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

American Federation of State, County and Municipal Employees, AFL-CIO
TEL (202) 429-1000 **FAX** (202) 429-1293 **TDD** (202) 659-0446 **WEB** www.afscme.org 1625 L Street, NW, Washington, DC 20036-5687

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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

[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.

[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.