

AMERICAN BENEFITS COUNCIL

YOUR ADVOCATE FOR EMPLOYER-SPONSORED BENEFITS SINCE 1967



May 23, 2017

The Honorable Orrin Hatch
Chairman, Senate Finance Committee
104 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Hatch,

Thank you for the opportunity to provide input on the future of health policy. The American Benefits Council (the Council) is a national association dedicated to protecting and fostering privately-sponsored health and retirement plans. In 2017, the Council is celebrating 50 years as an advocate for employer-sponsored benefits.

The Council's approximately 425 members are primarily large, multistate U.S. employers that provide employee benefits to active and retired workers and their families. Collectively, the Council's members sponsor directly or provide services to health and retirement plans covering more than 100 million Americans.

EMPLOYER-SPONSORED INSURANCE: THE STRONG FOUNDATION OF AMERICAN HEALTH COVERAGE

As stated in the Council's public policy strategic plan, [A 2020 Vision: Flexibility and the Future of Employee Benefits](#), employer-sponsored benefit plans are designed with the express purpose of giving employees the opportunity to achieve personal health and financial well-being. This serves as the foundation for employees to achieve higher productivity and, in turn, drives successful organizations. Employers currently provide health coverage to more than 177 million Americans, *nearly ten times more people* than are covered by the individual market. Employers typically pay, on average, 82 percent of the cost of coverage.¹ This is popular, affordable, high-quality coverage that leads to better health outcomes, lower costs and more satisfied and productive employees. Taxing these benefits could undermine the core of Americans' health coverage system.

¹ [Employer Health Benefits 2016 Annual Survey](#), Kaiser Family Foundation/ Health Research & Educational Trust, 2016

Any legislation to repeal, replace or reform the Affordable Care Act (ACA) must “first, do no harm” to this extremely successful system that covers the majority of Americans. Employers contribute over \$668 billion annually² – more than the federal government spends on Medicare – to their employees’ group health insurance costs. The following policy proposals will help preserve vital employer-sponsored coverage:

Address the Underlying Problems with High Health Care Costs

While the ACA made important strides in increasing health care coverage, the law failed to make any meaningful advances in lowering the cost of health care, which remains the source of many of our challenges today.

Economic gimmicks like the “Cadillac Tax” and capping the current tax exclusion for employees are unlikely to make a serious difference in the cost of health care, but delivery system reform has the potential to effect measurable change. Value-based purchasing and value-based insurance design, in which consumers and purchasers ultimately pay for care based on quality outcomes, are much more direct ways to address the key elements of high costs: unit price and chronic conditions. As such, the Council supports efforts to improve the transparency of price and performance data to enable individuals to become better consumers and to encourage continuous quality improvement.

Employers need flexibility to implement innovative payment methods. Employers should be incentivized to partner with public payers to implement multi-payer initiatives that improve quality and reduce costs.

The Council appreciates the multi-year work of your committee that resulted in unanimous approval of the [Creating High-Quality Results and Outcomes Necessary to Improve Chronic \(CHRONIC\) Care Act of 2017](#), and we hope this is a first step in a much more extensive project to reform the delivery system.

Fully Repeal the 40 Percent “Cadillac Tax” on Employer Plans

The “Cadillac Tax,” enacted as part of the ACA, imposes a 40 percent tax on the cost of employee health plans above a threshold set by the federal government. The “Cadillac Tax” was intended to address only overly generous plans, but the facts make clear that the tax will disproportionately affect certain populations and should be repealed.

² [US Bureau of Economic Analysis data](#) (Table 6.11D. Employer contributions for employee pension and insurance funds), revised Aug. 3, 2016

Health plans are often costly for reasons unrelated to the generosity of benefits. As a result, the “Cadillac Tax” will apply to employer-sponsored health plans that may be expensive solely because they cover large numbers of older or disabled Americans, women, families suffering catastrophic health events or chronic conditions, or those who live in high-cost areas.³ Workers that protect our safety, like firefighters and police officers, are also disproportionately affected.

Instead of reducing the actual cost of health care, the “Cadillac Tax” is forcing employers to shift costs to workers to avoid exceeding the ACA’s arbitrary thresholds. Americans already know this tax will increase their health care costs: in a survey earlier this year, when given arguments to keep or repeal the “Cadillac Tax,” voters – regardless of their political affiliation – favored repeal by a 2-to-1 margin. Voters recognize the tax will compel employers to drop or reduce health benefits and they are skeptical that employers will raise their workers’ taxable wages to make up for these reductions.⁴

Additionally, full repeal legislation introduced in the previous Congress garnered 350 cosponsors from both sides of the aisle, and [90 Senators voted](#) on the Senate floor to repeal the tax during the 2015 budget reconciliation debate.

Reject New Proposals to Tax Employees’ Health Benefits

Some policymakers in Congress have suggested replacing the “Cadillac Tax” with a tax on working Americans with employer-provided health insurance. These proposals would tax health benefits provided by employers, meaning higher income and payroll taxes for millions of hardworking people.

When Americans obtain their health care coverage through an employer, the cost of that coverage is “excluded” from an employee’s taxable income. “Capping” this exclusion – thereby subjecting the cost of coverage above the cap to payroll and income taxes – constitutes a direct tax increase on employees and their health benefits.

In the 114th Congress, the Congressional Budget Office estimated that capping the exclusion at levels just below those outlined in the Empowering Patients First Act would increase taxes on working Americans by an average of \$3,860 per taxpayer in 2026⁵ and would result in higher deductibles and greater out-of-pocket costs for

³ [New Analysis: Capping the Employee Tax Exclusion for Employer Health Coverage](#), Mercer, February 23, 2017

⁴ [Key Research Findings: Cadillac Tax](#), American Benefits Council and Public Opinion Strategies, January 2017

⁵ [Options for Reducing the Deficit: 2017-2026](#), Congressional Budget Office, December 2016

working Americans.⁶ Because a cap looks at the cost of coverage rather than the actual generosity of a plan, it also suffers from many of the same flaws as the “Cadillac Tax,” disproportionately affecting employer plans in high-cost locations or with older workers, to name just two factors other than plan design that affect health plan cost. In fact, capping the exclusion is essentially the “Cadillac Tax” under a different name.

We know you are committed to tax reform that results in a middle-class tax cut. Capping the exclusion would not achieve this goal and could in fact be a significant tax increase on working families. A recent study estimates that a cap on the exclusion would increase income taxes on families making between \$20,000 and \$30,000 annually by nearly 25 percent.⁷ Voters seem to recognize this, rejecting arguments for a cap on the exclusion by a two-to-one margin and predicting that the *worst* potential outcomes of the cap are the *most likely* to happen, and vice-versa.⁸

The concern about taxation of employees is not just manifested by the individuals, themselves, but also by their employers. A survey by Lockton of its corporate clients revealed *overwhelming* employer opposition (92% opposed) to a cap on the employee exclusion.⁹

Preserve ERISA’s Uniform Standard for Plan Administration

Innovation in employer-sponsored health care thrives in an environment of regulatory certainty. This is due in large part to Congress’ wisdom more than 40 years ago when it enacted the Employee Retirement Income Security Act (ERISA), to include a provision that ensures ERISA plans are free from most state and local regulation.

Not only does this critical federal standard help employers provide affordable health benefits to all employees, but without ERISA uniformity, employers would have to comply with a patchwork of varying state laws and also would need to monitor and adapt to constant state-level changes.

In recent years, however, cracks have begun to appear in the strong foundation provided by ERISA uniformity. Under the ACA, states may apply for Section 1332 waivers, which allow them to pursue myriad strategies for meeting certain terms of the

⁶ [Benefits of the Tax-Preferred Status of Employer-Sponsored Health Insurance](#), American Health Policy Institute, 2016

⁷ [New Analysis: Capping the Employee Tax Exclusion for Employer Health Coverage](#), Mercer, February 23, 2017

⁸ [Key Research Findings: Capping the Exclusion](#), American Benefits Council and Public Opinion Strategies, January 2017

⁹ [The Consequences of Taxing Healthcare Benefits: Survey of Businesses Shows Overwhelming Opposition and Disagreement with Policy Analysts](#), Lockton, March 22, 2017

health care law. Earlier this year, Secretary of Health and Human Services Tom Price invited the nation's governors to apply for these waivers. For large, multi-state employers whose employees live and work across the country, the potential for states to impose varying requirements on national employers would undermine the very purpose of ERISA's federal uniformity framework.

The American Health Care Act (AHCA), the "repeal-and-replace" bill approved by the House of Representatives, includes additional types of waivers, giving states even more authority to waive certain insurance requirements. So whether Congress approves the AHCA, or the ACA remains the law of the land, states could find it politically and financially attractive to assert more control in ways that, even unintentionally, could make it impossible for multi-state employers to sponsor health coverage for their employees in a consistent manner.

Language strengthening ERISA uniformity would help ensure states cannot impose any requirements or taxes on self-funded employer-sponsored health plans. Clearly, such state actions would erode ERISA preemption and the uniform scheme of regulating employer plans and could impose excessive costs on employers in those states where waivers are granted.

We urge Congress to avoid ceding further authority to the states, thereby potentially eroding ERISA's uniformity standard. If states are given greater authority it should extend only to the individual market and not to employer-sponsored plans.

Fully Repeal the Employer Mandate and Reduce Employer Reporting Burdens

As noted above, over 177 million Americans are covered by employer-sponsored health plans. It is expected that the vast majority of large employers will continue to sponsor coverage for their employees even if the employer mandate is repealed, just as they did prior to enactment of the ACA. The employer mandate is not needed and has added costs and complexities for large employers who have been longstanding providers of health coverage.

Complying with burdensome tracking requirements necessitated by the mandate consumes time and resources of employers and increases the costs of providing coverage to employees. The ACA added Internal Revenue Code sections 6055 and 6056, which established complex reporting requirements for employers regarding the health coverage they offer. These requirements provide the Internal Revenue Service with information needed to determine individuals' eligibility for ACA's premium tax credits. These reporting obligations require substantial time and resources to implement and overlap with the implementation of the law's employer mandate obligations, which separately require complex tracking of employee hours and coverage.

If Congress passes a bill that eliminates the employer mandate penalty, we urge

significant simplification of the employer reporting obligations related to the offer of coverage to employees. We support using the Form W-2 to fulfill reporting requirements necessary to implement any new premium tax credits, but it is imperative this new reporting requirement supplant the existing 6055 and 6056 reporting requirements. New reporting requirements must also recognize that flexibility is needed to reflect different circumstances, e.g., for employers that contribute to multiemployer plans.

Expand the Availability and Flexibility of Consumer-Directed Plan Designs

Since their inception, health savings accounts (HSAs) have been used to help make health coverage more affordable and encourage a wiser consumption of health services. We strongly support proposals that would increase the flexibility afforded to HSA plans, health reimbursement arrangements (HRAs) and flexible spending accounts (FSAs) including the following provisions, many of which are included in your legislation, the Health Savings Act of 2017:

- Create an HSA eligible High Deductible Health Plan (HDHP) safe harbor allowing plans the option of covering drugs and services used to treat chronic conditions on a pre-deductible basis.
- Allow employers to provide care at on-site medical clinics or via telemedicine providers on a pre-deductible basis to employees and eligible dependents enrolled in HSA-eligible HDHPs.
- Permit individuals and families to use HSA funds to pay for medical expenses for nondependent adult children under age 26.
- Permit employees age 65 and over to contribute to an HSA regardless of Medicare enrollment.
- Permit those with TRICARE coverage to contribute to an HSA.
- Permit early retirees to use HSA funds to pay premiums for retiree health insurance coverage.
- Permit individuals to purchase Medigap coverage with HSA funds.
- Permit an employee to contribute to an HSA, even if his/her spouse has a health FSA.
- Permit HSA-compatible HDHPs to begin paying benefits, on behalf of individual family members enrolled in family coverage under the HDHP, once the individual has satisfied the minimum *statutory* HDHP deductible for *single coverage*.
- Clarify that excepted benefit coverage, as defined under HIPAA, does not disqualify someone from having an HSA. Changing HSA/MSA definitions to

cross reference the HIPAA definition will eliminate confusion and simplify the law.

- Repeal the prohibition on the use of HSA and health FSA funds for over-the-counter medications unless prescribed by a physician.
- Increase the HSA contribution limits.
- Eliminate the \$2,500 cap on salary reduction contributions to FSAs.
- Allow employer contributions to an HSA that is equal to the employee's balance in an embedded HRA when an employee moves to the employer's HSA option from the employer's option that includes an embedded HRA (i.e. rollover).
- Expand upon provisions enacted in the 21st Century Cures Act that created Qualified Small Employer Health Reimbursement Arrangements by permitting large employers to establish stand-alone HRAs (or similar, tax-favored accounts) that can be used to purchase individual coverage. To ensure a viable, individual insurance market, there must be adequate protections to safeguard against adverse selection or risk segmentation

Maintain Treatment of HIPAA Excepted Benefits

Many employees currently have the option of obtaining dental, vision, and supplemental insurance such as accident, disability, specified disease or illness, and hospital or other fixed indemnity in addition to comprehensive medical coverage. These excepted benefits are not subject to HIPAA or ACA market reforms. ACA repeal-and-replace legislation should continue the status of excepted benefits as outside the scope of reforms aimed at major medical insurance.

Stabilize the Individual Market, Including Reliable Funding for the Cost-Sharing Reduction Subsidies

The individual market is an important source of coverage for individuals who may not have access to employer-sponsored coverage, including early retirees and part-time employees. An ill-functioning or non-existent individual health insurance market not only presents obvious concerns for those who rely directly upon it, but it also imposes significant costs and challenges for the employer-sponsored *group* health insurance system.

Section 1402 of the ACA sought to strengthen the individual market by requiring insurers to reduce costs for certain low-income enrollees, with insurers reimbursed through cost-sharing reduction (CSR) payments from the federal government.

While the health insurance marketplace is transitioning to a new structure, it is vital

that CSR payments be continued. If CSR payments were to cease, Americans could face higher premiums and more limited insurance choices, as insurers could choose or be forced to raise rates, terminate coverage or exit the exchanges. The loss of health coverage for potentially millions of people has obvious serious consequences for them and for the future viability of the individual insurance markets as a whole.

Correspondingly, if the exchanges and individual market are further destabilized, resulting in more people losing coverage, there could be further cost-shifting to large employer payers. Erosion of the individual market makes coverage in that venue a less viable coverage option for part-time workers, early retirees, and those who would otherwise elect to secure coverage through an ACA exchange (or the individual insurance market more generally) rather than sign up for, or remain on, COBRA.

Nearly 60 percent of all individuals who purchase coverage via the marketplace – 7 million people – receive assistance to reduce deductibles, co-payments, and/or out-of-pocket limits through CSR payments.¹⁰ The most critical action needed to help stabilize the individual market for 2017 and 2018 is to remove uncertainty about continued funding of CSRs. Additionally, funding mechanisms to stabilize the individual market should not increase the cost for employer-sponsored coverage. For example, employment based plans should not be required to fund reinsurance programs (as was the case under the ACA).

Additional Suggestions for Reducing Costs

Carefully crafted wellness programs have the potential to lower costs and improve workforce productivity. The Council applauds Congress for having worked on a bipartisan basis to craft the wellness provisions in the ACA that built upon the existing framework created in the Health Insurance Portability and Accountability Act of 1996. The ACA's bipartisan wellness provisions increased employer flexibility in designing programs to improve the health of employees and their families. We encourage Congress to continue this bipartisan effort and ensure that consistent federal policy that promotes the health of Americans is aligned across multiple agencies and Congress.

An additional seemingly small but important step on the road to reducing the cost of health benefits is to simplify the rules for electronic disclosure of any benefits documents employers are required to provide employees. Specifically, employers should be allowed to use electronic distribution as the default method of distribution, from which employees could affirmatively opt out in order to receive paper copies.

Finally, we recommend enacting medical liability reform at the federal level. Reasonable limits on damages and other tort reforms will protect individuals who are

¹⁰ [Letter to President Trump](#), Affordable Care Coalition, April 12, 2017

harmed by medical malpractice while helping curb excessive liability and unsustainable cost increases caused by “defensive medicine.”

CONCLUSION

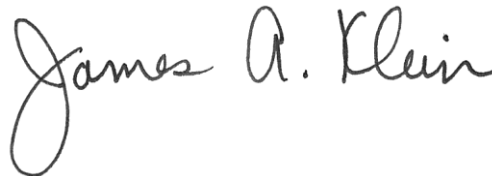
The American Benefits Council shares the same overall goals as lawmakers on both sides of the aisle: a thriving employer-sponsored system, a stable individual market for those without employer coverage, and meaningful long-term reductions in health care costs.

We believe that such outcomes are possible through engagement of key stakeholders and bipartisan cooperation. Your letter soliciting our feedback helps accomplish the former, and we are very grateful for the opportunity to share our views.

As to the latter, we hope the Senate will craft an overall bill that can attract bipartisan support, because bipartisan legislation is the foundation for durable policy that benefits all Americans.

We applaud you for your commitment to good policy and are ready to work with you in this challenging health reform effort.

Sincerely,

A handwritten signature in black ink that reads "James A. Klein". The signature is written in a cursive style with a large, looping initial "J".

James A. Klein
President