



AMERICAN BENEFITS

COUNCIL

TESTIMONY OF

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**PRESIDENT
AMERICAN BENEFITS COUNCIL**

BEFORE THE

**U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON EDUCATION AND LABOR**

HEARING ON

**THE TRI-COMMITTEE DRAFT PROPOSAL
FOR HEALTH CARE REFORM**

June 23, 2009

Mr. Chairman, Ranking Member Kline and members of the committee, thank you for the opportunity to join you today at this important hearing on the "Tri-Committee Draft Proposal for Health Care Reform." My name is James A. Klein, and I am President of the American Benefits Council (the "Council"). The Council is a public policy organization representing major U.S. employers that operate nationwide, as well as other organizations that assist employers of all sizes in providing benefits to their workers and families. Collectively, the Council's members either sponsor directly or provide services to retirement and health plans that cover more than 100 million Americans.

We commend the Education and Labor, Ways and Means and Energy and Commerce committees, for the collective commitment to reform of the nation's health care system and for providing the Council with this opportunity to share our perspectives on how best to achieve it.

Coverage, Cost and Quality

The Council's recommendations on health reform are contained in the January 2009 report *Condition Critical*,¹ which is aimed at achieving a stronger, more sustainable health care system. The Council's Health Care Reform Task Force worked throughout last year analyzing our health care system and developing a set of specific policy proposals that we believe would build on the system's strengths while improving health quality, lowering health costs and extending coverage to all Americans.

As a country, we spent approximately \$2.4 trillion on health care in 2007, according to the most recent available data from the U.S. Department of Health and Human Services.² This amount is almost twice as much as we spent in 1996, and total national health care spending is projected to double yet again by 2017.³ That level of increase is not sustainable. We already spend far more per capita on health care than any other developed nation, yet we rank well below other countries on many vital indicators of health status. However, perhaps even more troubling is the well-documented evidence that patients receive appropriate care for their conditions only about 55 percent of the time,⁴ and medical errors may account for as many as 98,000 fatalities each year.

¹ AMERICAN BENEFITS COUNCIL, *CRITICAL CONDITION: TEN PRESCRIPTIONS FOR REFORMING HEALTH CARE QUALITY, COST AND COVERAGE* (2009), available at http://www.americanbenefitscouncil.com/documents/condition_critical2009.pdf.

² NATIONAL COALITION ON HEALTH CARE, *HEALTH INSURANCE COSTS* (2008), available at <http://www.nhc.org/documents/Cost%20Fact%20Sheet-2009.pdf>.

³ See *id.*

⁴ Elizabeth McGlynn et al., *The Quality of Health Care Delivered to Adults in the United States*, 348:26 NEW ENG. J. MED. 2635 (June 26, 2003), available at <http://content.nejm.org/cgi/content/full/348/26/2635>.

It all adds up to an annual rate of increase in health care spending that exceeds by three or more times projected increases in the gross domestic product or the future growth in employee wages and far outpaces the expected growth in federal or state revenues.⁵ Taken together, these projections make it abundantly clear that no matter who ultimately pays the bill, health care must be made more affordable, or it cannot be made more available. In addition, our health care system is marked by wide and unexplained variations in both the overuse and underuse of health services and all too frequently subjects patients to preventable medical errors. Moreover, despite widespread agreement on the importance of extending health coverage for all Americans, too many people are left without coverage entirely, including an estimated nine million children.

There is now a broad consensus that we need to take well-reasoned steps to reform the current health care system. However, while doing so undoubtedly will be costly, simply spending more money is not the solution to the system's challenges. Indeed, among the most compelling reforms required are those that, if designed properly, will help reduce costs and obviate, to some extent, the need to raise revenue.

Building on the Employer-Sponsored Health Coverage System

The Council firmly believes that the employer-based health care system provides a solid foundation upon which to build toward the shared goal of achieving universal coverage. The current employer-based model for health care has been, and continues to be, very successful in delivering comprehensive health care to a majority of American families. In 2007, 61% of non-elderly Americans – or nearly 160 million Americans – were covered by employer-based health insurance.⁶

All available data indicates that, by and large, those 160 million Americans who receive health care coverage through the employment setting are exceedingly happy with the coverage. In a 2007 study by the National Business Group on Health, over 67% considered their employer-provided coverage to be either “excellent” or “very good”. Thus, for most Americans, the current employer-based system is not just working, it is winning at delivering critical and comprehensive health care coverage to our nation's families.

⁵ NATIONAL COALITION ON HEALTH CARE, HEALTH INSURANCE COSTS (2008), *available at* <http://www.nchc.org/documents/Cost%20Fact%20Sheet-2009.pdf>.

⁶ KAISER FAMILY FOUNDATION, THE UNINSURED: A PRIMER, KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE (2007).

The Value of Employer Engagement

In the Council's *Condition Critical* report, Prescription #1 calls for building on what works. For us, the best reform options are those that preserve and strengthen the voluntary role employers play as the largest source of health coverage for most Americans. By keeping employers engaged as sponsors of health coverage, we also keep the innovation and expertise employers bring to the table in the collective effort to achieve broad-based, practical health system reform.

One of the many strengths of our voluntary employer-based system is that group purchasing lowers health care costs because employers, especially larger employers, are able to effectively pool the risks of employees. In addition, employers are very demanding purchasers of health care services. They are focused on leveraging their health care dollars with those who can demonstrate proven value and improved health care status for their employees and their families. Because employers have a strong interest in the health and productivity of their workforce, they work hard to identify solutions that improve productivity, reduce chronic illness, and lower disability costs. These investments in the health of their workforce not only provide broad access to primary care and specialty services, they increasingly have engaged employees in innovative health coaching and healthy lifestyle programs, cost and quality transparency initiatives, pharmaceutical management programs, and value-based health plan designs.

Concerns with Pay or Play Mandate

Like the tri-committee reform proposals, the Council believes that all individuals should have an obligation to obtain health coverage and, accordingly, financial assistance will be required to enable some low and moderate income people to obtain that coverage. However, it does not follow that an employer requirement to provide coverage is needed to achieve universal coverage. It is important to keep in mind that nearly all employers with 200 or more employees provide health care coverage today. In fact, data from a 2008 Kaiser Family Foundation survey⁷ shows that 99 percent of employers with 200 or more employees offered health benefits to their workers, and that this percentage has never been lower than 98 percent at any time over the last ten years. By comparison, the same survey shows that 62 percent of firms with fewer than 200 employees offered health coverage.

One important reason we believe that a “pay or play” employer mandate approach would be an inappropriate coverage solution is that the myriad requirements that would inevitably be imposed on those who might prefer to sponsor health

⁷ THE KAISER FAMILY FOUNDATION & HEALTH RESEARCH & EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS 2008 ANNUAL SURVEY (2008), available at <http://ehbs.kff.org/>.

coverage would ultimately, if unintentionally, result in a net reduction in employer-sponsored coverage by leading some companies to simply “pay” rather than “play”. This would lower the level of active employer engagement and their important role as innovative and demanding purchasers of health care services.

Further, we are concerned about proposals under consideration that could require employers to pay their “normal” premium contribution to a health insurance exchange if an employee opts out of an employer plan. In particular, it would be inappropriate for such opt-out requirements to apply where employees are offered qualified coverage through an employer plan to satisfy their individual coverage obligation. Opt-out provisions would be particularly problematic for self-insured employers who could be required to contribute significantly more to the exchange than what some of these employees may have actually cost the employer if they had remained in their plan. This would occur whenever younger, healthier employees opt-out of the employer plan and obtain coverage through the insurance exchange. In effect, employers would be required to both “pay and play” for those employees who opt-out of their employer-sponsored plan and obtain coverage elsewhere.

Minimum Benefit Standard

We also believe that a federal minimum benefit standard is needed only for the purpose of determining whether individuals have enrolled in qualified health coverage and have met their individual coverage obligation. Once this standard is defined, employers will have strong incentives to ensure that their plans meet or exceed the minimum coverage standard applied to individuals. To not do so would leave their employees without adequate levels of coverage and subject to year-end penalties. Individuals who enroll in these employer plans will therefore satisfy their individual coverage obligation and those without employer coverage will be able to enroll in a wide range of health plan choices in the reformed insurance marketplace.

Further, we recommend that a safe harbor be available for qualified high deductible health care coverage. By doing so, individuals who enroll in a high deductible plan that meets existing federal standards would be assured of fulfilling their individual coverage obligation. This also helps ensure that high deductible plans are not required to become more costly and retains this affordable health plan choice.

Maintaining the ERISA Framework

We believe that a vitally important component of maintaining a strong employer-based health system starts with protecting the federal regulatory framework established by the Employee Retirement Income Security Act (ERISA) that allows employers to offer valuable benefits to their employees under a single set of rules,

rather than being subjected to conflicting and costly state or local regulations. Employers that operate across state borders consider ERISA's framework essential to their ability to offer and administer employee benefits consistently and efficiently. This regulatory approach also translates into better benefits and lower costs for employees. In addition, holding employer-sponsored benefits accountable under a single set of rules – interpreted at the federal level, as ERISA now does – is fundamentally fair to all employees covered under the same plan regardless of where they may live.

State benefit mandates alone can add as much as 12 percent to the total premium according to a 2008 report by the Massachusetts Division of Health Care Finance and Policy⁸, a cost that must be borne by both employers and employees who share the full cost of coverage. Importantly, most large employers who operate on a multi-state or national basis consistently report that without the ERISA framework they would face the untenable choice of attempting to maintain health coverage for their employees at even higher costs because of the need to meet each state's separate set of benefits and regulatory requirements, or dropping health coverage entirely.

However, ensuring the maintenance of a federal framework is not the only concern that employers have with regard to ERISA. Equally important is to ensure that new burdensome requirements are not imposed in ERISA itself. Such changes that might expose employers to greater liability would have a chilling effect on employers' willingness and ability to continue sponsoring plans.

Our initial review of the tri-committee draft proposal raises serious concerns with regard to ERISA, since it appears to establish two different penalty regimes within the insurance exchanges. For health plans there would be varied and unlimited penalties prescribed under state law. By contrast, in the federal public plan outlined in the draft, a uniform federal enforcement regime (i.e. as prescribed for Medicare) would apply. Yet a third regime would apply for health coverage provided outside the exchanges. Inasmuch as employers will be permitted to obtain coverage through the exchanges, this will subject employers to expansive new liabilities.

The potential for varied state remedies or onerous new federal remedies to erode private employer-sponsored health coverage cannot be overestimated. Employers would face the prospect of either maintaining health benefits for their employees or being subject to unlimited state law remedies or dropping coverage to avoid excessive financial risk. We believe that this provision alone could seriously destabilize employer-based coverage.

⁸ MASSACHUSETTS DIVISION OF HEALTH CARE FINANCE AND POLICY, COMPREHENSIVE REVIEW OF MANDATED BENEFITS IN MASSACHUSETTS REPORT TO THE LEGISLATURE (2008), *available at* http://www.heartland.org/custom/semof_policybot/pdf/23617.pdf

Improving the Individual Insurance Market and Public Programs

Health care reform will also require measures to ensure that those outside of employment-based health coverage are able to obtain meaningful, affordable coverage through the individual health insurance market. The Council's proposals enumerated in *Condition Critical* include recommendations that would ensure that any person without health coverage through an employer and who is not otherwise eligible for coverage under a state or federal health insurance program could obtain in any state at least one individual market insurance plan that meets minimum federal requirements. These insurance products should be exempt from additional state benefit mandates, but for all other purposes – such as consumer protections, solvency requirements, rating rules and other requirements – state standards would continue to apply.

We also believe that reformed state-based high-risk pools that meet minimum federal standards for coverage and rating can play a significant role in helping to keep the individual insurance market more affordable and competitive. In order to keep coverage affordable for those enrolled in high-risk pools, we propose that premiums paid by enrollees in these state-based programs be limited and claims expenses that exceed the funding from enrollee premiums be shared by state and federal governments.

In addition to employer-based health coverage and improving the individual health insurance market, we believe that public health insurance programs such as Medicaid, Medicare and the Children's Health Insurance Program (CHIP) all must be improved, particularly by moving toward payment systems that reward health care providers who consistently meet evidence-based performance standards and away from payments based simply on the quantity of services delivered. Our recommendations for health care reform also call for the establishment of a federal eligibility floor for coverage for adults under Medicaid and more effective outreach and incentives for states to reach the more than 10 million individuals who are estimated to be eligible for health coverage under state-based health programs, but are not yet enrolled.

We recognize that several public plan alternatives are still under consideration by Congress. These alternatives range from permitting a "Medicare-like" plan to compete with private health plan options in the reformed health insurance market, to having a third party administrator or public cooperative organize networks of health providers and negotiate payment rates for public plan options that would compete with private health plans, or possible fallback options similar to the approach Congress adopted as part of the Medicare Part D program.

The conditions needed to achieve a reformed and well regulated private market will be challenging enough without attempting to introduce public plan options that

risk destabilizing the insurance market at the time when it will be undergoing significant change and meeting demanding new standards. Moreover, we are confident that responsible federal insurance reform standards will lead to wide availability of private health plan options in all parts of the country, as it did for plans providing the Medicare prescription drug benefit. In this regard, it is very encouraging that the private insurance industry has already expressed its clear support for the range of reforms (e.g. guaranteed issue and renewability, prohibitions on pre-existing condition exclusions, etc.) that are needed and that acceptable in a system in which everyone has the obligation to obtain coverage.

The appropriate role for public health insurance programs is to complement, rather than compete with, private health plan options. Our vision of health reform calls for improvements in both private health insurance products, especially in the individual insurance market, and in public programs. Both have important roles to play in a reformed and robust health care system. However, we also think that both sources of health coverage have worked best by serving distinctly different roles and populations.

Improving the Quality and Efficiency of Health Care

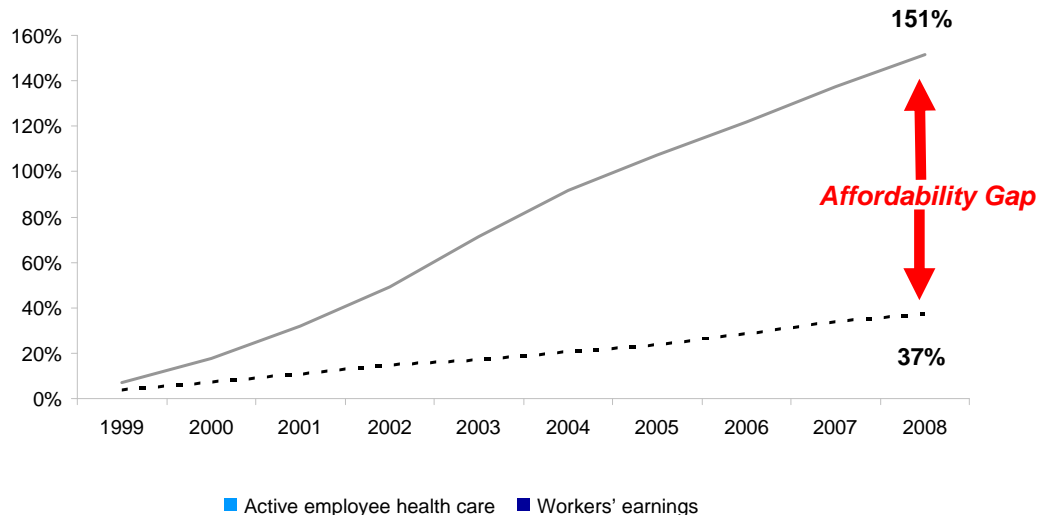
According to the most recent Towers Perrin survey of health care costs⁹, employers reported that the average per employee cost for health coverage in 2009 is \$9,660 and that this represents an average increase of 6 percent over last year. As in previous years, the survey also indicates that employers will shoulder the lion's share of these costs, subsidizing, on average, 78 percent of the premium and asking employees to cover the remaining 22 percent, plus applicable cost sharing for co-pays, deductibles and coinsurance for covered services.

Average employee health care costs vary significantly depending on whether the coverage is for an employee-only, where average 2009 costs are \$4,860, while the average cost of family coverage is expected to be \$14,244 this year. While these numbers are remarkable in themselves, the impact of annual health care cost increases is most starkly evident when compared with average wage increases over the last eight or 10 years. This gap between average increases in health costs and average wage increases forms what we refer to as the "affordability gap". Over time, this results in erosion of total compensation and employee purchasing power.

⁹ TOWERS PERRIN, HEALTH CARE COST SURVEY (2008), available at http://www.towersperrin.com/tp/showdctmdoc.jsp?url=Master_Brand_2/USA/Press_Releases/2008/20080924/2008_09_24b.htm&country=global.

The growing affordability gap

Cumulative active employee health care costs vs. wage increases



Source: Towers Perrin *Health Care Cost Survey 2009* (active employee data) and Bureau of Labor Statistics, seasonally adjusted data from the Current Employment Statistics Survey Sept-Sept, 1999-2008.

Reform Through System-Based Savings

The Council's *Condition Critical* report includes numerous recommendations directed at achieving higher quality, more affordable health care.

Reduced Costs Through Increased Quality of Care

Health care may be the one service or product in the United States, where many purchasers routinely and willingly pay as much, or more, for poor quality as for good quality. Notably, some of the largest contributing – and most controllable – factors fueling the rapid rise in health care costs are the uneven quality of care and a system that too often provides unnecessary, ineffective, or insufficient treatment.

The Council believes there are a host of reforms that can be undertaken to increase the quality of care, and that will also result in significant cost savings system-wide. They include the following:

- *Implement nationwide interoperable health information technology.* Providers and other stakeholders must be linked to ensure that patient records and other information are readily available. Overall, the health care system lags far behind

other industries in the use of information technology to advance efficiency, consistency and safety.

- *Provide safe harbor protections for health care providers and payers for decisions and practices that are evidence-based.* Determinations that are consistent with consensus-based quality measures or comparative effectiveness research should be protected by liability safe harbors.
- *Establish a national review process to rigorously examine existing and proposed state and federal benefit mandates.* This review process should aim to sunset existing benefit mandates that are not evidence-based, consistent with best practices in benefits design and clinical care, or are contributing unnecessarily to increases in health care costs.
- *Promote personal wellness and ownership for maintaining a healthy lifestyle.* Incentives should be strengthened for the expansion of benefit plans, workplace wellness programs and educational programs that promote wellness and encourage greater personal responsibility for adopting a healthy and safe lifestyle.
- *Increase participation in chronic disease management programs.* The availability of, and participation in, focused care management initiatives to address chronic diseases and other health care priorities should be significantly expanded.
- *Expand the understanding and availability of appropriate end-of-life care options.* Best practices research should be expanded to assist patients, families, health care providers and other caregivers in considering therapeutically appropriate end-of-life care options.

Increased Savings Through Transparency in Pricing and Quality

Another area where system-based reforms can deliver significant cost savings is by making price and performance information more easily accessible, so consumers can identify providers with a proven record of delivering high quality care. A more transparent system also gives health care providers needed tools to evaluate their performance and encourages continuous quality improvement. A transparent health care system provides incentives to move consumers and health care providers in the direction of evidence-based care by relying on clear, objective information on treatment options and costs. Transparency also protects patients from unsafe or unproven care. Finally, while consumers should certainly be armed with information to identify high performance health care providers, they should also be able to steer clear of those with high rates of medical errors or who fail to deliver evidence-based care.

Employers play a unique role in making the health care system more transparent by working with health care providers, insurers, consumer groups and government officials to help identify and disseminate the type and amount of information needed for better health care decision making. Many employers have developed effective incentives to encourage broad employee participation in a wide range of health improvement initiatives. This experience will be essential in creating a critical mass of users of cost and quality information in order to establish a consumer-centric health care system.

The following changes can help increase transparency, thus leading to better, more informed health care purchasing decisions and significant cost savings for the system as a whole:

- *Design and implement consensus-based quality and cost measures.* Public-private partnerships representing major health care system stakeholders have proven to be effective in developing initial sets of quality measures. Cost measures should also be developed based on episodes of care rather than unit prices for components of health care services.
- *Transform the current payment structure from a procedure-based, fee-for-service system to a value-based system.* Health care providers should be rewarded by a payment system that initially provides financial incentives for routine reporting of quality and cost information based on nationally adopted consensus measures. Ultimately, health providers should be rewarded for their demonstrated performance in the delivery of quality care, rather than simply the volume of services provided.
- *Foster continuous improvement by health care providers.* Health care providers should be equipped with comparative clinical performance information to support continuous improvement in patient care.
- *Expand the use of consumer incentives in a broader range of health plan options.* Health plans should provide incentives for plan participants to choose services from health care providers who deliver care consistent with consensus-based quality measures and demonstrate a commitment to quality improvement. Greater use of “consumer-directed” plans is one such strategy to achieve this objective.
- *Expand the practice of nonpayment for serious preventable medical errors.* All payers for health care services should adopt the practice, used by Medicare, where no payments are made for certain serious preventable medical errors, also known as “never events”. A consistent response by all public and private payers to end such payments will lead to more effective internal controls to improve patient care and safety. Health care providers also should be required to report all medical errors as a condition of payment by Medicare.

- *Establish a national entity with a broad-based governance body to significantly increase the capacity for independent, valid comparative research on clinical and cost effectiveness of medical technology and services.* Rigorous comparative effectiveness research is needed to examine clinical and cost evidence to support decisions on medical technology, treatment options and services to help ensure that more patients receive the right care for their condition.

All of the above-mentioned proposals are systemic improvements that should generate cost savings that can be used as part of a fiscally sound approach to overall health system reform. In addition, reform of medical liability rules that address unwarranted attorney's fees and excessive damage awards is an important component of legal system reform that will have beneficial affects on the health system in terms of reducing the need for unneeded tests and procedures that are performed not because of any medical necessity but purely as a means of curtailing the risk of medical malpractice lawsuits.

Shared Responsibility

There is broad national consensus that we need health reform. The Council strongly shares that view. We do, however, believe that the costs associated with health reform should be shared equitably by all stakeholders within the system. Although the proposals to finance health reform do not lie directly within the purview of the Education and Labor Committee, we appreciate that all three committees of jurisdiction are working closely with one another and therefore we wish to share our thoughts on these matters for the formal hearing record.

Significantly, employers and employees already expend a significant amount of financial resources to ensure that employees and their families have health coverage. In 2007, employers as a group paid an astounding \$530+ billion for group health plan coverage for their workers and their families.¹⁰ On average, this amounted to \$9,325 per employee for family coverage in 2008.¹¹ Notably, employees have also been working hard to pay their share of our nation's health care burden. In 2008, in addition to the employer premium contributions noted above, employees paid on average \$3,354 towards the premium costs associated with their employment-based health coverage.¹² Accordingly, to the extent that additional revenue sources are needed, after taking into

¹⁰ EMPLOYEE BENEFIT RESEARCH INST., EBRI DATABOOK ON EMPLOYEE BENEFITS tbl.2.2f (2009), <http://www.ebri.org/publications/books/index.cfm?fa=databook>.

¹¹ THE KAISER FAMILY FOUNDATION & HEALTH RESEARCH & EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS 2008 ANNUAL SURVEY (2008), *available at* <http://ehbs.kff.org/>.

¹² *Id.* This amount reflects the portion of the premium paid by an employee for coverage for a family of four.

account those generated from system-based changes, Congress should acknowledge that employers and employees already are contributing a substantial sum.

On a related note, given that the costs associated with health reform will not be insignificant, Congress should ensure that any reforms are both desirable and effective. History has shown that where the American taxpayer is asked to “foot the bill,” reforms enacted without deliberate consideration can result in taxpayer disapproval, unanticipated additional costs and even wholesale repeal of the reform. Perhaps the best example of this is the enactment and prompt repeal of the Medicare Catastrophic Coverage Act in the late 1980s.¹³ The reform was intended to help our aging population enhance Medicare coverage, and was to be paid for by Medicare-eligible individuals in the form of higher Medicare premiums. Once enacted, however, many of these individuals were soon confronted with higher premium costs for a benefit they were already receiving from other sources or did not desire. With widespread and growing dissatisfaction among seniors over the change, Congress eventually repealed the measure.¹⁴

Undoubtedly, Congress recalls the lessons learned by this experience. Even where reforms are based on lawmakers’ best intentions, if the reform is not one valued or desired by the American public, especially where we are asking them to pay for the reforms in the form of higher taxes or reduced employer-based benefits, this can lead to an unsustainable system of changes.

Notably, in the Medicare catastrophic example, many of the benefit improvements were lost when the financing mechanism proved unsustainable and the law was repealed. With comprehensive health care reform, if we fail to move in a reasoned and fiscally sound manner, it is likely to be very difficult, if not impossible, to undo any unintended negative consequences. Accordingly, the Council urges Congress to carefully consider any and all legislative changes only if economically and politically sustainable sources of financing are available.

Capping the Exclusion on Employer-Provided Health Coverage

There has been considerable discussion as to whether the employee exclusion for employer-provided coverage should be modified. Some have suggested that the value of the current employee exclusion should be limited or otherwise “capped” – either by limiting the amount of the exclusion to some specific amount – thereby taxing employer-paid coverage in excess of such amount – or by allowing the availability of the employee exclusion only to persons with incomes below a certain threshold.

¹³ Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360.

¹⁴ Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. No. 101-234.

It would be a mistake to limit or otherwise undermine the exclusion. Accounting for less than 10% of our annual health expenditures, there can be little doubt that the employee exclusion makes possible essential coverage for a significant majority of American families. Limiting the exclusion based upon the cost of some level of coverage raises a number of issues:

- *Geographical differences in cost.* In order to ensure that all individuals are taxed fairly, any limit to the employee exclusion would need to take into account the very real variations in cost depending on where an individual resides. Unless this reality is taken into account, any limit on the current employee exclusion would operate as nothing more a tax on individuals who live in higher-cost areas. But even those in lower-cost areas might not be protected. For example, if an individual works for a large multi-state employer, with most of its employees in high cost areas, such individual might be subject to tax because the insurance cost for the group as a whole is generally higher.
- *Differences in age among employees.* Any limit on the employee exclusion could penalize workers based on age. Most notably, older workers likely would be subject to a higher tax than younger workers because their coverage generally costs more. Additionally, younger workers who are employed by a company with a comparatively older, more expensive workforce, likely would be taxed more than their counterpart at another company with an overall younger workforce.
- *Family and other coverage classes.* Almost all employers provide a set number of classes of coverage. They can be as few as self-only coverage or self-only and family coverage. Alternatively, they can be more numerous, based on an individual's specific number of dependents (such as employee +1 dependent, employee +2 dependents, employee +3 dependents, etc.), although most employers have some upper limit at which all persons with this number or more dependents are all placed within the same class for purposes of determining their premium cost. Unless any limit on the exclusion takes this fact into account, it is quite likely that the limit could treat people inequitably because, for example, all persons who are enrolled in family coverage with a given employer would likely pay the same tax even though persons with fewer dependents effectively have much less valuable coverage than those with more dependents.
- *Treatment of multi-state plans.* In order for any limit not to result in tax inequities, an extraordinarily complex set of rules would need to be devised to specify if, and how, multi-state employers can combine worksite employee groups for purposes of valuing and pricing health insurance. Without such rules, workers whose employers combine their workforces from high cost areas would be more likely to run afoul of any limit on the employee

exclusion than workers whose employer combines workforces from high and low cost areas for purposes of valuing and pricing health coverage. Complexity and inequity would result.

- *Indexing.* Unless any limit on the current employee exclusion is indexed using an appropriate measure that reflects real cost increases, any such limit is unlikely to keep pace with increasing health costs. The end result would be that the tax benefits delivered vis-à-vis the employee exclusion in Year 1 would be less in each subsequent year. Notably, this is, in part, how the Bush Administration's health reform proposal was scored as revenue neutral over 10 years, by indexing the proposed standard above-the-line deduction based on the overall Consumer Price Index (CPI), not the health factor of the CPI, which is a much more reliable indicator of annual health cost increases.

Some have suggested that a "cap" on the amount of the exclusion and/or the absence of any meaningful indexing would help contain health costs. It is true that changes in the employee exclusion would likely make health care more expensive for employees and that generally when you make something more expensive people tend to use less of it. If only it were that simple when it comes to health coverage! It is hard to imagine that employers or employees need any additional incentives to try and reduce health care costs. It is unclear whether such cost containment would in fact be realized. We doubt that the nation would want to experience diminished health care coverage based on such an untested theory.

As the above discussion is intended to demonstrate, it would be very difficult, if not impossible, to design a limit to the current employee exclusion that did not result in tax inequities and/or require a burdensome and costly set of valuation rules for employers and workers. Notably, this was tried once before with the enactment of Internal Revenue Code Section 89 and it was famously unsuccessful. Despite best intentions, the statutory and regulatory regime established by Congress and the Treasury Department for purposes of valuing employer-provided health coverage proved completely unworkable. The regime was extremely expensive and burdensome for employers to administer and would have resulted in diminished coverage for American workers. Congress was left with no choice but to repeal section 89 just as the law was going into effect after employers had wasted countless millions of dollars in a futile effort to comply with a set of ill-advised requirements.

One reason the valuation rules were so complex under section 89 is because there is great diversity among employer plans. This diversity is driven in large part by employer innovations in plan design fashioned to provide the coverage that best meets a workforce's specific coverage needs. So quite apart from the cost and complexity that section 89 imposed on employers, had it gone into effect, it would have stifled innovation and inexorably led to coverage that was less responsive to workers' needs.

A limit on the exclusion based not upon the extent of coverage, but rather on the income of the family receiving such coverage has its own set of complexities and inequities. It is essentially nothing more than an effective tax increase on higher-income individuals, just a less straightforward and explicit one. This is because the value of any employer-paid coverage would be taxable to such individuals as additional W-2 wages. One can only begin to imagine the complexities and inequities that would result from imposing a tax on families whose incomes are above the specified threshold, but whose members have differing levels of health coverage from multiple sources. Limits on the employee exclusion undoubtedly would have a destabilizing effect on the employer-sponsored health coverage system. An even more obvious and greater destabilization of the system would result if limits were imposed on employers' ability to deduct health care expenditures.

Conclusion

These are times of extraordinary economic turmoil and challenges. If approached with great care, addressing the nation's health policy challenges can be an integral element of – rather than an obstacle to – economic recovery and achieving personal financial security. The American Benefits Council stands ready to continue providing information and the perspectives of the companies and professionals who are designing, administering and paying for health plans providing comprehensive health coverage for workers and their families. We thank you for the opportunity to serve the Congress as you undertake the important task upon which you have embarked.