not to undermine employer-sponsored plans. However it is characterized, though, capping the exclusion for employer-sponsored health insurance would have the same negative impact on employers and employees as the Cadillac tax and create the same administrative burdens applying to the tax. Both are counterproductive policies that undermine the one part of the health care system that has worked.

Employers are deeply concerned about the Cadillac tax because of its virtually unimaginable complexity as well as the fact that it does not tax "generous" plans; rather, it penalizes plans that are expensive because they cover individuals in high-cost areas, have high percentages of older, sicker people, and/or have a large gender imbalance, among other factors. In addition, although the threshold for the Cadillac tax is indexed, it is indexed at a lower rate than the rate at which medical costs actually increase. Thus, in practice, although a significant number of plans will be subject to the tax when it begins, over subsequent years it will touch all employer-sponsored insurance. This is likely to have the same impact as capping the exclusion for employer-sponsored care; it will lead to a massive disruption in this type of health insurance, causing many workers and their families to lose the many significant benefits of employer-sponsored health plans.

In other words, support for capping the exclusion is the equivalent of supporting the Cadillac tax, and both have the potential to significantly disrupt or end the employer-sponsored health system. Without employer-sponsored insurance, 175 million people would be likely to seek health insurance through exchanges, which are ill-prepared to deal with such a large influx of new customers, in addition to other problems that members of this Committee have frequently pointed out about ACA exchanges.

Go With What Works

While there is concern that individuals who obtain health coverage directly rather than through an employer do not receive the tax benefit afforded those in employer coverage, it is inappropriate to implement policies that risk dismantling the employer system in order to "raise" revenue to spend on pursuing equitable treatment for those without employer coverage.

Separately, for decades, academic economists have advocated for an end to the employer-sponsored system, which has and continues to work well for 175 million Americans. Their reasoning relies on purely theoretical assumptions, and the solutions they develop in order to help a relatively small number of people would have outsized negative consequences on a majority of Americans. Perhaps because they know how unpopular it would be to simply abolish the tax-favored status of health insurance benefits, some advocate for policies that would have the same effect, albeit in a less visible fashion. They assume that consumer pressure and competition would lead to all the same innovations and improvements that

employer involvement as plan sponsors has achieved, but conveniently overlook the fact that employers and individuals do not have the same leverage. They assert that the current system is unfair and creates "job lock," even though those who do not have an offer of affordable employer coverage may be offered generous premium support, and virtually every major employer does offer health insurance benefits. They claim that the employer-sponsored system is regressive, even though it is the only non-government system that offers individuals uniform benefits, and pays most of their premiums, no matter where they work, where they live, or where they receive medical care.

Instead of exploring ways to undermine the employer-sponsored system, we urge Congress to consider ways to improve health care for all Americans, such as advancing consumer-driven options like Health Savings Accounts, improving quality and transparency for patients, and ensuring innovation for more therapies to treat and cure Americans.

Above all, instead of threatening the employer-sponsored system, we urge Congress to strengthen it by reducing onerous rules and regulations that inhibit the ability of employers to offer high-quality health care to their employees and their families. Congress should consider eliminating administratively wasteful and unnecessary reporting requirements on employers, assuring employers that their ability to offer onsite medical care, meaningful wellness programs and health savings accounts will not be threatened, and ensure that employers are incentivized to offer generous benefits and full-time positions to Americans by defining the work week as 40 hours. And most of all, instead of doubling-down on the dangerous Cadillac tax, Congress should repeal it.

Conclusion

Thank you for this opportunity to submit testimony on this important issue. ERIC stands ready to work with Congress to enact legislative changes that will strengthen the employer-sponsored system, improving health coverage, cost and quality for the 175 million Americans who currently receive health insurance through employers. If ERIC can be of further assistance, please do not hesitate to contact James Gelfand, Senior Vice President for Health Policy, at jgelfand@eric.org or (202) 789-1400.

Statement by the National Association of Worksite Health Centers re:
House Committee on Ways and Means on
the Tax Treatment of Health Care

On behalf of the National Association of Worksite Health Center (NAWHC), I'm pleased to submit to you our organization's views and recommendations related to how employer onsite and near-site health and wellness centers ("clinics") should be treated under the Affordable Care Act's provisions related to applying an excise tax on employer health benefits over specific threshold amounts.

The Chicago-based, NAWHC (www.worksitehealth.org) is the nation's only non-profit association supporting employer-sponsors of onsite, near-site, mobile health, pharmacy, fitness and wellness centers. It assists employers in exploring this benefit strategy and in developing and expanding the capabilities of onsite centers to integrate all worksite primary, acute, behavioral health, occupational health and chronic care services and wellness programs.

We conduct educational programs, networking and benchmarking activities, while serving as an advocate for the employer-sponsors of worksite health centers. NAWHC also provides online resource materials on worksite health and fitness centers, on-site pharmacies and wellness centers at www.worksitehealth.org.

Overview of Worksite Health Activities

It's important for the Committee to understand that even before the ACA was passed, employers of all sizes offered a broad array of services to workers:

- Treatment of injuries
- Occupational health
- Identification of risks
- Prevention of illness
- Health education
- Chronic disease management
- Wellness programs
- Primary care
- Health coaching
- Ancillary services, such as pharmacy, lab, therapy, dental and other services

Since the 1930's, employers, especially manufactures, began providing first aid or occupational health clinics to address worksite injuries and accidents. These have now evolved to address the high cost, fragmentation and limited resources of various communities health care systems, as well as the needs of covered populations.

The Value and Prevalence of Employer Health Clinics

Employers have found that an onsite center offers a vehicle to integrate, enhance and increase the coordination of care and the engagement of workers in employer-sponsored health-related services and programs.

Today, around 30% of public and private employers offer some form of onsite, near-site or mobile health services to employees, dependents, retirees and others. While many vendors recommend at least 1000-1500 employees in a single location to support center, many employer-sponsors of centers have smaller populations. Centers range from one day a week operations, led by Nurse Practitioner or Physician Assistant, to 5-7 day a week centers, open evenings and weekends, primarily staffed by physicians.

Worksite health centers are not limited to large employers or manufacturers or those in rural locations. We find employers as small as 100 workers, in all industries and communities ,have found value in offering onsite care.

Employers find onsite or near-site clinics help them and their workforces deal with a variety of key problems and challenges, including access to care, having to leave work for extended time to get care or services, lower productivity, high out of pocket costs for community providers, high use of emergency rooms for non-emergency conditions and lack of time to address health problems.

While many employers who have clinics locate them onsite, an increasing number use near-site clinics, mobile vans, telemedicine or even physician visits to the worksite to provide easily accessible services. Over 60% offer services at no or minimal cost to employees.

Regardless of the model used, employers find these clinics meet their financial, health and wellness objectives, lowering the need for outside high cost services, increasing the health of the workforce, enhancing productivity levels, reducing absenteeism, all while providing a benefit that is highly regarded by employees.

Onsite Clinics and the Excise Tax

As we look at the ACA and its relationship and impact of employers, it seems clear to us that that the law seeks to achieve the Triple Aim of reducing costs, improving patient experiences and improving the health of populations. Employer onsite clinics were developed and are successful in achieving these same objectives.

The excise tax was intended to reduce costs in the health care system by having employers reduce or eliminate high cost- Cadillac- benefits. Clinics accomplish this reduction of costs by offering workers improved access to convenient no or low cost services, reducing the need for expensive emergency room care for non-emergency conditions.

We believe that employers who sponsor clinics should be incentivized to expand and offer more clinics, not penalized which will discourage their growth and use.

COBRA and legislators at its passage never contemplated the evolution of onsite clinics from basic first aid to what they are today. Subsequently, the old language defining "clinics" should not be barrier to how onsite clinics have evolved or taxed.

If clinics are subject to the excise tax, this may significantly undermine the progress employers have made in reducing costs and improving the health of their workforces. It will discourage expansion of these accessible, affordable and integrated medical settings.

Recommendations for Clinic Services to be Excluded from the Excise Tax

There are a number of services offered thru clinics that are either government mandated or represent a very small percent of the total cost of care that should be excluded from the excise tax calculation. These include the following:

1. Any service required by federal, state or local laws or intended to protect the safety and health of workers, i.e. OSHA, workers comp and occupational health services

2. Low cost, insignificant services: allergy shots, minor injuries, accidents, immunizations, tobacco cessation, weight loss, prenatal services, condition monitoring-wellness programs – such as those provided in retail clinics

3. Primary care services, which represent a small amount -less than 5% - of an employer's total health care costs. The ACA doesn't tax local providers for these services, so neither should employer clinics be taxed

4. Clinic services offered at fair market value, which should not be strictly defined, as each community has its own levels of cost for care

5. Clinic utilities and other expenses provided in an employer's normal course of business when the medical facility is housed in an employer's building and such services and costs cannot be separately identified as specific to the clinic.

6. Onsite services provided as a stand-alone plan, subject to COBRA

nawhc
NATIONAL ASSOCIATION OF WORKSITE HEALTH CENTERS

7. Onsite service by an outside health care provider, where the employer only offers space

8. Behavioral health, EAP services provided as part of an employer's drug/alcohol programs

We would also propose two alternative approaches to excluding clinics and their services:

- Exempt the cost of services up to a certain amount, such as annual covered life $750 a year or 10% of the existing excise tax; or
- Exempt clinic services that paid for thru an employer's health plan, which is already to be taxed, as this would result in double taxation, but still exclude the items in 1-8 above for the tax calculation of an employer's plan.

I would be pleased to provide additional information or insight into any of the above background or recommendations, either via email, on the phone or in person.

Thank you for your consideration of our perspective and recommendations.

Sincerely.

Larry S. Boress
Executive Director

April 12, 2016

The Honorable Kevin Brady
Chairman
Committee on Ways & Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Sander Levin
Ranking Member
Committee on Ways & Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Pat Tiberi
Chairman, Subcommittee on Health
Committee on Ways & Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Jim McDermott
Ranking Member, Subcommittee on Health
Committee on Ways & Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Charles Boustany, M.D.
Chairman, Subcommittee on Tax Policy
Committee on Ways & Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Richard Neal
Ranking Member, Subcommittee on Tax Policy
Committee on Ways & Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Committee Chairmen and Ranking Members:

The undersigned organizations encourage your prompt consideration of the Small Business Healthcare Relief Act (H.R. 2911) as leaders on the Committee on Ways and Means. This important legislation would protect small businesses from punitive fines for helping employees with health care costs and restore the ability to provide a flexible and valued benefit.

Soaring health insurance premiums have thwarted the ability of many small business owners to provide, and their employees to obtain, health coverage. From 2010 to 2015, premiums for small firms increased 25 percent, from an average monthly family premium of $1,104 to $1,385.[1] Similar, if not greater, premium increases are expected to continue in the years ahead.

To provide much-needed relief, we support allowing employers to provide employees with a defined financial contribution toward the cost of health care coverage. Under this approach, employers could provide employees with a set dollar amount to use on a tax-preferred basis when purchasing health care coverage.

Historically, many small business owners directly paid for or reimbursed employees for medical care and services through an employer payment plan, such as a Health Reimbursement Arrangement (HRA). However, the Affordable Care Act (ACA) requires that all group health plans meet certain benefit requirements, such as first dollar coverage of preventive services and no annual dollar limits on essential health benefits. Because HRAs are reimbursement

[1] "2015 Employer Health Benefits Survey." Kaiser Family Foundation, Sep 2015. http://kff.org/health-costs/report/2015-employer-health-benefits-survey/

arrangements, they violate these rules according to the Internal Revenue Service (IRS) and are therefore unlawful on a stand-alone basis.

As a result, since July 1, 2015, small businesses who do not offer a group health plan with the HRA face $100 per day, per employee fines. That totals $36,500 annually per employee up to $500,000 in total, or 18 times more than the $2,000 employer mandate penalty for larger employers who do not provide any coverage. Affected small businesses are trying to help their workers, but the IRS says their effort violates ACA requirements.

Many small business owners and employees are not aware of the prohibition, meaning this upcoming tax season could trigger surprising audits and costly penalties. For example, a small business owner who has been offering an HRA to his or her four employees since July 1, 2015, will owe the IRS $220,000 by the end of this year. Small employers, who want to help employees, simply cannot afford financial punishment of this magnitude. As a result, employees will lose their employer-provided health benefits and pay more for health care.

We strongly support the Small Business Healthcare Relief Act (H.R. 2911), which currently has 77 bipartisan cosponsors, including 28 House Ways & Means Committee members. This critical legislation would allow small businesses with fewer than 50 employees to offer employer payment plans and HRAs to employees for the payment of premiums or qualified medical expenses associated with insurance coverage without facing outrageous fines.

Thank you in advance for your consideration of our request for a prompt mark-up of this bipartisan, responsible small business health care bill. We look forward to working with you to address employer payment plans and account-based plans, such as HRAs, which provide small businesses with important and necessary relief from rising health costs.

Sincerely,

Air Conditioning Contractors of America
American Horticulture Industry Association – AmericanHort®
American Dental Association
American Farm Bureau Federation
American Independent Business Coalition
American Rental Association
American Subcontractors Association, Inc.
America's Business Benefit Association, Inc.
Associated Builders and Contractors, Inc.
Associated General Contractors
Auto Care Association
Communicating for America, Inc.
Council for Affordable Health Coverage
Door Security and Safety Professionals
Evolution1 Inc. – a WEX Company
Family Business Coalition
Global Cold Chain Alliance

Healthcare Leadership Council
Heating, Air-conditioning & Refrigeration Distributors International
Independent Community Bankers of America
International Association of Refrigerated Warehouses
International Franchise Association
Insurance Benefits & Advisors, LLC
Mid-America Lumbermens Association
Mountain States Lumber and Building Material Dealers Association
National Association of Electrical Distributors
National Association of Home Builders
National Association of Manufacturers
National Association for the Self-Employed
National Association of the Remodeling Industry
National Association of Towns and Townships
National Association of Wholesaler-Distributors
National Christmas Tree Association
National Club Association
National Federation of Independent Business
National Grange
National Lumber and Building Material Dealers Association
NPES, The Association for Suppliers of Printing, Publishing, and Converting Technology
National Restaurant Association
National Retail Federation
National Small Business Association
Northeastern Retail Lumber Association
Padgett Business Services
Pet Industry Distributors Association
Promotional Products Association International
Retail Industry Leaders Association
Saturation Mailers Coalition
Secondary Materials and Recycled Textiles Association
Service Station Dealers of America and Allied Trades
Small Business & Entrepreneurship Council
Small Business Council of America
Small Business Legislative Council
Small Business Majority
Society of American Florists
Southern Consumers Alliance
The Latino Coalition
Tire Industry Association
U.S. Chamber of Commerce
Western Equipment Dealers Association
Window and Door Manufacturers Association
Zane Benefits

HR POLICY ASSOCIATION®
The Association of Chief Human Resource Officers

April 14, 2016

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
U.S. House of Representatives

Dear Chairmen Brady:

HR Policy Association welcomes the opportunity to provide a statement for the record to the Committee on Ways and Means regarding the hearing on the tax treatment of health care. HR Policy is the lead organization representing chief human resource officers of more than 360 of the largest corporations doing business in the United States. The member companies provide health care coverage to over 20 million employees, dependents and retirees, and collectively spend more than $106 billion annually on health care in the U.S.

Private sector employers strongly urge Members of the House Ways & Means Committee to carefully consider any changes to the tax treatment of employer-sponsored health benefits that may adversely impact employees and employers. Providing tax credits for purchasing individual coverage should not come at the expense of those who receive health care through their employer.

According to the Congressional Budget Office, limiting the tax incentives for employment-based health care benefits would increase the financial burden on some people with substantial health problems, and employees in firms in areas with above-average health care costs would be more likely to see their taxes increase.

Instead of discussing policy changes that could potentially increase taxes on employees, Congress should repeal the Affordable Care Act's 40 percent excise tax on high-value employer-sponsored health care benefits. The threat of the tax, which is scheduled to take effect in 2020, is continuing to undermine benefits employees greatly value, and limiting innovative approaches to health and wellness that are reducing, rather than driving, national health expenditures.

Sincerely,

Daniel V. Yager
President and Chief Executive Officer

Statement for the Record
U.S. House of Representatives
Ways and Means Committee

Regarding
Tax Treatment of Health Care

April 14, 2016

Submitted by:
The National Association of Health Underwriters

National Association of Health Underwriters
1212 New York Avenue, NW
Suite 1100
Washington, DC 2005
(202) 595-5060
(202) 747-6820 Fax
www.nahu.org

Chairman Brady,

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing more than 100,000 licensed health insurance agents, brokers, general agents, consultants and employee benefit specialists. Our members service the health insurance policies of millions of Americans and work on a daily basis to help individuals and employers purchase, administer and utilize health insurance coverage that best fits their needs and budgets, and service this coverage on a year-round basis. NAHU appreciates the opportunity to provide written testimony for the House Committee on Ways and Means hearing on "The Tax Treatment of Health Care," and we would like to take this opportunity to encourage the committee's support for the continuation of the "employer exclusion."

The employer exclusion is used to reference the tax benefit that excludes employer-provided contributions toward an employee's health insurance from that employee's compensation for income and payroll tax purposes. This exclusion makes employer-provided health coverage an attractive form of compensation for workers. According to a new poll from Accenture, three-quarters of workers see health benefits as a "vital reason" for continuing to work for their employers, and one-third would quit if their employers stopped offering insurance. A similar percentage said they wouldn't work as hard if their benefits disappeared.[1]

Employer-sponsored coverage is the bedrock of private insurance coverage in the United States. According the Bureau of Labor Statistics, about 175 million Americans have employer-sponsored coverage and are statistically more likely to maintain coverage year after year.[2] Providing coverage through employers or other group arrangements offers controlled entry and exit in the health insurance market, which ensures the spreading of risk, federally guaranteed consumer protections like portability rights, the ease of group purchasing and enrollment, and the economies of scale of group purchasing power. In addition, it is a means for employers to provide equitable contributions for their employees.

Several recent health insurance and tax-reform proposals have suggested eliminating or capping the tax exclusion provided to individuals who have employer-provided group coverage and perhaps substituting it for some other tax preference. Capping the exclusion for employees would degrade the benefit and serve as a tax increase for middle-class Americans. Eliminating the exclusion would mean that most of the advantages of employer-provided coverage would no longer exist: No longer would there be a potent means for spreading risk among healthy and unhealthy individuals; employers and individuals would lose many group purchasing efficiencies; workers would be less likely to have their employer as an advocate in coverage disputes; employers would be less likely to involve themselves in matters of quality assessment and innovation; and employers could suffer in terms of worker productivity and labor costs because employer-sponsored insurance leads far more workers to purchase health insurance than they would on their own. Some employers would not meet participation requirements for group coverage so the entire workforce would lose employer-sponsored coverage. This shift might seem minor, but it could compel employers to stop providing health insurance, according to the

[1] http://www.plansponsor.com/Health-Insurance-Critical-for-Retaining-Employees/
[2] https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf, Table 1

Congressional Budget Office and the Joint Committee on Taxation.[3] Companies will expect their employees to secure affordable coverage in the individual market. For many people, particularly older and lower-income workers, that may be impossible, even with the implementation of the Affordable Care Act.

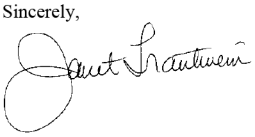
One plan would eliminate the tax exclusion for employer-provided health insurance, preventing companies from purchasing coverage with pre-tax dollars, and instead provides individuals with a tax deduction of $7,500 a year for buying insurance. Families would receive a deduction worth $20,500.[4] These types of tax deductions would encourage young, healthy workers to forgo employer-sponsored insurance because they could purchase cheaper plans elsewhere. Employers would be left with an older, sicker risk pool, thus higher costs – if the can get group coverage at all. As costs escalate, even the most generous employers may quit offering health insurance altogether. De-linking coverage from employment like this would make health insurance more expensive and less accessible, thereby contradicting the objectives of the Affordable Care Act.

Adding to the threat to employer-sponsored insurance is the increase in cost to the employers. In a recent survey, almost 90 percent of businesses reported that their costs had increased because of the law.[5] Employers are responding by laying off workers, making full-timers part-time so the mandate doesn't apply or dropping coverage altogether. In all three cases, the result is fewer people with employer coverage.[6] [7] [8] [9]

Getting businesses out of the healthcare business would be a mistake. We urge you to maintain the system that has worked for Americans for decades, and preserve employer-sponsored health coverage through the continuation of the employer exclusion.

NAHU sincerely appreciates the opportunity to provide these comments and we look forward to working with you as you continue to make improvements for health insurance consumers and employer-sponsored coverage. If you have any questions, or if NAHU can be of further assistance to you, please feel free to contact me at 202-595-0787 or jtrautwein@nahu.org.

Sincerely,



Janet Trautwein
CEO, National Association of Health Underwriters

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[3] http://www.cbpp.org/research/health/republican-study-committee-health-plan-would-likely-result-in-many-more-uninsured
[4] http://eba.benefitnews.com/news/health-care-reform/republicans-propose-controversial-aca-fix-eliminating-employer-exclusion-2746596-1.html
[5] https://www.ifebp.org/bookstore/aca2014/Pages/default.aspx
[6] http://news.investors.com/politics-obamacare/090514-669013-obamacare-employer-mandate-a-list-of-cuts-to-work-hours-jobs.htm?fromcampaign=1
[7] http://www.help.senate.gov/imo/media/doc/Webb.pdf
[8] http://healthaffairs.org/blog/2014/06/04/repeal-and-replace-the-employer-mandate/
[9] http://www.mlive.com/business/west-michigan/index.ssf/2015/01/affordable_care_act_prompting.html

Statement
of the
U.S. Chamber
of Commerce

ON: "The Tax Treatment of Health Care"

TO: The House Ways and Means Committee

FROM: Randel K. Johnson, Senior Vice President
Labor, Immigration, & Employee Benefits,
U.S. Chamber of Commerce

DATE: April 28, 2016

The Chamber's mission is to advance human progress through an economic, political and social system based on individual freedom, incentive, initiative, opportunity and responsibility.

The U.S. Chamber of Commerce is the world's largest business federation representing the interests of more than 3 million businesses of all sizes, sectors, and regions, as well as state and local chambers and industry associations. The Chamber is dedicated to promoting, protecting, and defending America's free enterprise system.

More than 96% of Chamber member companies have fewer than 100 employees, and many of the nation's largest companies are also active members. We are therefore cognizant not only of the challenges facing smaller businesses, but also those facing the business community at large.

Besides representing a cross-section of the American business community with respect to the number of employees, major classifications of American business—e.g., manufacturing, retailing, services, construction, wholesalers, and finance—are represented. The Chamber has membership in all 50 states.

The Chamber's international reach is substantial as well. We believe that global interdependence provides opportunities, not threats. In addition to the American Chambers of Commerce abroad, an increasing number of our members engage in the export and import of both goods and services and have ongoing investment activities. The Chamber favors strengthened international competitiveness and opposes artificial U.S. and foreign barriers to international business.

The U.S. Chamber of Commerce ("Chamber") welcomes the opportunity to submit this statement for the record following the April 16, 2016, hearing of the House Ways and Means Committee on "The Tax Treatment of Health Care." The Chamber is the world's largest business federation representing the interests of more than 3 million businesses of all sizes, sectors, and regions, as well as state and local chambers and industry associations. The Chamber is dedicated to promoting, protecting, and defending America's free enterprise system.

More than 96% of Chamber member companies have fewer than 100 employees, and many of the nation's largest companies are also active members. We are therefore cognizant not only of the challenges facing smaller businesses, but also those facing the business community at large.

Besides representing a cross-section of the American business community with respect to the number of employees, major classifications of American business—e.g., manufacturing, retailing, services, construction, wholesalers, and finance—are represented. The Chamber has membership in all 50 states.

The U.S. Chamber of Commerce has long advocated for meaningful health care reform. After convening a cross section of our member companies in 2012, our Health Care Solutions Council articulated a commitment to: "achieving greater value in health care, as measured by more affordable coverage options and greater access to higher-quality, prevention-oriented care, leading to better population health and sustainable U.S. health care costs. By prioritizing efforts to improve the employer-sponsored health system which covers millions of Americans, we will use these solutions to drive system-wide changes."

As an organization, we remain committed to preserving and improving the employer-sponsored system where in 2014 over 175 million Americans received their health care coverage.[1] The employer-sponsored health care system is not only where the majority of Americans receive private health care coverage, but it is also where innovation in benefit and plan design are advancing, where chronic disease management and population health efforts are improving productivity and wellbeing, and where unnecessary health care costs are being reduced. Further, recent surveys show that this benefit remains paramount to employees. Millions of Americans like the plans that they have through the employer-sponsored system.

- Eighty-eight percent of workers report that employment-based health insurance is extremely or very important, far more than for any other workplace benefit.[2]

- More than one in five workers report accepting, quitting or changing jobs because of the benefits, other than salary or wage level, that an employer offered or failed to offer.[3]

- Eighty-five percent of workers take the health insurance coverage they are offered through their employer.[4]

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[1] http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf Table 1, page 5, 2014 column.
[2] Views on the Value of Voluntary Workplace Benefits from the 2015 Health and Voluntary Workplace Benefits Survey, Employee Benefits Research Institute, November 2015 Volume 36, No. 11, page 3
[3] Ibid
[4] Ibid, page 7

Beyond being the coverage of choice, there are many ways that employer-sponsored coverage benefits employees and employers.

- Economies of scale allow for lower premiums and costs when purchasing coverage as a group because administrative costs are lower.

- Employers spend less money paying for health coverage than the federal government. An American Health Policy Institute study found that employers spent $3,430 on health care per person in 2012; government programs spent $9,130.

- On average, employer-sponsored coverage costs less than coverage on the exchange. The cost of health plans in the individual market surged past those for employer-based plans in 2015. Monthly costs per covered member in the individual market reached an average of nearly $500 in October 2015 compared to $460 monthly for employer-based plans, according to data from S&P Dow Jones Indices. A year earlier, by contrast, the average employer-based plan was nearly 6 percent more expensive than the average individual plan.[5]

- Job satisfaction and worker morale are strongly correlated with benefits satisfaction – more than 54 percent of those who are extremely satisfied with their benefits are also extremely satisfied with their current job.[6]

As you evaluate health care reform alternatives, we wish to emphasize three important messages regarding the importance of employer-sponsored health care system. First, over **175 million** Americans are enrolled in employer-sponsored coverage. A recently released report from the Employee Benefit Research Institute says this number has grown. We urge you to protect ERISA and employer-sponsored coverage.

Second, we urge you to repeal the Affordable Care Act's (ACA) 40% excise tax on high-cost plans and preserve the longstanding tax treatment of employer-sponsored coverage for employers and employees alike. There is no direct evidence that changing the tax treatment of these benefits will result in savings. Instead, a change in the tax treatment of employer-sponsored benefits is likely to have an adverse effect, especially on those employers who have an older workforce, or a workforce with employees and family members who have chronic illnesses, or employees who live in high - cost areas of the country. Additionally, the political challenge of replacing the ACA will not be eased by creating a de facto tax increase for many employees.

Finally, we believe that greater innovations in employer-sponsored coverage may continue to help to reduce health care spending. Employers are adopting new strategies to improve the delivery of health care and are empowering employees and their families with more tools to help them avoid chronic illnesses that can be prevented. Some are providing employees with on-site or access to mobile or nearby clinics to receive routine screening services, while others are driving greater performance in their provider networks – all advancements that we believe improve each and every community where employees live. Employers have crafted workplace wellness, disease management, and care coordination programs to improve the health of their employees. These

[5] http://www.pnhp.org/news/2016/april/costs-in-individual-insurance-market-skyrocketing
[6] Views on the Value of Voluntary Workplace Benefits from the 2015 Health and Voluntary Workplace Benefits Survey, Employee Benefits Research Institute, November 2015 Volume 36, No. 11

programs offer another way to advance our country's evolving health care approach beyond simply treating diseases and caring for the sick to improving health and maintaining wellness. These workplace wellness programs give people tools to identify their risk factors, improve their health, modify unhealthy behavior and stay well both in the workplace and at home.

We support your efforts to strengthen the individual market where many people buy health care coverage, but not at the expense of the employer system that is highly valued by the majority of Americans who receive their health coverage through employers today. Any forthcoming health care reforms must take into consideration the vital role of the employer-sponsored system in facilitating the innovation and creativity that is happening in the private sector offering of health care coverage. As the foundation of our health care system, we support flexibility for our nation's employers as they continue their commitment to providing innovative, sustainable and high-value care for all Americans.

The Chamber thanks you for taking the time to hold this important hearing on the tax treatment of health care. We look forward to working with you as you continue to examine this important issue. Please do not hesitate to contact us if we may be of assistance in this matter.

Randel Johnson
Senior Vice President
Labor, Immigration & Employee Benefits
U.S. Chamber of Commerce

Statement for the Hearing Record

The Tax Treatment of Health Care
House Committee on Ways and Means
April 14, 2016

Barbara Dobberthien
Executive Director and Chief Operating Officer
Yoga Alliance

Submitted: April 27, 2016

Statement submitted on behalf of Yoga Alliance, a nonprofit 501(c)(6) membership association.

Statement for the Record

Chairman Brady, Ranking Member Levin, and Members of the House Committee on Ways and Means:

I am writing on behalf of Yoga Alliance, the yoga community's largest nonprofit membership association, representing over 73,000 yoga teachers and schools. We appreciate the opportunity to share this testimony as you consider the tax treatment of health care in the United States.

As you examine this important issue, we urge your consideration of and support for H.R. 1218, the Personal Health Investment Today ("PHIT") Act, bipartisan legislation that would enable Americans to use pre-tax medical accounts to pay for physical activity expenses, including expenses related to yoga. We believe that this legislation represents a critical component of our ongoing national effort to promote healthy lifestyles and to reduce health care costs via prevention.

Currently, pre-tax medical accounts, namely health savings accounts ("HSAs") and flexible spending accounts ("FSAs") may be used for reimbursement of medical expenses to treat illnesses or other medical conditions experienced by account holders or covered beneficiaries. The PHIT Act would expand the definition of tax-free medical expenses covered by HSAs and FSAs to include "qualified sports and fitness expenses," allowing an individual taxpayer to claim up to $1,000 per year for physical activity expenses or joint filers to claim up to $2,000 per year. This means that the PHIT Act will provide an incentive to ease the financial burden of engaging in physical activity. In turn, the increased physical activity that the PHIT Act encourages will reduce health care costs related to obesity and sedentary lifestyles.

Under the PHIT Act, "qualified sports and fitness expenses" are those expenses paid for the sole purpose of participating in physical activity, including expenses related to facility memberships, participation or instruction in physical exercise or activity programs, and equipment used exclusively for physical exercise or activity. For the yoga community, passage of the PHIT Act would enable many more Americans to access yoga instruction, and with it, the associated health and wellness benefits of yoga practice.

Specifically, according to the 2016 *Yoga in America Study*,[1] there are currently 36.7 million U.S. yoga practitioners, up from 20.4 million in 2012. In addition to practicing yoga, practitioners are also significantly more involved in other forms of exercise such as running, cycling, and weightlifting than non-practitioners. Further, practitioners report that the top reasons for starting yoga are flexibility, stress relief, general fitness, improvement of overall health, and physical fitness. These are all benefits that stave off chronic conditions associated with a lack of physical activity. Of course, the PHIT Act would not only afford greater access to yoga, but also support greater involvement in numerous physical activities for all Americans.

Health care costs in the United States are skyrocketing, and a top priority of all health care reform initiatives is to slow spending without compromising care. For this reason, measures like the PHIT Act that incentivize and expand access to physical activity and accompanying health and wellness benefits will be a vital component of any solution to lower health care costs and promote healthy living. For this reason, we ask

1 Yoga Journal and Yoga Alliance, Yoga in America Study (2016), available at www.yogaalliance.org/2016YogaInAmericaStudy.

that the Ways and Means Committee consider the PHIT Act promptly and that the Committee's members support this bipartisan legislation.

Thank you for your attention to the tax treatment of health care in the United States and common sense solutions for our nation. We are available to answer any questions you may have, and would appreciate any opportunities to be of further assistance to your Committee.