



*A not-for-profit health and tax policy research organization*

## **Examining Threats to Workers with Preexisting Conditions**

**Committee on Education and Labor  
2175 Rayburn House Office Building  
February 6, 2019**

**Chairman Bobby Scott**

**Ranking Member Virginia Foxx**

**Testimony by Grace-Marie Turner  
President  
Galen Institute**

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## Committee on Education and Labor. Bobby Scott, Chairman

### Testimony by Grace-Marie Turner, President, Galen Institute

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Chairman Scott, Ranking Member Foxx, and members of the committee, thank you for the opportunity to testify today on “Examining Threats to Workers with Preexisting Conditions.”

My name is Grace-Marie Turner, and I am president of the Galen Institute, a non-profit research organization focusing on patient-centered health policy reform. I also have served as an appointee to the Medicaid Commission, as a member of the Advisory Board of the Agency for Healthcare Research and Quality, and as a congressional appointee to the Long Term Care Commission.

Today, I will discuss the central role that the employer-sponsored health insurance market plays in our health sector and economy, the value that employees place on their employer-sponsored insurance, bipartisan support for pre-existing condition protections, and new opportunities to reduce costs and expand access to coverage.

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**Employer-sponsored health insurance:** My colleague at the Galen Institute Doug Badger provides a detailed history of how the employer-based health insurance system evolved in the United States and how central it is to the network of programs in our health sector today.<sup>1</sup> He explains that “The vast majority of workers—89 percent according to the Kaiser survey<sup>2</sup>—worked for companies that sponsored health insurance coverage in 2016, and an estimated 79 percent of those employees were eligible to enroll in their firm’s plan. In all, 62 percent of those working for employers that sponsor coverage enrolled in that coverage in 2016.”<sup>3</sup>

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<sup>1</sup> Doug Badger, “Replacing Employer-Sponsored Health Insurance with Government-Financed Coverage: Considerations for Policymakers,” Galen Institute, December 2018. <https://galen.org/assets/Replacing-Empl-Spons-Insur-112618.pdf>

<sup>2</sup> Kaiser Family Foundation/Health Research & Education Trust 2016 Employer Health Benefits Survey. Sep 14, 2016. <https://www.kff.org/report-section/ehbs-2016-summary-of-findings/>

<sup>3</sup> Badger explains that some may have chosen to remain uninsured despite exposure to tax penalties on the uninsured. Others may have had other sources of coverage—through a working spouse, for example, a parent (in the case of those under 26), or through another public program such as Medicaid or Medicare.

In 2016, an estimated 173 million Americans received health coverage through the workplace, either as an employee or as a dependent.

Badger describes the cost in terms of tax preference for employer-sponsored health insurance (ESI) and how that is leveraged to produce a nearly 3-1 ratio in value to tax expenditures:

ESI offers considerable benefits to the government. Premiums for those with ESI totaled nearly \$991.3 billion in 2016.<sup>4</sup> Of that amount, 73 percent was contributed by employers and 27 percent by workers.<sup>5</sup> Government does not tax health benefits. If it treated ESI the same as it does wages, federal income and payroll tax revenues would increase.<sup>6</sup> The Treasury Department estimates that, absent the tax exclusion, federal revenues would have been \$348 billion higher in fiscal year 2016.<sup>7</sup>

By not taxing ESI, the government leveraged nearly \$1 trillion in private health insurance spending at a net cost to the federal budget of less than \$350 billion.<sup>8</sup> To finance that sum through payroll taxes in 2016 would have required raising the OASDI [Old-Age, Survivors, and Disability Insurance] tax by 9.6 percentage points, from 12.4 percent to 22.0 percent of taxable payroll.<sup>9</sup>

... Instead of taxing workers and corporations and directly financing their medical

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<sup>4</sup> CMS, National Health Expenditures, Table 24.

<sup>5</sup> CMS, National Health Expenditures, Table 24. It is generally accepted that the employer contribution is, in fact, a form of compensation or, to put it somewhat differently, a labor cost.

<sup>6</sup> Firms do, of course, deduct their contribution to ESI from their corporate taxes but they also deduct the wages they pay. The difference between wage and non-wage compensation is the latter's exclusion from federal income and payroll taxes.

<sup>7</sup> Department of Treasury, "Tax Expenditures," Table 1, line 128 and footnote 12. Line 128 estimates the FY 2016 federal income tax loss at \$216.1 billion. Footnote 12 estimates lost payroll tax revenue of \$131.6 billion.

<sup>8</sup> This paper is concerned largely with federal expenditures and consequently makes no effort to estimate the effects of the exclusion on state tax revenues. A very rough estimate of the benefit to the government in 2016 can be derived by subtracting the amount of federal revenue lost to the exclusion (\$348 billion) from the total amount of ESI premiums (\$991.3 billion), yielding \$643.3 billion. That is a rough estimate of the net cost of supplanting ESI with direct government financing in 2016.

<sup>9</sup> Wages subject to OASDI taxes totaled \$6.7 trillion in 2016. 2017 SSA Trustees Report, Table VI.G6, p. 216. This is not to suggest that the government would finance health care through an increase in the OASDI payroll tax, but merely to provide perspective on the amount of private health spending government leverages through the exclusion.

care, the U.S. government exempts ESI from taxation, leveraging \$2.85 in health insurance spending for every \$1 in federal revenue losses.<sup>10</sup>

**ESI Supports Public Programs:** Badger also points out the important role that employer-sponsored health insurance plays by paying doctors and hospitals more than Medicare and Medicaid do, providing the margins many providers need to maintain quality and even keep their doors open.

It can be argued that the employer-sponsored health insurance system is a vital part of the reimbursement matrix supporting the U.S. health sector.

Reimbursement rates to physicians and hospitals are generally substantially less under Medicare and Medicaid than under private employer plans. Leading proposals to extend Medicare coverage to all Americans would extend these public reimbursement rates universally, with a detrimental effect on quality and access to medical care.

The number of employers offering health coverage has remained steady over the last five years at 55 percent, even as firms are struggling to provide this valued benefit despite steadily rising health costs.<sup>11</sup> But that number still is down from the 65 percent of firms that offered coverage in 2001.

Employers know that high quality health coverage leads to better health outcomes and a healthier workforce. Long before the ACA mandate, they offered preventive and wellness services because they know that addressing health issues before they become a crisis can minimize costs and lead to better outcomes.

Employers and employees both have a vested interest in getting the best value for their health care dollars to obtain the highest quality care and coverage at the lowest cost. But costs remain a major concern.

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<sup>10</sup> Others have arrived at a higher ratio. The American Benefits Institute has estimated that employers paid \$4.45 to finance health benefits for every \$1.00 in foregone federal revenue. (See *American Benefits Legacy: The Unique Value of Employer Sponsorship*, American Benefits Institute, October 2018, p. 31. <https://www.americanbenefitscouncil.org/pub/?id=b949f447-f1ca-4dd0-817a-a7e96d8e3bfc>.) There are several reasons for the difference between this ratio and the one used in this paper. First, the American Benefits Institute (ABI) paper derives its employer payments for group health insurance from the Commerce Department's National Income and Products Accounts. This paper uses National Health Expenditures data compiled by the CMS Actuary. Second, ABI uses tax expenditure data compiled by the Joint Committee on Taxation. This paper uses Treasury Department data. Most importantly, this paper takes into account both foregone income and payroll taxes that result from the tax treatment of ESI. That yields a denominator of \$348 billion in this paper, compared with \$155.3 billion in the ABI report.

<sup>11</sup> Badger argues that the employer mandate instituted by the ACA appears to have had very little effect on the percentage of workers enrolled in ESI. In general, it appears that larger firms, which are subject to the mandate, sponsored health insurance before the government required them to do so, while a fairly substantial percentage of smaller firms, which are generally exempt from the mandate, did not offer coverage to their employees.

**Costs and Coverage:** Annual premiums for employer-sponsored family health coverage reached \$19,616 in 2018, up 5 percent from the previous year, with workers on average paying \$5,547 toward the cost of their coverage, according to a Kaiser Family Foundation survey.<sup>12</sup>

The Trump administration is offering several options through its regulatory authority to help employers and employees get and keep more affordable coverage.

**Association Health Plans:** First, the administration has created new options for smaller and medium-sized firms through its new Association Health Plans rule.

*The Washington Post* reported last week that: “Chambers of commerce and trade associations have launched more than two dozen of these ‘association health plans’ in 13 states in the seven months since the Labor Department finalized new rules making it easier for small businesses to band together to buy health coverage in the same way large employers do. And there are initial signs the plans are offering generous benefits and premiums lower than can be found in the Obamacare marketplaces.”<sup>13</sup>

There have been some criticisms that these plans might not be offering the same protections as ACA-compliant plans. But a new study shows that they are offering benefits comparable to most workplace plans, and they haven't tried to discriminate against patients with preexisting conditions, according to an analysis by Kev Coleman, a former analyst at the insurance information website HealthPocket.<sup>14</sup> “We’re not seeing skinny plans,” he said.

**Health Reimbursement Arrangements:** The administration’s proposed rule is an enhancement of Health Reimbursement Arrangements (HRAs), originally created by the Bush administration to give employers more flexibility in their benefit offerings. Under those rules, HRAs, which are tax-preferred, notional accounts, can be integrated with group health coverage sponsored by the employer. They cannot be integrated with individual health insurance coverage. As I mentioned, many workers who are offered

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<sup>12</sup> Kaiser Family Foundation/Health Research & Education Trust 2018 Employer Health Benefits Survey. Sep 2018. <http://files.kff.org/attachment/Summary-of-Findings-Employer-Health-Benefits-2018>

<sup>13</sup> Paige Winfield Cunningham, “The Health 202: Association health plans expanded under Trump look promising so far,” January 30, 2019, *The Washington Post*. [https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2019/01/30/the-health-202-association-health-plans-expanded-under-trump-look-promising-so-far/5c50ba751b326b29c3778d05/?noredirect=on&utm\\_term=.6435676a70d4](https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2019/01/30/the-health-202-association-health-plans-expanded-under-trump-look-promising-so-far/5c50ba751b326b29c3778d05/?noredirect=on&utm_term=.6435676a70d4)

<sup>14</sup> Kev Coleman, “First Phase of New Association Health Plans Reveal Promising Trends,” Association Health Plan News, January 2019. <https://www.associationhealthplans.com/reports/new-ahp-study/>

health coverage at work do not participate in their employer plans, often because of costs, and therefore are more likely to be uninsured.

In a 2017 executive order, President Trump directed administration officials to “increase the usability of HRAs, to expand employers’ ability to offer HRAs to their employees, and to allow HRAs to be used in conjunction with nongroup coverage.”<sup>15</sup>

The proposed rule would allow HRAs to be integrated with individual health coverage. This would allow workers to use their accounts to fund both premiums and out-of-pocket costs associated with individual health insurance coverage.<sup>16</sup>

The Galen Institute has submitted public comments encouraging the administration to take it one step further by allowing spouses to integrate HRA funds to obtain a family plan.<sup>17</sup> We argue that current law would allow the integration of HRAs with group health plans sponsored by the employer of a spouse.<sup>18</sup>

As an example, consider that one spouse is offered health insurance at work. The employer may allow the plan to be extended to cover the family but only if the employee pays the full extra costs, which may be prohibitive for this lower-income worker.

If the other spouse’s employer offers an HRA contribution, that employee could use the funds to buy into the first spouse’s plan. This working couple could benefit from the ability to combine the HRA funds and obtain a family health insurance plan.

We believe the administration has the authority to include this change when it publishes the final rule. This would provide a new funding option and could expand insurance coverage, especially for those currently shut out of the market.

**New Section 1332 Guidelines:** States have new flexibility offered under Section 1332 of the Affordable Care Act to lower costs and increase access to health insurance choices by using existing resources to better tailor coverage to the needs of their states.

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<sup>15</sup> Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States, The White House, October 12, 2017. <https://www.whitehouse.gov/presidential-actions/presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/>

<sup>16</sup> <https://www.federalregister.gov/documents/2018/10/29/2018-23183/health-reimbursement-arrangements-and-other-account-based-group-health-plans>

<sup>17</sup> <https://galen.org/2019/increasing-access-to-health-insurance-for-working-families/>

<sup>18</sup> Doug Badger and Grace-Marie Turner, “Give Working Families A Break,” *RealClearHealth*, January 7, 2019. [https://www.realclearhealth.com/articles/2019/01/07/give\\_working\\_families\\_a\\_break\\_110856.html](https://www.realclearhealth.com/articles/2019/01/07/give_working_families_a_break_110856.html)

The Centers for Medicare and Medicaid services issued in October new guidance for state innovation authority in the ACA.<sup>19</sup> It would allow states more flexibility to create their own programs to help improve their individual and small group markets.

I would welcome the opportunity to work with you in developing additional ways to help lower the costs of health coverage, providing employers and employees and those in the individual market with more choices of affordable health coverage while maintaining quality and consumer protections.

The current system is far from perfect, and many people fear the financial impact of losing coverage.

**Protection for the vulnerable.** There is strong bi-partisan support for pre-existing condition protections.<sup>20</sup> A number of provisions were included in the Affordable Care Act (ACA) to ensure that coverage is available and affordable to those with pre-existing conditions.<sup>21</sup> The law stipulates that people cannot be turned down or have their policies cancelled because of pre-existing conditions and that they are able to purchase policies without facing huge spikes in premium costs because of their health status. These protections are still in place.

Legislation passed by the House of Representatives in 2017 would have preserved pre-existing condition protections, and other legislative and policy proposals offered since then to improve the private health insurance market also provide pre-existing condition protections.

**A group of policy experts**—the Health Policy Consensus Group<sup>22</sup>—has developed a plan<sup>23</sup> to help the millions of people who are struggling to afford health insurance, particularly in the small group and individual markets, to have access to more choices of

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<sup>19</sup> <https://www.cms.gov/newsroom/press-releases/trump-administration-announces-state-relief-and-empowerment-waivers-give-states-flexibility-lower>

<sup>20</sup> Morning Consult+POLITICO, National Tracking Poll, Sept. 6-9, 2018. [https://morningconsult.com/wp-content/uploads/2018/09/180919\\_crosstabs\\_POLITICO\\_v1\\_DK.pdf](https://morningconsult.com/wp-content/uploads/2018/09/180919_crosstabs_POLITICO_v1_DK.pdf)

<sup>21</sup> Karen Pollitz, Testimony before the House Committee on Ways and Means on pre-existing conditions and health insurance, January 29, 2019. <http://files.kff.org/attachment/Testimony-of-Karen-Pollitz-Committee-on-Ways%20and-Means-Pre-existing-Conditions-and-Health-Insurance>

<sup>22</sup> The Health Policy Consensus Group is comprised of state health policy experts, national think tank leaders, and members and leaders of grassroots organizations across the country. Participants are committed to market-based policy recommendations that give people access to the health plans and doctors they choose at a price they can afford so that they can get the care they need, with strong protections for the most vulnerable.

<sup>23</sup> [www.healthcarechoices2020.org](http://www.healthcarechoices2020.org)

more affordable insurance while protecting the poor and the sick, including those with pre-existing conditions.

It is based upon formula grants to the states, using existing Obamacare resources, but with guidelines that incentivize states to provide people with more choices of more affordable coverage (and even provide an option for some people on Medicaid and CHIP to obtain private coverage, if that is their choice). It provides generous resources for those needing help in purchasing coverage and important protections for those with expensive and chronic illnesses.

Unlike the ACA, the Health Care Choices plan has money dedicated to creating guaranteed protection programs. Rather than forcing those participating in the ACA insurance pools to pay extra to support people with high medical expenses, we would stipulate that dedicated resources be devoted to providing extra financial support for their care.

By putting the sickest people in the same pool with others, premiums are higher, often much higher, for those not eligible for subsidized exchange coverage. Virginia State Sen. Bryce Reeves read in a recent speech<sup>24</sup> an email he received from one of his constituents in Fredericksburg. The constituent wrote he made a good living and tried to provide for his family. But his insurance premiums cost \$4,000 a month! “That’s more than my mortgage,” he told Sen. Reeves. There is only one carrier offering coverage in his area. “What am I supposed to do?”

An analysis by the Center for Health and Economy has shown the Health Care Choices Plan would reduce premiums by one third while keeping coverage numbers level.<sup>25</sup> By encouraging healthy people to remain covered, insurance pools are healthier, and resources can be directed to help those with greater health needs.

**State Solutions:** States that have used early waiver authority to create risk-mitigation programs have seen in many cases dramatic results with no new federal spending.

Doug Badger and Heritage scholar Ed Haislmaier explain how early targeted waivers granted to states are helping them to better manage patients with chronic and pre-existing conditions.<sup>26</sup> “Several states have successfully used a waiver to change market

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<sup>24</sup> Grace-Marie Turner, “Health Care Choices Proposal: A New Generation of Health Reform,” *Forbes*, June 22, 2018. <https://www.forbes.com/sites/gracemarieturner/2018/06/22/health-care-choices-proposal-a-new-generation-of-health-reform/#1106ce6664f1>

<sup>25</sup> <http://healthandeconomy.org/the-health-care-choices-proposal/>

<sup>26</sup> Doug Badger, Ed Haislmaier, “State Innovation: The Key to Affordable Health Care Choices,” The Heritage Foundation, September 27, 2018. <https://www.heritage.org/health-care-reform/report/state-innovation-the-key-affordable-health-care-coverage-choices>

conditions sufficiently that premiums fell for individual health insurance while still protecting the ability of people with high health care costs to access care,” they write.

After the waiver reform in Alaska, premiums for the lowest-cost Bronze plans fell by 39 percent in 2018, they report. Oregon showed similar results in 2018, with premiums for the lowest-cost Bronze plans falling by 5 percent. Premiums for the highest-cost Bronze plans plunged by 20 percent. In Minnesota, the third state with an approved waiver, premiums dropped in both 2018 and 2019. Average premium for ACA coverage in 2019 will be lower for every Minnesota insurer than they were in 2017. Four other states have had waivers approved for 2019: Maryland, Maine, New Jersey, and Wisconsin.<sup>27</sup>

According to the paper, “States repurpose a portion of federal money that would otherwise have been paid to insurers as premium subsidies, supplement this federal money with non-federal sources, and then use the resulting pool of money to pay medical claims for policyholders who incur high medical bills. Since this process would reduce premiums, it also would reduce federal premium subsidies, making it budget neutral to the federal government.”

States are employing various risk mitigation strategies to finance coverage for those with high health costs, repurposing federal money to pay medical bills for residents in poor health. By separately subsidizing those with the highest health costs, they can lower premiums for individual health insurance, and the lower premiums also mean increased enrollment.

**Guaranteed protection programs** are key for policymakers to protect those with pre-existing conditions and also to ensure access to affordable coverage for those who need insurance to guard against future health risks.

A woman with serious health problems provided a testimonial about why the ACA protections aren’t working for her:<sup>28</sup>

“In 1999, I was diagnosed with Hepatitis C, which made me ineligible for insurance (denied for pre-existing conditions). I live in Colorado, and they had a high-risk pool that covered people like me. I applied for that and was accepted,” she said.

“My premiums in 2010 were \$275/month with a total out of pocket of \$2,500. [While I was on] this plan, my liver failed, and I needed a liver transplant. It was approved

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<sup>27</sup> Grace-Marie Turner, Doug Badger, “Several States Have Found Ways To Mitigate Obamacare’s Damage To Their Health Insurance Markets,” *Forbes*, October 3, 2018.

<https://www.forbes.com/sites/gracemarieturner/2018/10/03/several-states-have-found-ways-to-mitigate-obamacares-damage-to-their-health-insurance-markets/#56d1b71730da>

<sup>28</sup> From HealthCareChoices2020.org testimonials:

<https://www.healthcarereform2018.org/testimonial/janets-story-high-medical-costs-worse-coverage/>

without a question. My \$600,000 transplant was covered 100% with a \$2,500 out of pocket maximum!”

When Obamacare went into effect, Colorado’s high-risk pool was closed. “I was forced into the regular marketplace that everyone was telling me was a good thing because I couldn’t get denied. I think my first year on that policy, my premiums were in the \$450 range—which I thought wasn’t too terrible, but still more than I had been paying.

“The thing I noticed from the start was that instead of full coverage, almost everything I needed was denied, which threw me into the world of having to appeal (sometimes several times) to get the basic care I needed.

“Since then, my premiums skyrocketed. In 2017, I paid \$735 a month with total out-of-pocket costs of \$5,500. In 2018, my premiums went up to \$1,100 a month with a deductible of \$6,300. Once I hit that mark, I’m covered 80%.

“Further, none of my anti-rejection meds are on the formulary of my insurance. If I could not afford them, my body would most certainly reject my liver, causing another liver transplant that would not be covered 100%.

“I don’t get any credits from the government to reduce my premiums. Those of us who are self employed but make more than the threshold for tax credits wind up footing the whole bill ourselves. I have to spend \$19,500 before my insurance pays anything, and it doesn’t cover all my prescription costs. My old plan was almost a third of what I have to pay now.

“I have many friends and work associates in the same boat as me. Many of them are doing without insurance and are betting that they won’t need more than what they can afford to pay out of pocket. I cannot do that, because if something happened and I needed another transplant, it would bankrupt my family.”

Janet has coverage for pre-existing conditions, but her access to care is inferior to the state high-risk pool coverage she had before, and the cost of her coverage is much higher.

Thank you for the opportunity to testify today. I look forward to your questions and would welcome the opportunity to work to with you to achieve the goals of better access to more affordable coverage and better protection for those with pre-existing conditions.