Statement for the Record

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Senate Committee on Finance
Roundtable on Financing Health Care Reform

Good morning, Chairman Baucus, Ranking Member Grassley and members of the Committee. I am Steve Wojcik, Vice-President of Public Policy for the National Business Group on Health, a member organization of 300, mostly large employers—including 64 of the Fortune 100—that provide coverage to more than 55 million U.S. employees, their families, and retirees. The National Business Group on Health is devoted exclusively to finding innovative and forward-thinking solutions for large employers' and our nation's most important health care and related benefits issues. Thank you for the opportunity to participate in today's roundtable to share our organization's views on health reform generally, and financing health reform in particular.

Health care in the United States is very expensive and, although we have some of the best health care in the world, too often we have uneven, inadequate and unsafe care. At the same time, millions of people cannot afford health coverage. The strains caused by all three of these problems increasingly call into question the sustainability of the status quo.

The per employee cost for health care averaged $9,144 in 2008.[1] Compared to just seven to eight years ago, employers are paying 100% more for health care and people who purchase insurance on their own have seen even greater price increases. As a result, it is increasingly difficult for employers to provide affordable health benefits to employees, for employees to pay their cost sharing, and for people without employer-sponsored coverage to purchase insurance.

Although the rate of increase in health care costs has slowed in recent years, increases are still well above the overall level of inflation and the lower percentage is on top of an ever rising base. American employees have been giving most or all of their pay raises to health care for the past eight years. Rising health care expenses contribute significantly to stagnating wages, leaving consumers with less money for food, housing, education and other goods and services. High costs are also making it more difficult for American companies and American workers to compete in the increasingly global economy. With national health expenditures exceeding $2.5 trillion, a projected 17.6% of the gross domestic product (GDP) in 2009, and estimated to be over $4 trillion dollars in 2018, (20.3% of GDP)[2], the problem is not just that the country spends too much on health care. The United States spends much more on health care per person than any other country in the world, including other countries with high standards of living, and the price tag makes many American goods and services relatively more expensive than those produced in other countries.

The National Business Group on Health believes that the degree to which we can expand access to health care services depends greatly on our ability to achieve greater affordability, value, quality and safety in health care. Health care costs cannot be contained if we continue to provide and pay for large amounts of inappropriate and poor quality care. An effective, workable health

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[1] Towers Perrin. 2008 Health Care Cost Survey. January 2008. Available at: http://www.towersperrin.com/tp/getwebcachedoc?webc=HRS/USA/2008/200801/hccs_2008.pdf

[2] Centers for Medicare and Medicaid Services. Office of the Actuary. National Health Statistics Group. 2008 Available at: http://www.cms.hhs.gov/NationalHealthExpendData/
(Historical data from NHE summary including share of GDP, CY 1960-2007, file nhegdp07.zip; Projected data from NHE Projections 2008-2018, Forecast summary and selected tables, file proj2008.pdf).

reform must successfully address the interrelationships among costs, quality and access. We applaud your leadership and this Committee's wisdom in holding these roundtables, each of which addresses one of these three interconnected aspects of health reform.

The financial crisis and subsequent economic recession has made it even more imperative that we waste less and produce more real value for what we spend on health care. Virtually all experts agree that, with a few notable exceptions, health care in the United States is inefficient, with enough genuine waste to produce real savings. **The Office of Management and Budget (OMB) Director Peter Orszag recently testified that "health care costs could be reduced by a stunning 30 percent—or about $700 billion a year**—without harming quality if we moved as a nation toward the proven and successful practices adopted by lower-cost areas and hospitals."[3] **That amounts to $15,000 per uninsured person—more than enough to pay for their health coverage.**

The National Business Group on Health believes that, to achieve a lasting and workable health reform, we must improve efficiency, reduce costs and improve the quality and safety of health care delivery. Without them, any expansion of coverage will only be temporary and exacerbate cost problems. The following elements are critical to effective and efficient health care delivery:

— **A culture of quality and patient safety,**
— **Payment systems that reward outcomes not just utilization,**
— **Payment systems that support primary care and care coordination,**
— **Transparency of health care price and quality information,**
— **Comparative effectiveness research of health care interventions,**
— **Evidence-based medicine wherever possible,**
— **A secure, nationwide electronic health information network,**
— **Portable, personal health records for all,**
— **A focus on prevention and primary care,**
— **Capital spending only where truly needed,**
— **Personal responsibility for health and engagement in care decisions, and**
— **Reform of the health care legal system.**

Stakeholders agree on so many matters, such as the critical importance of health information technology, better information and more transparency; patient safety and quality; a focus on wellness, primary care, care coordination and prevention; a reduction in obesity; elimination of health care disparities;, and the need to *reduce* the costs of health care, not just moderate the rate of growth. We must seize this opportunity for workable, lasting health reform so that we all can enjoy affordable, high quality care efficiently delivered.

In addition to our strong belief that workable, sustainable health reform must simultaneously address the cost and quality challenges as we expand access to coverage and care, our toolkit on

[3] Orszag, Peter. Testimony of the Director of the Office of Management and Budget before the Committee on the Budget. U.S. House of Representatives. March 3, 2009. Available at: http://budget.house.gov/hearings/2009/03.03.2009_Orszag_Testimony.pdf

the "Imperative for Health Reform," released in early 2008, also emphasizes the importance of the following:

- Every Adult Should Be Required to Have Health Coverage for Themselves and Their Dependent Children.

  The following conditions are needed to make this possible: A strong health care safety net and public programs such as Medicaid and SCHIP that provide effective and efficient care will be a critical part of the solution and should provide high quality care to those with little or no income who cannot afford coverage.

  People under age 65 should have access to a range of coverage choices through employers, the federal or state governments, insurers, or other pooling arrangements that includes at least one option with a core benefits package that includes essential evidence-based preventive, primary, prenatal, maternity, urgent and emergent care, chronic condition management, care coordination, and hospitalization insurance.

- Oppose Mandates Requiring Employers to Either Offer Health Coverage or Pay the Government

  States and the federal government should be working with health plans, employers and other stakeholders to develop, offer, and promote low cost, voluntary programs (including health insurance exchanges, new pooling arrangements, and the ability to purchase coverage approved in other states) to cover working families who have low or moderate incomes, and programs to assist small employers in offering health coverage to their employees.

- Support the Federal Framework of ERISA for Employer-Sponsored Health Benefits

  Employers must continue to have the flexibility to determine the types of benefits they offer and to tailor benefit plans to the specific needs of their employees and the circumstances of their companies.

- Maintain the Current Favorable Tax Treatment of Employer-Sponsored Coverage and Level the Playing Field for Individually-Purchased Insurance

As requested, this statement will highlight both the key role of the current tax treatment of employer-sponsored health coverage in assuring coverage for so many Americans and identify some areas to improve efficiency and reduce waste to help finance health care reform.

THE IMPORTANCE OF THE TAX EXCLUSION TO EMPLOYEES AND EMPLOYER-SPONSORED COVERAGE

As you know, today, employers are the principal source of health coverage for non-elderly people in the United States, voluntarily providing health benefits to about 161 million

Americans.[4] More than 60 percent of the population under age 65 is currently covered by employment-based plans.[5] The decision to provide health coverage, the level and scope of benefits, and the amount of money that employers contribute to employees' health care depend on a number of factors including the importance of employee health and productivity; the needs and preferences of employers' workforces; its use as a recruiting tool to attract and retain the best talent; labor market conditions; economic conditions; company growth and profitability; the relative cost of health and other benefits; and the tax advantages, which play a very important role.

As sponsors of health plans, employers currently use their flexibility, under the Employee Retirement and Security Act (ERISA), to innovate and close the gap between the quality of care that we have and the quality of care that we should have and need. Many employers develop and implement strategies aimed at improving the quality and value of the health care for employees.

Current tax rules permit employers to deduct their contributions for employees' health care from corporate income just as they deduct employees' wages and salaries as ordinary business expenses. Simultaneously, employees can exclude the value of these contributions from their income for tax purposes. They can also use pre-tax dollars to pay for their share of health premiums and often use pre-tax dollars for their out-of-pocket health expenses through flexible spending accounts (FSAs), other health accounts, and cafeteria plans offered by their employers.

For a long time, the Federal government has consciously used this favorable tax policy to encourage health coverage and the current favorable tax treatment of employer-sponsored coverage is a key reason that so many families have affordable coverage. This policy helps employers provide more comprehensive health benefits at a lower cost to employees and their dependents. **In the context of health reform and the push to expand coverage, it seems counterproductive and incongruous to talk about taxing the source of coverage for the majority of non-elderly Americans, making it more expensive for them and potentially jeopardizing their coverage. Though some may believe that this is an easy way to "finance" reform and "bend the cost curve," it does nothing to solve the crisis of affordability in the long-run and sidesteps the hard payment and delivery reforms that would create lasting, workable reform.**

- **Tax Advantages Help Make Health Care More Affordable for Employees**

For some employees, the tax advantages make the difference between taking up their employers' coverage and declining it because it is too expensive. Younger, healthier employees elect to participate in employer-sponsored coverage because the personal tax exclusion for benefits, along with their employers' tax-deductible contribution, makes the coverage more affordable. Many are at the lower income levels when just beginning their families and careers; their first priority is typically net pay. These employees frequently do not have an immediate expectation of requiring health care and in fact may only occasionally utilize the coverage. They participate

[4] Fronstein, Paul and Dallas Salisbury. Health Insurance and Taxes: Can Changing the Tax Treatment of Health Insurance Fix Our Health Care System? EBRI. September 2007.
[5] Ibid.

primarily because health care benefits are so heavily subsidized by employers and there are no adverse personal tax consequences.

- **Employees Value Employer-Sponsored Coverage**

Employees and job candidates expect and value health benefits as a key part of their employment and compensation. A soon-to-be-released survey of over 1,500 employees in March 2009, commissioned by the National Business Group on Health, found that 75 percent of employees considered their employment-based health plan their most important benefit and 83 percent would rather see their salary or retirement benefit reduced over their health benefit. About three out of four employees (75 percent) who responded to the survey said they would prefer to continue obtaining health benefits through their employer rather than receiving additional salary to purchase benefits on their own.[6]

Other surveys have found similar results about the value that employees place on their health benefits. A recent Kaiser Family Foundation Health Tracking Poll found that when people who are currently covered through their employers were asked for their initial reactions to buying health insurance on their own, 63 percent said it would be harder to find a plan that matches their needs as well; 64 percent said they would find it harder to handle administrative issues such as filing a claim or signing up for a policy; 80 percent said they would find it harder to keep health insurance if they were sick and 81 percent said they would find it harder to get a good price for health insurance.[7]

- **A Majority of Employees Oppose Taxing Employer Health Care Contributions**

A 2007 survey of over 1,600 employees with employer-sponsored coverage, conducted by Matthew Greenwald & Associates for the Business Group, found that **the majority of the employees, 57 percent, oppose treating employers' contributions to health plan premiums as taxable income, while only 30 percent favored this change.[8]**

- **Taxing Employees' Health Benefits Will Increase the Uninsured**

Many families would simply find health coverage unaffordable, particularly in these economic times, if they were taxed on their employers' portion of their health care costs and/or they were unable to use pre-tax dollars to pay their premiums and out-of-pocket expenses under employer-sponsored plans. Removing this ability and/or imposing a tax burden on them for their employers' contribution toward their health care plan costs would result in a significant number of employees simply discontinuing their coverage, causing an increase in adverse-selection in employers' plans, a decrease in their ability to cross-subsidize, and subsequent cutbacks in health care benefits offered.

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[6] Greenwald, Matthew and Associates. National Business Group on Health Employer-Based Health Benefits Survey. April 2007.
[7] Kaiser Family Foundation. Kaiser Health Tracking Poll: Election 2008. Conducted June 3-8, 2008. Available at: http://www.kff.org/pullingittogether/062608_altman.cfm
[8] Greenwald, Matthew and Associates. National Business Group on Health Employer-Based Health Benefits Survey. April 2007.

The favorable tax status of employer-sponsored coverage plays an important role in keeping employer risk pools intact so they are able to cover people of every age group and health status. Depending on the industry and labor market conditions, some employers who continue to offer health care at the same level could see increased labor costs as they are pressured to compensate employees for their higher tax payments.

Studies by the Urban Institute-Brookings Tax Policy Center and the National Bureau of Economic Research (NBER) estimated that eliminating the tax exclusion of employer health care contributions from income and payroll taxes would reduce employer health benefit offerings by 17 to 30 percent, and would decrease employer premium shares for those who continue to offer coverage by 30 to 42 percent.[9] The study by the NBER also found that smaller employers would be more likely to stop offering coverage if the tax exclusion were eliminated and larger employers would be more likely to cut back on the amount they subsidize, both of which would increase the number of the uninsured substantially. **Another study estimated that the total number of employees offered health insurance would drop by 15.5 percent if all of the exclusions were repealed and by 9.7 percent if the income tax exclusion were repealed, but the payroll and state tax exclusions remained.[10]**

IMPROVEMENTS IN QUALITY, REDUCTIONS IN WASTE AND INCREASES IN EFFICIENCIES TO PRODUCE SAVINGS IN HEALTH CARE DELIVERY

- **Use Health Information Technology to Identify Waste in Health Care**

The National Business Group on Health and the business community believe that it is critical to target the unprecedented level of federal funds for health information technology (HIT) in the American Recovery and Reinvestment Act (ARRA) to physicians, hospitals, and other health care providers who demonstrate that they will use it to improve the effectiveness and efficiency of care. Helen Darling, President of the National Business Group on Health, recently submitted testimony to the National Committee on Vital and Health Statistics on the "meaningful use" of HIT, which would eliminate waste in current health care delivery.[11]

As you know, studies at The Dartmouth Institute have shown significant variation in health care spending between regions of the United States with no difference in outcomes, only 40 percent of which can be attributed to different rates of illness and price[12]. The remaining variation can be explained in part by practice variations that have little or nothing to do with evidence-based medicine, but rather with local medical opinion and local supply of medical resources, regardless of whether such care is warranted. **This "over spending" is substantial and one report indicates that Medicare spending would decrease by 30 percent (approximately $133 billion based on OMB Fiscal Year 2009 historical spending tables) if spending in medium- and**

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[9] Burman, Leanord. Et al. Tax Incentives for Health Insurance. Discussion Paper 12. The Urban-Brookings Tax Policy Center. May 2003.: Gruber, Jonathan, and Michael Lettau. How Elastic Is the Firm's Demand for Health Insurance? NBER Working Paper 8021. National Bureau of Economic Research. 2000.

[10] Gruber. Jonathan and Michael Lettau. "How elastic is the firm's demand for health insurance?"Journal of Public Economics. Vol. 88. 2004. Pages. 1273-1293.

[11] Darling, Helen. Testimony to the National Committee for Vital Health Statistics on the "Meaningful Use" of Health Information Technology. April, 28, 2009. Available at: http://www.businessgrouphealth.org/pdfs/TEST%20HIT%20Testimony%20to%20the%20NCVHS%20Final%20%20-%2042809.pdf

[12] Fisher, Elliot. Et. al. The Implications of Regional Variations in Medicare Spending. Part 1, Part 2: Health Outcomes and Satisfaction with Care. Annals of Internal Medicine. 2003. 138. Pages 273-298.

high-spending regions fell to the level of that in low-spending regions.[13] An interoperable HIT system could quickly identify and target areas of over spending and reduce unnecessary costs and produce savings.

Recently, a study by the National Priorities Partnership (NPP)—a collaborative effort of 28 major national organizations that collectively influence every part of the heath care system—concluded that a significant portion of care is actually redundant and unwarranted—and, in some cases, even harmful.[14] An interoperable HIT system could also effectively focus on the 8 areas of waste, overuse or harm identified by the NPP including inappropriate medication use, unnecessary laboratory tests, unwarranted maternity care interventions, unwarranted diagnostic procedures, inappropriate non-palliative services at the end of life, unwarranted procedures and consultations, preventable emergency department visits and hospitalizations, and potentially harmful preventive services that have no benefit. Providers could use this information to eliminate waste and produce savings that could be used to finance needed care such as primary care and care coordination.

- **Increase the Use of Evidence-Based Care**

Increasing the use of evidence-based care will also produce savings that could be used to finance health reform by eliminating duplicative, unnecessary and potentially harmful care. Objective evidence is needed to support national and regional decisions about Medicare coverage, development of practice guidelines and performance measures, design of value-based insurance plans, and informed patient and clinician decision making about treatment alternatives. Critical gaps in evidence are widespread for both new and existing technologies and services. A prominent and tragic example was the use of autologous bone marrow transplant/high-dose chemotherapy (ABMT/HDC) to treat metastatic breast cancer. Rigorous trials performed in the 1990s showed that contrary to the preliminary findings from the late 1980s, conventional therapy is superior to ABMT/HDC. By then, some 30,000 women had already been unnecessarily subjected to AMBT/HDC, and an estimated 600 women died prematurely as a result.

The Institute of Medicine (IOM) has set a goal that, by 2020, 90 percent of clinical decisions should be supported by accurate, timely, up-to-date clinical information. The additional $1.1 billion in funding in the economic recovery package for comparative effectiveness research that will be conducted by the Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health will produce additional savings so that instead of more care, we start paying for the right care, for patients at the right time.

- **Improve Patient Safety**

Billions of dollars in savings are available to finance reform of our nation's health care system by simply improving patient safety and the quality of care.

[13] Congressional Budget Office (CBO), Geographic Variation in Health Care Spending, 2008. CBO. February 2008. Available at: www.cbo.gov/doc.cfm?index=8972 : Wennberg, John E.. Et. al. Geography and the Debate Over Medicare Reform. Health Affairs. Web exclusives. February 13, 2002. Pages W96–W114. Available at: http://content.healthaffairs.org/cgi/content/full/hlthaff.w2.96v1/DC1
[14] National Priorities Partnership. National Priorities and Goals. National Quality Forum. November 2008. Available at: http://nationalprioritiespartnership.org/uploadedFiles/NPP/08-253-NQF%20ReportLo[6].pdf

AHRQ recently released a report that patient safety measures have worsened by nearly 1 percent each year for the past 6 years and that one in seven hospitalized Medicare patients experience one or more adverse events.[15] This lack of progress on improving patient safety measures is unacceptable.

Approximately 1.7 million healthcare-associated infections (HAIs) occur annually in U.S. hospitals and are responsible for nearly 99,000 deaths; patients who survive them frequently have longer and more expensive hospital stays and longer recovery times.[16] Expanding Medicare's National Coverage Determination and non-payment policy for "never events" to HAIs could produce significant health care savings and reduce the additional costs when patients contract deadly and expensive infections.

- **Implement Pay-for-Performance**

Too often, payment under Medicare, the federal government and throughout the health care system in the U.S. is made without regard to whether services are needed or are performed well. We need to pay for value, not volume. As stated earlier, up to 30 percent of Medicare spending may be for excessive and unnecessary care.[17]

Medicare claims data from 2003-2004, suggest that the U.S. needs better discharge planning, patient education, and payment methods that provide hospitals incentives to discharge healthier, better-informed patients—which could save up to $17.4 billion spent annually by Medicare for unplanned rehospitalizations.[18] Another study by AHRQ found that reducing preventable hospitalizations by only 5 percent for ambulatory care-sensitive conditions could result in savings of more than $1.3 billion.[19]

While payment is tied to quality or performance in most other industries, in health care, including in Medicare and the federal government, the opposite tends to happen—we end up paying more for poor service and the additional health care needed to "correct" poor quality. Fortunately, Medicare is beginning to reverse this tendency in its recent National Coverage Determinations and by not paying the additional costs for so-called "never events." We encourage CMS to go farther, faster in rationalizing payment in Medicare.

Mr. Chairman, thank you and the Committee for this opportunity to share the National Business Group on Health's perspective on the financing of health care and the essential importance of effective, efficient health care delivery that will produce more than enough savings to create sustainable health care reform that covers all Americans. Changing the tax status of employer-sponsored coverage would only increase health care costs for 161 million employees and their families and would not address the inefficiencies and poor quality that are too costly for our nation to afford any longer. We understand the challenge that you—and we all—face. Only by

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[15] Agency for Health Research and Quality (AHRQ). National Healthcare Quality Report. Publication No. 09-0001. Page 8. March 2009. Available at: http://www.ahrq.gov/qual/nhqr08/nhqr08.pdf

[16] Klevens RM. Et al. Estimating health care-associated infections and deaths in U.S. hospitals, 2002. Public Health Report, 2007.

[17] Fisher, Elliot. Et. al. The Implications of Regional Variations in Medicare Spending. Part 1, Part 2: Health Outcomes and Satisfaction with Care. Annals of Internal Medicine. 2003. 138. Pages 273-298.

[18] Jencks, Stephen. Rehospitalizations among Patients in the Medicare Fee-for-Service Program. New England Journal of Medicine. April 2009.

[19] AHRQ. Preventable Hospitalizations: Window into Primary and Preventive Care. AHRQ. 2000.

restructuring the way we pay for and deliver care will we “bend the curve” and keep health care spending sustainable for the long-term. We look forward to continue working with you on this most important endeavor that is essential for our future health and economic well-being.