The Tri-Committee Draft Proposal for Health Care Reform

Testimony Submitted to

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Subcommittee on Health

By

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The AFL-CIO represents 11 million members, including 2.5 million members in Working America, our community affiliate, and 56 national and international unions that have bargained for health benefits for more than fifty years. Together, unions negotiate benefits for some 50 million people in America.

Our members have a significant stake in health care reform because unions represent the largest block of organized consumers in the nation. In addition, unions also sponsor health plans through funds that are jointly-trusteed with management. Many union members work in health care, as well, so they have a dual interest in health reform.

Even as unions continue to negotiate benefits for our members, American labor has long advocated for health care for everyone, not just those in unions or with stable jobs. For over 100 years, America's unions have called for universal coverage built on a social insurance model, an approach that has proven effective and efficient across the globe and one we have employed successfully for decades to provide income and health security for the elderly.

The AFL-CIO led the lobbying effort to enact Medicare in 1965, and we have backed many legislative efforts since then to expand coverage. We continue to believe that a social insurance model is the simplest and most cost effective way to provide benefits for all.

However, the condition of health care in America is too dire for those of us lucky enough to have good coverage to debate endlessly over what the best approach would be. It is time—indeed, it is past time—to enact comprehensive health care reform. Today our members are ready to stand with President Obama and Congress and help pass the President's plan for comprehensive health care reform.

AFL-CIO's VIEWS ON COMPREHENSIVE HEALTH CARE REFORM

Today I would like to explain the AFL-CIO's views on what comprehensive health care reform should look like, and specifically our views on the historic tri-committee discussion draft unveiled in the House of Representatives last week.

We start from the premise that we can fix our broken health care system by building on what works. For most Americans, that means employer-sponsored health insurance (ESI), which is the backbone of heath care financing and coverage in America.

The AFL-CIO has advocated a three-point program to guarantee quality affordable health care for all—a program that consists of: (1) lowering costs; (2) improving quality; and (3) covering everyone by ensuring full participation of all public and private sector employers and making affordable health coverage available to everyone. All three of these objectives must be achieved together; none can be achieved in isolation. And we believe the tri-committee discussion draft will in fact help achieve all three of these objectives simultaneously.

We caution, however, that one financing option under consideration in the Senate Finance Committee—the taxation of employer-sponsored health benefits—would go in the exact opposite direction by destabilizing the employer-based health insurance system.

OUR PRESENT COURSE IS UNSUSTAINABLE

Whatever one may think about the way health care should be reformed, we can all agree that our present course is not sustainable—for workers, for businesses, for the federal budget, or for the economy as a whole. If we continue down the current path, health care costs will crush families, business and government at all levels.

Our members are among the most fortunate workers. Thanks to collective bargaining, they generally have good benefits provided by their employers. Yet even well-insured workers are struggling with health care cost increases that are outpacing wage increases. And far too many working families find themselves joining the ranks of the uninsured or under-insured as businesses shut down or lay off employees.

In April and May 2009, the AFL-CIO conducted our 2009 Health Care for America Survey, which showed that people need urgent relief from the pressure of rising health care costs that are bankrupting families and endangering their health.

More than half of respondents said they cannot get the care they need at a price they can afford. Three quarters were dissatisfied with their household's health care costs.

> Ann from Georgia (self-employed with two children) wrote: "We have that HSA plan with supposedly low premiums. However, those 'low' premiums only start low. Every year they get higher and higher. One year they increased 129 percent in just one year. Our health care costs have exceeded 35 percent of our income for two years. We are on the verge of canceling health care insurance. We would have already done this if we didn't have two children."

A third of those with insurance—and three quarters of those without—reported that they forgo basic medical care because of high costs.

> Karen from Florida wrote: "My insurance deductible equals four to five months of take home pay each year. My insurance bill is split with my employer but equals two days of pay each month. How am I supposed to go to a doctor?"
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> Iris from Florida writes: "I am unemployed because I had to quit my job to care for my elderly mother. My children decided to pay [for medical insurance] for me. So what is the problem? The deductibles are so high that I cannot go to the doctor. And we keep paying $300 monthly just in case I have to go to the hospital. In the meantime, I cannot afford to go to the doctor."

As economic conditions have gotten worse, workers who lose their jobs have been losing their health care. Nearly a quarter of respondents said someone in their household lost coverage in the past year due to losing or changing jobs.

> Renee from Ohio wrote: "It is pretty scary that millions of hard working retirees as well as those working may lose their insurance, and yes I am talking about the auto industry. My husband could lose his benefits, which he thinks he will. I don't know how my kids will be able to get their annual checkups. How can anyone get ahead in this country? I don't understand how it came to this. I just don't want to think about the future anymore."

Once workers lose their health care coverage, it is hard for them to get it back. One quarter of those without health insurance said they were denied coverage in the past year due to "pre-existing conditions."

> Kerry from New Mexico wrote: "I am desperate for our country to finally do something for my family so a health crisis does not kill one of us or leave us completely financially devastated."

The data bear out the stories these workers are telling us. Between 1999 and 2008, premiums for family coverage increased 119 percent, three and a half times faster than cumulative wage increases over the same time period.[1]

Workers' out-of-pocket costs are going up as well, leading to more under-insured workers who can no longer count on their health benefits to keep health care affordable or protect them from financial ruin. Between 2003 and 2007, the number of non-elderly adults who were under-insured jumped from 15.6 million to 25.2 million.[2]

Skyrocketing costs are pushing more workers out of insurance altogether. The current number of uninsured almost certainly exceeds 50 million. The Council of Economic Advisers estimates that number will rise to 72 million by 2040 in the absence of reform.[3]

Health costs are burdening American businesses, as well as workers. U.S. firms that provide adequate health benefits are put at a significant disadvantage when they compete in the global marketplace with foreign firms that do not carry health care costs on their balance sheets. The same is true for U.S. businesses in domestic competition against employers that provide little or no coverage.

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[1] Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2008. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2000-2008; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2000-2008 (April to April). Accessed: http://ehbs.kff.org/images/abstract/EHBS_08_Release_Adds.pdf.

[2] C. Schoen, S.R. Collins, J.L. Kriss and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, w298-w309. June 10, 2008.

[3] Council of Economic Advisors. "The Economic Case for Health Care Reform." June 2009. Accessed: http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf.

The present course is unsustainable for the economy as a whole, as well. Health care expenditures currently amount to about 18 percent of our GDP. The Council of Economic Advisers estimates that this percentage will rise to 34 percent by 2040 in the absence of reform.[4] The Congressional Budget Office (CBO) projects that health care expenditures will rise to 49 percent of GDP by 2082.

The present course is likewise unsustainable for the federal budget. If we fail to "bend the cost curve," health care spending will balloon our federal budget deficit and squeeze out funding for essential non-health care priorities. Almost half of current health care spending is covered by federal, state, and local governments. If health care costs continue to grow at historical rates, the Council of Economic Advisers estimates that Medicare and Medicaid spending will rise to nearly 15 percent of GDP by 2040.[5] As then CBO director and now OMB director Peter Orszag has noted, health care cost trends are the "single most important factor determining the nation's long term fiscal condition."

To fix our long-term structural budget deficits, we have to fix Medicare and Medicaid, and to fix Medicare and Medicaid, we have to control health care costs in the private sector. There is no practical way to control public health care costs without addressing private health care costs as well. Private and public health care are delivered largely by the same providers, using the same drugs, the same treatments, and the same procedures.

In short, the health of our family budgets, our federal budget, and our economy depends on the success of health care reform this year.

BUILDING ON WHAT WORKS

The AFL-CIO believes comprehensive reform can build on what works in our current health care system while creating new options for obtaining coverage and lowering costs for families, business, and government at all levels.

For the majority of Americans, what works in our current health care system is employer-based coverage—the backbone of health care coverage and financing in America. Over 160 million people under age 65 have health benefits tied to the workplace.

Employer-sponsored coverage has proven remarkably stable in the face of exorbitant health care cost inflation. Its survival is testimony to the strong interest workers have in keeping coverage tied to the workplace—even at the expense of wage gains for the past 30 years—and the interest of employers to recruit and retain talented workers through job-based benefits.

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[4] Council of Economic Advisors. "The Economic Case for Health Care Reform." June 2009. Accessed: http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf.
[5] Ibid.

In fact, it is hard to imagine successful health reform that does not include a substantial role for employer-based coverage. Building on the core foundation of employer-provided health coverage will allow working families to keep what they now have...or choose from a new set of options to maintain coverage. We think building on this foundation will also help minimize the disruption that results from the difficult changes that are a necessary part of any reform, and thereby maximize public support for reform.

In order to build on this foundation, we must stabilize the employment-based system, which risks being destabilized by unsustainable cost inflation. We must reverse the steady erosion of employer-provided coverage in recent years. The percentage of 18 to 64-year-olds with ESI dropped five percentage points from 2000-2007, and without prompt dramatic action the rate of decline is expected to increase sharply.[6]

We believe the tri-committee discussion draft will stabilize the employer-based health care system through the following specific policy proposals: (1) a requirement that employers assume responsibility for contributing to the cost of health care for their employees through a "pay or play" system; (2) special assistance for firms that maintain coverage for pre-Medicare retirees, which will prevent further deterioration of the employer-based system; (3) a public health insurance option, which will inject competition into the health care system and lower costs throughout the system for employers and workers alike; (4) health care delivery reforms to get better value from our health care system and contain long-term costs; and (5) insurance market reforms, individual subsidies, Medicaid expansion, and improvements to Medicare, which will help make affordable coverage available to everyone.

PAY OR PLAY

A key reform needed to stabilize the employer-based coverage system is the requirement that public sector and private sector employers assume responsibility for contributing toward the cost of health care for their employees. Employers should be required either to offer health benefits to their workers directly, or to pay into a public fund to finance coverage for uninsured workers—a proposal known as "pay or play."

The tri-committee discussion draft outlines a reasonable and effective employer responsibility requirement that we believe would help shore up employer-based coverage. The proposal would ensure that workers could get affordable coverage either through their employer-sponsored plan or through a national exchange with a contribution from their employer. And it would extend, on a pro-rated basis, an employer's responsibility for part time workers, to eliminate any incentives for employers to move workers to part-time status to avoid the new requirement.

We believe such a "pay or play" system has many virtues. It would bring in needed revenue from firms that opt to "pay," which would hold down federal costs associated with providing subsidized coverage for low-income workers in those firms.

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[6] Elise Gould. "The Erosion of Employer-Sponsored Health Insurance." Economic Policy Institute. October 2008. Accessed: http://epi.3cdn.net/d1b4356d96c21c91d1_ilm6b5dua.pdf.

"Pay or play" would likewise hold down federal costs by keeping employers from dumping their low-wage employees into new subsidized plans. In the absence of an employer responsibility requirement, publicly subsidized coverage for low-wage workers would prompt many employers of low-wage workers to discontinue current coverage to take advantage of available subsidies. The resulting increase in federal costs could well doom health care reform.

"Pay or play" would help stabilize the employer-based health care system in several ways. It would level the playing field so that free rider businesses could no longer shift their costs to businesses offering good benefits. A recent study found more than $1,000 of every family plan premium goes to cover the cost of care for the uninsured, most of whom are employed.[7] "Pay or play" would encourage employers to offer their own coverage and penalize employers that do not. And it would minimize disruption for workers who already have health care coverage and wish to keep it.

"Pay or play" would thus go a long way towards extending coverage to the uninsured, since most of the uninsured have at least one full-time worker in their family. And it would be critical in making coverage affordable for workers who do not qualify for income-based credits or subsidies, especially if health care reform includes a new requirement that all individuals obtain coverage.

Arguments against Pay or Play

Opponents of an employer responsibility requirement raise the objection that "pay or play" would increase payroll costs for businesses. We believe this objection is misplaced.

First of all, it should be emphasized that the overwhelming majority of businesses already provide health benefits that would likely meet the new requirements, so they would not see any new costs. In fact, they would see their costs **go down** as health care coverage is expanded—thanks to the elimination of cost shifting—and as other health care reforms take hold that drive down costs throughout the health care system.

The only firms that might see an increase in costs are firms that do not currently offer health care benefits, or firms that offer benefits that are inadequate to meet a reasonable standard. The vast majority of firms that currently do not offer health care benefits are small firms, and they are mostly low-wage employers. Comprehensive health care reform generally would give small firms more affordable options for providing health benefits for their workers, probably in combination with additional subsidies for employers of low-wage employees.

Opponents of an employer responsibility requirement warn that employers that have to pay more for health insurance would be less likely to raise wages in the short term. The

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[7] Families USA. "Hidden Health Tax: Americans Pay a Premium." May 2009. Accessed: http://www.familiesusa.org/assets/pdfs/hidden-health-tax.pdf.

widely endorsed economic view, however, is that such employers would still raise wages over the long term.

Opponents of "pay or play" next argue that employers required to pay more for health insurance might eliminate jobs or hire more slowly as a result. But the same dire predictions have been made routinely about proposals to increase the minimum wage, with comparable increases in employer costs, and those predictions have not been borne out. Recent studies of minimum wage increases have found no measurable impact on employment.[8] Economists have observed that employers faced with higher payroll costs from a minimum wage increase can offset some of those costs through savings associated with higher productivity, decreased turnover and absenteeism, and improved worker morale.[9]

The same would be true of an employer responsibility requirement. Any increase in employer costs would be offset by productivity gains and by a healthier workforce. The Council of Economic Advisers notes that the economy as a whole would benefit from more rational job mobility and a better match of workers' skills to jobs when health benefits are no longer influencing employment decisions.[10] Finally, it should be noted that the majority of firms that currently do not offer health benefits compete in markets where their rivals likewise do not provide benefits, so they would not be put at a competitive disadvantage.

Pay or Play and firm size

Health care reform must make coverage affordable for small businesses that have difficulty obtaining coverage in the current market. However, the AFL-CIO believes the "pay or play" requirement should apply to firms regardless of their size.

Smaller businesses will be allowed to meet the "play" requirement by buying coverage that meets fair rating rules through the new exchange, which would include the option of a public health insurance plan that makes coverage more affordable. We do support the inclusion of a small business tax credit, targeted at the smallest firms with low-wage workers, precisely because we believe an employer requirement should not exempt businesses based solely on size.

If small businesses are exempted from "pay or play," the number of employees is a particularly poor measure for the exemption because it is a poor predictor of a firm's ability to pay. A doctor's office or small law firm may have more capacity to pay than a larger restaurant or store. A carve-out for small firms with fewer than a specified

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[8] A. Dube, T. W. Lester, M. Reich, "Minimum Wage Effects Across State Border: Estimates Using Contiguous Counties," Institute for Research on Labor and Employment Working Paper Series No. iiwps-157-07, August 1, 2007.

[9] J. Bernstein, J. Schmitt, "Making Work Pay: The Impact of the 1996-1997 Minimum Wage Increase," Economic Policy Institute (1998); D. Card, A. Krueger, "Myth and Measurement: The New Economics of the Minimum Wage," Princeton University Press, 1995.

[10] Council of Economic Advisors. "The Economic Case for Health Care Reform." June 2009. Accessed: http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf.

number of employees also creates a potentially costly hurdle for firms nearing the threshold to hire additional employees. A better approach would be to apply the requirement based on payroll or gross receipts. Finally, we believe special treatment for such businesses should be phased out over time to eliminate disparities based on firm size.

Also, any "pay or play" requirement should take into account how workers in certain segments of our economy, such as airlines and railroads, schedule their hours and the classification of workers as full-time or part-time should ensure that these workers are not inadvertently excluded from coverage.

Special assistance for companies that maintain benefits for pre-Medicare retirees

We look forward to working with the committees to develop greater specificity on the proposal for a federally-funded catastrophic reinsurance program for employers that provide health benefits to retirees age 55 to 64. Such a reinsurance program would help prevent further deterioration of the employer-provided health care system, and is an essential component of any health care reform legislation.

A reinsurance program is critically necessary to help offset costs for employers that contribute to health benefits for pre-Medicare retirees. The pre-Medicare population generally has higher health care costs, and employers offering them coverage retirees incur enormous expense. But without that coverage, individuals in this age bracket have tremendous difficulty purchasing health insurance in the individual market, or they are able to do so only at a very high cost.

We believe such a reinsurance program must have dedicated funding. In addition, in the longer term, we believe firms should be able to purchase coverage for their retirees through the exchange. This would help make coverage more affordable for firms that provide retiree health benefits.

PUBLIC HEALTH INSURANCE PLAN OPTION

The AFL-CIO supports the creation of a strong public health insurance option to compete with private health insurance plans. The tri-committee discussion draft includes a strong public plan that would compete on a level playing field with reformed private health plan options in a new national exchange.

We believe a public health insurance plan is the key to making health care coverage more affordable for working families, businesses, and governments, all of which are increasingly burdened by escalating health care costs. A public plan would have lower administrative costs than private plans and would not have to earn a profit. These features, combined with its ability to establish payment rates, would result in lower premiums for the public plan.

A public health insurance plan would also promote competition and keep private plans honest. Consolidation in the private insurance industry has narrowed price and quality competition. In fact, in 2005, private insurance markets in 96 percent of metropolitan areas were considered highly concentrated and anti-competitive, which left consumers with little choice.[11] A public health insurance option, coupled with a more regulated private insurance market, would break the stranglehold that a handful of companies have on the insurance market and would give consumers enough choices to vote with their feet and change plans.

We also believe a public health insurance plan would be critical for driving quality improvements and more rational provider payments throughout the health care system. A public health insurance plan can introduce quality advancements and innovation that private insurance companies or private purchasers have proven themselves unable to implement. For example, until Medicare took the lead in reforms linking payment to performance on standardized quality measures, private insures and payers were not making appreciable headway towards a value-based health system. Just as Medicare is driving quality improvements that private plans are now adopting, a public health insurance plan could lead the way in developing innovative quality improvement methodologies, stronger value-based payment mechanisms, more substantial quality incentives, and more widespread evidence-based protocols.

Because increased competition and quality reforms would help contain costs throughout the health care system, employers that continue to provide benefits directly would benefit from these savings, as would employers that purchase coverage for their workers through the exchange. And because premiums would be lower, spending on federal subsidies for individuals who qualify for subsidies would also be lower.

A public health insurance plan would also guarantee that there will be a stable and high quality source of continuous coverage available to everyone throughout the country. By contrast, private insurance plans can change their benefits, alter cost-sharing, contract with different providers, move in and out of markets, and change benefit or provider networks. A public health insurance plan would be a reliable and necessary backstop to a changing private insurance market, and a safe harbor for working families that lose their workplace coverage.

A public health insurance plan available to everyone would also provide rural areas with the security of health benefits that are there when rural residents need them, just as Medicare has been a constant source of coverage as private Medicare Advantage and Part D plans churn in and out of rural areas every year.

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[11] American Medical Association. "Competition in Health Insurance: A Comprehensive Study of U.S. Markets." 2007. http://www.ama-assn.org/ama1/pub/upload/mm/368/compstudy_52006.pdf.

Clearly, the public supports a public health insurance plan option. A recent New York Times poll shows that the public health insurance plan is supported by 72 percent of voters.[12]

DELIVERY SYSTEM REFORM

Variation in Medicare spending across states suggests that up to 30 percent of health care costs could be saved without compromising health care outcomes. Differences in health care expenditures across countries suggest that health care expenditures could be lowered by 5 percent of GDP without compromising outcomes by reducing inefficiencies in the current system.

Experts estimate we waste one third of our health care spending, or $800 billion, every year on health care that is no real value to patients. According to the Council of Economic Advisers, the sources of inefficiency in the U.S. health care system include payment systems that reward medical inputs rather than outcomes, high administrative costs, and inadequate focus on disease prevention.[13]

We must restructure our health care system to achieve better quality and better value, and we must transform our delivery system into one that rewards better care, not just more care. We can start by doing the following:

- Measure and report on the quality of care, the comparative effectiveness of drugs and procedures, and what medical science shows to be best practices and use that information to create quality improvement tools that allow doctors to individualize high-quality care for each of their patients;
- Put technology in place to automate health care data; and
- Reform the way we pay for care so doctors have the financial incentives to continuously improve care for their patients.

The February 2009 economic recovery package, with its substantial investment in health information technology (HIT) and research on the comparative effectiveness of drugs and medical devices, marks an historic first step in the right direction.

The tri-committee discussion draft builds on the investments of the economic recovery package by encouraging greater emphasis on primary care and prevention, and greater emphasis on innovative delivery and payment models, such as accountable care organizations and bundled payments for acute and post-acute care. The draft also makes needed investments in our health care workforce—with emphasis on primary care—to ensure access to needed care and better reward primary care providers.

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[12] New York Times/CBS News Poll on Health. Telephone Interviews conducted June 12-16, 2009. Accessed: http://graphics8.nytimes.com/packages/images/nytint/docs/latest-new-york-times-cbs-news-poll-on-health/original.pdf.

[13] Council of Economic Advisors. "The Economic Case for Health Care Reform." June 2009. Accessed: http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf.

The tri-committee discussion draft emphasizes and invests in quality measurement and improvement methodologies. But we believe more can be done to foster innovation in health care delivery by building on the significant quality measurement and improvement underway within health care in recent years. The AFL-CIO has invested considerable resources and time working on system reform, as part of the broad collaboration of consumers, purchasers, physician organizations, hospitals, and government agencies at both the state and federal levels.

This strong collaboration between payers and providers has created breakthrough improvements in health care delivery. The process improvement techniques pioneered in other U.S. industries—for example, six sigma quality standards and rapid-cycle problem analysis, solution development and testing, and wide-spread diffusion in a short time period—have been shown to work and hold enormous promise, but federal leadership in delivery system reform is indispensable.

We must also put into place a system of broad consultation with consumers, purchasers, physicians, insurers and health care organizations in setting national priorities for health care quality improvement and in implementing standardized measures of quality throughout health care. With quality measurement as a foundation, reform can empower those who deliver care, pay for care, and oversee care to work with those who receive care to innovate and modernize health service delivery.

AFFORDABLE COVERAGE FOR EVERYONE

Today we have a fragmented health care system characterized by cost shifting and price distortions because as many as 50 million people have no coverage.

According to Families USA, the uninsured received $116 billion worth of care from hospitals, doctors, and other providers in 2008, about $42.7 billion of which was uncompensated care.[14] The costs for uncompensated care are shifted to insurers and then passed on to families and businesses in the form of higher premiums. For family health coverage, the additional annual premium due to uncompensated care was $1,017 in 2008.

While our members generally have employer-based health coverage, stabilizing the employer-based health system will require covering the uninsured to make health care more efficient and prevent cost-shifting. We cannot cover everyone without bringing down costs overall, and we cannot control costs without getting everyone in the system.

The good news is that, according to the Council of Economic Advisers, expanding health insurance coverage to the uninsured will increase net U.S. economic well-being

[14] Families USA. "Hidden Health Tax: Americans Pay a Premium." May 2009. Accessed: http://www.familiesusa.org/assets/pdfs/hidden-health-tax.pdf.

by roughly $100 billion per year, which is substantially more than the cost of insuring the uninsured.[15]

The most important policy proposal for extending health care coverage to the uninsured is "pay or play," which I discussed earlier in my testimony. But the tri-committee discussion draft includes several other proposals that would also expand health care coverage, including insurance market reforms, the establishment of an insurance market exchange, individual subsidies, the expansion of Medicaid, and improvements to Medicare.

Insurance market reforms

Ensuring access to health care coverage will require significant changes to the current private insurance market, in which people are now denied coverage or charged more because of their health status. Market reforms for everyone who buys coverage in the individual and group market will make coverage more fair, transparent, affordable, and secure.

The AFL-CIO fully supports the prohibition on rating based on health status, gender, and class of business; the prohibition on the imposition of pre-existing condition exclusions; guaranteed issue and renewal; and greater transparency and limits on plans' non-claims costs. While we would prefer a flat prohibition on rating based on age, we believe the proposal to limit age rating to 2 to 1 is a strong alternative. Any variation allowed above that limit threatens to make coverage unaffordable for older individuals.

Insurance market exchange

The AFL-CIO also strongly supports the proposal to create a national health insurance exchange to provide individuals and businesses with a place to enroll in plans that meet certain criteria on benefits, affordability, quality, and transparency. We believe this will be a mechanism for simplifying enrollment and applying uniform standards.

The tri-committee discussion draft establishes a mechanism that offers consumers a way to compare plans based on quality and cost. While the exchange will initially be open to individuals and small employers, we believe there should be a commitment to allowing public and private sector employers beyond the small group definition to purchase coverage through the exchange after the first two years that the exchange is operational.

Subsidies for low- and moderate-income workers

Subsidies will be essential for making coverage affordable for low- and moderate-income individuals and families. We support the proposal to make subsidies relative to

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[15] Council of Economic Advisors. "The Economic Case for Health Care Reform." June 2009. Accessed: http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf.

income, with more substantial subsidies applied to more comprehensive coverage for the lowest income enrollees. We also support ensuring that coverage is affordable by applying the subsidies to premiums as well as out of pocket costs.

Medicaid expansion

We strongly support extension of Medicaid coverage to all under 133 percent of poverty, with sufficient resources to states to offset the new costs.

Medicare improvements

In addition to eliminating subsidies that give private Medicare Advantage plans a competitive advantage over traditional Medicare and deplete the Trust Fund, the tri-committee discussion draft makes needed improvements in benefits for Medicare beneficiaries. The draft closes the gap in prescription drug coverage over time, eliminates cost sharing for preventive services, and improves the low-income subsidy program.

FINANCING HEALTH CARE REFORM

There are at least three key elements of health care reform that will also affect savings and revenues available for reform: a public health insurance option, delivery system reform, and an employer responsibility requirement. Though these policy proposals are absolutely necessary to improve the value we get for our health care spending, in the short run they will not be sufficient to fund reform.

The Senate Finance Committee has said that all savings and revenue for health reform must come from within the health care budget. However, because health care reform is an urgent national priority that will produce benefits across our economy and improve our national budget outlook, we agree with the President that we should look beyond health care spending to obtain additional revenues. We support the major elements of the President's budget proposal for the Health Reform Reserve Fund, including savings in Medicare and Medicaid, limiting the itemized deductions for households in the top two tax brackets, and other modifications to reduce the tax gap, as well as making the tax system fairer and more progressive.

One financing option under consideration in the Senate Finance Committee is a cap on the current tax exclusion for employer-provided health care benefits so that some portion of current health care benefits would be subject to taxes. We believe this is an extraordinarily bad idea.

Taxing benefits would disrupt the employer-based system

Capping the tax exclusion would undermine efforts to stabilize the employer-provided health care system. Employers would likely respond by increasing employee cost-sharing to a level at which benefits would become unaffordable for low-wage workers,

or by eliminating benefits altogether. Capping the exclusion would also encourage workers to seek coverage outside their ESI group when this is economically advantageous, thereby complicating the role of employers enormously and giving them another incentive to discontinue coverage.

Congress and the President have assured Americans that they will be able to keep the health care coverage they have if they like it. This approach makes enormous sense and generates broad public support. A cap on the tax exclusion would violate this basic understanding and threaten to disrupt the primary source of health care coverage and financing for most Americans.

Until health care reform has been proven successful in lowering costs and making coverage available to uninsured workers through new private and public plan options, we should not make any changes that threaten the source of health care coverage for 160 million Americans.

Taxing benefits would be unfair to high cost workers

The Senate Finance Committee is considering capping the tax exclusion for relatively high cost plans. This would be an unfair tax on workers whose benefits cost more for reasons beyond their control.

The exact same plan could cost well under $15,000 in one company and more than $20,000 in another depending on factors that have nothing to do with the generosity of coverage. According to one study, premiums for the same health benefits can more than double when an individual crosses state lines.[16]

The cost of coverage can be the reflection of many factors: the size of the firm; the demographics of the workforce; the health status of the covered workers and families; whether the industry is considered by insurers to be "high risk"; geographic differences in cost; and whether there are pre-Medicare retirees covered through the same plan. Studies show that placing a cap on tax-free benefits would have the greatest impact on workers in small firms; firms with older workers and retirees, and workers with family plans that cover children. This is because insurance companies regularly charge higher rates for coverage for these workers.

Under one proposal, over 41 percent of workers at a firm with older workers would be taxed on their health care benefits, but only 16 percent of workers at a firm with younger workers would be taxed. Almost 30 percent of workers at a smaller firm would be taxed, but only 17 percent of workers at a larger firm. Over 41 percent of workers with family

[16] Stan Dorn, "Capping the Tax Exclusion of Employer-Sponsored Health Insurance: Is Equity Feasible," Urban Institute. June 2009. Accessed: http://www.urban.org/UploadedPDF/411894_cappingthetaxexclusion.pdf.

coverage would be taxed, but less than 20 percent of workers with individual coverage.[17]

If workers have to pay more taxes because some of their co-workers have costly medical conditions, health coverage would be transformed from a workplace benefit that everyone supports to one that splits workforces between the healthy and the sick.

Some argue that the existing tax exclusion is regressive, because higher income workers get a bigger tax advantage. But this is only one part of the story.

A recent report points out that while households in higher tax brackets get a greater benefit from the tax exclusion in absolute dollar amounts, low and moderate income workers would be impacted more from capping the exclusion because their taxes would increase by a larger share than those of higher income workers. The report found that workers with employer-provided health benefits who make between $40,000 and $50,000 would see their tax liability increase on average 28 percent, while those who make between $50,000 and $75,000 would see their tax liability increase on average 20 percent. By contrast, workers who make more than $200,000 would see an average increase in their tax liability of only one tenth of one percent. In short, capping the tax exclusion would not make it more progressive.[18]

Taxing health care benefits would not bring down health care costs, either. It would just shift more of those costs onto workers. Economists say the tax exclusion leads workers to get too much coverage, but capping the tax exclusion would not do anything to address a key cost driver: the fact that 20 percent of the population consumes 80 percent of our health care spending. Taxing health benefits would not change that fact.

CONCLUSION

The AFL-CIO applauds the work of the committees in outlining a strong, effective, comprehensive plan for guaranteeing quality affordable health care for all. We believe the tri-committee discussion draft would stabilize the employer-based health insurance system by simultaneously achieving the goals of lowering costs, covering everyone, and improving quality. We stand ready to work with all three committees to enact reform that achieves these goals. America's working families can wait no longer.

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[17] Elise Gould. "How Capping the Tax Exclusion May Disproportionately Burden Children & Families." Economic Policy Institute and First Focus. May 2009. Accessed: http://www.firstfocus.net/Download/GOULD.pdf.

[18] Commonwealth Fund. "Progressive or Regressive: A Second Look at the Tax Exemption for Employer-Sponsored Health Insurance Premiums." May 2009. Accessed: http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/May/Progressive%20or%20Regressive%20A%20Second%20Look%20at%20the%20Tax%20Exemption/PDF_1269_Schoen_progressive_or_regressive_ESI.pdf.