



AMERICAN BENEFITS

COUNCIL

STATEMENT OF JAMES A. KLEIN

ON BEHALF

OF THE

AMERICAN BENEFITS COUNCIL

SUBMITTED TO THE

COMMITTEE ON FINANCE

OF THE

UNITED STATES SENATE

FOR THE ROUNDTABLE DISCUSSION

ON

FINANCING HEALTH CARE REFORM

MAY 12, 2009

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Chairman Baucus, Ranking Member Grassley, and Members of the Committee, thank you for the opportunity to participate in this roundtable discussion on financing 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 plan sponsors, principally Fortune 500 companies, and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council’s members either sponsor directly or provide services to retirement and health plans that cover more than 100 million Americans.

Mr. Chairman, I commend you and the other Members of the Committee for holding today’s roundtable to focus on the important issue of health care reform financing. Your leadership is critical to ensuring that we as a country continue to take the necessary steps to ensure that all Americans have affordable and comprehensive health care coverage, while also ensuring that these steps are undertaken in a sustainable and fiscally sound manner.

In considering the financing of health care reform, we urge that Congress adhere to four foundational principles:

- (1) In conjunction with ensuring health coverage for all Americans, enact systemic changes that will mitigate cost increases and, thereby, restrain the need for greater revenue;
- (2) Proceed conservatively in estimating costs, savings and revenue – it is better to err on the side of overestimating the cost of expanding health coverage and underestimating the savings or revenue from various financing proposals;
- (3) Reforming the health care system is a societal imperative, and the responsibilities associated with doing so should be shared equitably by the stakeholders in the system; and
- (4) Ensure that Americans can keep the coverage they enjoy, which for most people is employer-sponsored coverage. Financing and other policies should protect and build upon employer-based health coverage.

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.¹ 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 2017.² 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,³ and medical errors may account for as many as 98,000 fatalities each year.⁴

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.⁶

There is now a broad consensus that we need to begin the process of taking well-reasoned steps to reform the current health care system. However, while doing so will be costly, spending more money is not the only 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. The Council believes that a significant amount of financing for health reform can be found from reforms made to, and within, the health care system – through, for example, increased efficiencies, continuous improvements in quality of care, better transparency in the pricing and quality of providers and their services, and through the use of standard health information technologies among providers and related institutions.

¹ NAT'L COAL. ON HEALTH CARE, HEALTH INSURANCE COSTS 1 (2008), *available at* <http://www.nchc.org/documents/Cost%20Fact%20Sheet-2009.pdf>.

² *See id.*

³ *See* Elizabeth A. McGlynn et al., *The Quality of Health Care Delivered to Adults in the United States*, 348:26 NEW ENG. J. MED. 2635, 2635 (June 26, 2003), *available at* <http://content.nejm.org/cgi/content/full/348/26/2635>.

⁴ INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 26 (Linda T. Kohn, Janet M. Corrigan & Molla S. Donaldson eds., 2000), *available at* <http://www.nap.edu/openbook.php?isbn=0309068371>.

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

⁶ COVER THE UNINSURED, QUICK FACTS ON THE UNINSURED, *available at* <http://covertheuninsured.org/content/quick-facts-uninsured>.

Moreover, the current income and payroll tax exclusion for employer-paid health coverage (“employee exclusion”) represents a comparatively small portion of our current annual health expenditures – and it works! It helps deliver comprehensive and affordable health coverage to a significant majority of American families. Thus, although the employee exclusion is perhaps more easily identified and quantified than other aspects of health financing – because we are able to put our metaphorical hands on it – the Council believes, for reasons more fully described below, that any reform measures should build upon, rather than replace, the current employer-based system and preserve the employee exclusion. The key components of any proposed health reform initiative should be carefully assessed to determine if they will strengthen, impede or reduce participation in the employer-based health system.

PRINCIPLE #1 – In conjunction with ensuring health coverage for all Americans, enact systemic changes that will mitigate cost increases and, thereby, restrain the need for greater revenue.

As we discuss in our recent report, *Condition Critical: Ten Prescriptions for Reforming Health Care Quality, Cost and Coverage*, the Council’s members strongly believe that “we can, and must, achieve a more affordable, more inclusive and higher quality health care system,” and that we must “close the coverage gap and bring all Americans into the health care system.”⁷

As we consider next steps for moving toward this important goal, we must be mindful of not only the current economic climate and of already sky-high levels of health care spending, but also of the need to build a long-term sustainable reformed health system. Accordingly, the Council believes that we need to look for cost savings from within the system as one important way to help finance any reform measures.

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 that will also result in significant cost savings system-wide. They include the following:

⁷ AMERICAN BENEFITS COUNCIL, *CRITICAL CONDITION: TEN PRESCRIPTIONS FOR REFORMING HEALTH CARE QUALITY, COST AND COVERAGE 1* (2009), available at www.americanbenefitscouncil.com/documents/condition_critical2009.pdf.

- *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. Finally, transparency also protects patients from unsafe or unproven care. 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 care 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 conditions.

In addition to the above, the following must also be part of comprehensive reform:

- *Reform the individual insurance market.* Many current rules foster adverse selection within the individual insurance market and limit the pooling of risk for pricing and selling insurance. A more efficient individual insurance market reduces the cost of insurance for individual purchasers.
- *Reform medical liability rules.* Reasoned reform of unwarranted attorney's fees and excessive damages awards is an important cost savings initiative.

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.

PRINCIPLE #2 – Proceed conservatively in estimating costs, savings and revenue – it is better to err on the side of overestimating the cost of expanding health coverage and underestimating the savings or revenue from financing proposals.

The Council urges the Committee and Congress as a whole to proceed in a careful and deliberate manner in considering the nature and cost of any reforms. As part of this process, the Council urges the Committee not to underestimate the costs of health reform and to be conservative in determining the savings or revenue that is likely to be raised from any financing proposals, especially those where accurate valuations may be particularly difficult to obtain.

We likely can all agree that the cost of expanding health coverage to millions of currently uninsured Americans will not be an inexpensive venture and will require significant and sustained financial investment. We cannot, however, begin to have a meaningful discussion regarding health reform financing unless and until we better understand the expected costs associated with expanding coverage. Accordingly, the Council urges the Committee to use the myriad of resources at its disposal to understand as fully as possible the expected costs of health reform.

On a related note, it is important for all of us to keep in mind that there likely will be times when we might otherwise want to avoid confronting head-on the cost and financing realities. There is little doubt that the process of accurately estimating the projected costs of

health reform is no easy task. As quoted by the *The Wall Street Journal* on May 5, 2009, Douglas Elmendorf, director of the Congressional Budget Office, acknowledged that, with respect to the process of accurately estimating the cost of health reform, “[t]his is as complicated as all get out.”⁸ The American people are not well served by failure to fully account for the expected costs of health reform. The long-term result of doing so could be unexpected tax increases on the American public and/or a system – albeit well-intentioned – that is not sustainable in the long-term.

We must be equally vigilant that we do not undertake processes that unintentionally or otherwise give undue value to potential financing vehicles. For example, this statement addresses how meaningful savings can be realized from system-based changes, including those designed to increase the quality and efficiency of health care and transparency in pricing. The Council strongly believes that real and significant cost savings can be achieved through implementation of these changes and that these savings can be used to help finance broader health reform measures. Nonetheless, we are not unaware of the complexities inherent in trying to quantify the expected revenue that could be raised for health reform through these systemic changes. Accordingly, we urge all parties involved to be conservative in valuing those savings. As a country, we will be best served by being measured in calculating the financial aspects of health reform.

PRINCIPLE #3 – Reforming the health care system is a societal imperative, and the responsibilities associated with doing so should be shared equitably by the stakeholders in the system.

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.

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.⁹ On average, this amounted to \$9,325 per employee for family coverage in 2008.¹⁰ 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.¹¹ Accordingly, to the extent that

⁸ Janet Adamy, *Need For Cost Data Slows Health-Care Overhaul*, WALL ST. J., May 5, 2009, at A2.

⁹ EMPLOYEE BENEFIT RESEARCH INST., EBRI DATABOOK ON EMPLOYEE BENEFITS tbl.2.2f (2009), available at <http://www.ebri.org/pdf/publications/books/databook/DB.Chapter%2002.pdf>.

¹⁰ THE KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS 2008 ANNUAL SURVEY 1ex.A (2008), available at <http://ehbs.kff.org/pdf/7790.pdf>. This amount reflects the portion of the premium paid by an employer for coverage for a family of four.

¹¹ *Id.* This amount reflects the portion of the premium paid by an employee for coverage for a family of four.

additional revenue sources are needed, after taking into account those generated from system-based changes, Congress should acknowledge that employers and employees already – as the saying goes – generously “give at the office.”

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.¹² 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.¹³

Undoubtedly, the Committee 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 coverage 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 the Committee and Congress as a whole to carefully consider any and all legislative changes only if economically and politically sustainable sources of financing are available.

PRINCIPLE #4 – Ensure that Americans can keep the coverage they need and value, which for most people is employer-sponsored coverage. Financing and other policies should protect and build upon employer-based health coverage.

The current employer-based model for health care has been, and continues to be, very successful in delivering comprehensive health coverage to a majority of American families.

¹² Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360.

¹³ Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. No. 101-234.

In fact, in 2007, 61% of non-elderly Americans were covered by employer-based health insurance.¹⁴

All available data indicates that, by and large, those 160 million Americans who receive health care coverage through the employment setting are exceedingly satisfied. A 2007 study by the National Business Group on Health reported that over 67% considered their employer-provided coverage to be either “excellent” or “very good.” Thus, the Council urges the Committee to recognize the inherent value of the current employer-provided system (including the existing tax treatment) in delivering comprehensive coverage to American families. The Council believes that any reform measures should be designed to build upon the current employer-based model.

Notably, there has been discussion as to whether the employee exclusion 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.

It would be a mistake to limit or otherwise undermine the exclusion. Equating to less than 10 percent 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. Raising taxes on those who participate in health plans is not the way to solve the health care system’s ills. Limiting the exclusion based upon the cost of some level of coverage raises a number of issues:

- *Geographical differences in cost.* Any limit on the current employee exclusion would operate as nothing more than a tax increase for individuals who live in higher-cost areas given the very real variations in health care costs depending on geographic location. 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 counterparts at another company with an overall younger workforce.

¹⁴ KAISER FAMILY FOUNDATION, THE UNINSURED: A PRIMER, KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE 1 (2007), available at www.kff.org/uninsured/upload/7451-03.pdf.

- *Treatment of multi-state plans.* A limit on the employee exclusion would necessitate an extraordinarily complex set of rules 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 89¹⁵ 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.

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

¹⁵ I.R.C. § 89.

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. 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.

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 a tax increase on individuals with income above whatever threshold is set – simply 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

The Council believes that adherence to the four principles set forth in this testimony will provide a logical and equitable basis for evaluating the costs of health reform and a sustainable and equitable framework for financing those reforms. Thank you for the opportunity to share the Council's perspectives. We look forward to working with the Committee on the important efforts upon which it has embarked.